PRISONS AND PROBATION OMBUDSMAN
for England and Wales

Independent Investigations

PRISONS AND PROBATION OMBUDSMAN
ANNUAL REPORT
2011 – 2012

Prisons and Probation Ombudsman for England and Wales

Annual Report 2011–2012

Presented to Parliament
by the Lord Chancellor and Secretary of State for Justice
by Command of Her Majesty

September 2012

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Vision

To be a leading, independent investigatory body, a model to others, that makes a significant contribution to safer, fairer custody and offender supervision.

Values

- We are **independent, impartial, fair and honest** in all our dealings, internally and externally.
- We **take pride in delivering** both quality and value for money.
- We have **respect for**, listen to and respond to each other, the users of our service and wider stakeholders.
- We **celebrate diversity**, both internally and externally, so that everyone can give their best.
- We approach our work with **determination, dedication and integrity**.
- We are **committed to improvement** through learning lessons internally and influencing how lessons are learned externally.

FROM INSPECTOR TO INVESTIGATOR

In September 2011, I took up the daunting challenge of becoming the Prisons and Probation Ombudsman for England and Wales after nearly nine years as Deputy Chief Inspector of Prisons. This was a great honour and I have been hugely excited by the role and the opportunity to contribute to the development of the office and its important work.

A clear vision in challenging times

So what of the early ambitions for my tenure? To begin with, I am pleased to have inherited a committed and value driven organisation. To reinforce these strengths, one of my first steps has been to ask my staff to revisit our vision and values. The new vision emphasises our independence and the desire to make a significant contribution to safer, fairer custody and offender supervision. The values will drive our behaviours, including our absolute commitment to equality and diversity, both internally and in the agencies we investigate.

Another change of emphasis has been to place greater focus on identifying where we can learn from investigations and improve dissemination of that learning, so that services are encouraged to improve. This search for improvement is integral to the new vision: investigation is what we do, but I want us also to contribute to change. Put simply, if I can help the agencies I investigate to learn the lessons from investigations, this will help avoid the next complaint by remedying the issue at source and helping to prevent avoidable deaths by contributing to safer custody and safer approved premises.

More pragmatically, in these austere times, I have also had to focus on how to sustain and protect the strengths of my office. Unfortunately, as with all public services, considerable efficiencies are being required of me (my budget allocation reduced by 7% this year and it has been indicated that it will reduce overall by some 21% between 2010–11 and 2014–15). This is entirely to be expected but my office's work is demand led and this demand continues to grow: 2011–12 saw a sharp increase in the number of deaths we were required to investigate and there was no let up in the number of complaints.

A tragic rise in deaths in custody

We started 229 investigations into deaths in prison, immigration detention and probation service approved premises in 2011–12. This is the highest annual figure since we took on this onerous responsibility in 2004 and a 15% rise on the previous year. Even among so many tragedies, some stand out: for example the year saw three apparently self-inflicted deaths of children in custody, the first such deaths in over three years. These are deeply troubling figures.

The majority of deaths investigated were from natural causes: 142 deaths, a rise of 20 from the previous year. This continues an upward trend over recent years which may, in particular, reflect the fact that more prisoners now serve longer sentences, more prisoners are sentenced later in life and some prisoners display significant health deficits. This has led to an aging and ailing population. In consequence, the past decade has seen deaths from natural causes replace self-inflicted deaths as the principal cause of death in custody.

Unfortunately, the number of apparently self-inflicted deaths also rose to 71, 13 more than the previous year and a reversal of the downward trend seen in recent years. This rise in apparently self-inflicted deaths is particularly worrying, reflecting as it does the chronic despair of the individuals concerned, but it is also troubling that prisons, in particular, are now having to care for increasing numbers of people who are growing old and dying of natural causes in their care.

Each death, of whatever cause, is a matter of immense sadness to family and friends and a cause for reflection in our investigations about what more could have been done to prevent an unnecessary death or provide better care for the dying. Spotting potential trends and seeking to learn lessons is therefore important. For example, we saw the apparent growth in the number of cases where the deceased was undergoing methadone treatment and had also been taking other drugs, either licit or illicit. I raised my concerns, and those of a number of coroners with the Chief Executive of the National Offender Management Service (NOMS) and I am pleased he took the matter seriously and launched his own inquiry – this is an encouraging example of how important it is to look at investigations collectively, how lessons emerge and how important the dissemination of findings can be.

No let up in numbers of complaints

There has been no lessening of demand for the other principal part of my remit: the independent investigation of complaints. This is to be expected with the prison population at an all time high. For reasons which remain unclear, there was a drop in the numbers of complaints from those under supervision by the probation service.

Overall, the total number of complaints received, at around 5,300, was very similar to last year. However, as we began 4% more investigations than in the previous year, we recorded a significant rise in substantive casework. Frustratingly for complainants and, in some ways, wasteful of my office's time, around half the complaints received were found to be ineligible under my terms of reference. This was mainly because the internal complaints process of the services concerned had not been exhausted and this is something I am addressing with a new communications strategy.

With the prison population as it is, there is no reason to suppose that this large volume of investigations will not be sustained. It is also entirely feasible that, as greater efficiencies are required of the agencies I investigate, so further increases in demand will feed through to this office. At its simplest, if regimes and services have to be trimmed, detainees and probationers may have more to complain about. Similarly, cost saving exercises within the services in remit may have unintended consequences. For example, the internal complaints system in prisons has been streamlined from April 2012 and this may push more complaints through to me more quickly. I will monitor the impact of such changes carefully.

Rising to the challenges

I am convinced that my staff will rise to these challenges and I am committed to ensuring that the combination of decreasing resources and increasing demand will not be allowed to become an excuse for poor performance. My office must strive to improve the quality of its service wherever it can and with whatever resources it has – and I recognise that there is some way to go to deliver the quality of service to which I aspire.

Timeliness of investigations, particularly into fatal incidents, needs to improve. In 2010–11, only 14% of draft reports into self-inflicted deaths and 16% of those into natural cause deaths were produced within our time targets. There was some improvement in 2011–12, but still only 22% of the former and 24% of the latter were within target. Much of this delay is outside my control. In particular, I am obliged by my terms of reference to always have a review by clinicians of the quality of healthcare provided to those who have died in custody. These reviews are commissioned by Primary Care Trusts (PCTs).[1] Unfortunately, too often they are late which impacts on the timeliness of my own reports. A lot of effort has gone into trying to improve the quality and timeliness of clinical reviews. I am particularly pleased that Ministers and senior officials in the Ministry of Justice have sought assistance on the issue from their Department of Health counterparts. Inevitably, the problem is a low priority for the National Health Service but new national commissioning arrangements for offender health from April 2013 may offer a way forward. Meanwhile, I and my staff will

[1] In Wales, clinical reviews are conducted by the independent Healthcare Inspectorate Wales.

redouble our efforts to improve performance, as delays hinder bereaved families gaining a measure of closure from our investigations and add to delays in the inquest system.

More for less

So I must deliver more for less. Already a range of internal reforms are underway, including work to create the organisational design I need and can afford, work to re-engineer casework processes, and the introduction of greater prioritisation and proportionality into our investigations.

Proportionality means targeting our resources more effectively. I need to ensure we do a first class job in our most serious cases where there is most to put right and most to learn. One size of investigation cannot fit all, and we will continue to decline to investigate where no worthwhile outcome can be achieved or no substantial issue is at stake. We will also ensure that we respond proportionately to prolific complainants so that resources are spread as equitably as possible. In every case, however, fairness and protection of complainants will remain the touchstone: I recognise that small things can mean a lot to a prisoner with little.

I am also introducing greater proportionality into fatal incident investigations and reports, particularly where there are likely to be fewer lessons to be learned, such as when death from natural causes is reasonably foreseeable and greater standardisation, brevity and expedition should be expected. In this way, we will be able to direct more resources to where our findings can have most impact while always remaining sensitive to the needs of bereaved families in all our investigations.

Maintaining independence

I hope that my lengthy time in the Inspectorate of Prisons has eased my transition into my new role as Prisons and Probation Ombudsman. There is much that is similar between the two offices: both are robustly independent and respected bodies which report without fear or favour. As a result, they both carry out crucial work to support fairness and safety in the criminal justice system, and offer a means to reassure the public about the appropriateness of what happens in custody in their name.

However, there are differences, not least constitutional. The Chief Inspector is a Crown appointment and a creature of statute. My role is not on a statutory footing, although I was recruited in line with the public appointment process, confirmed by a Parliamentary Select Committee with written guarantees of operational independence. Nor do I have the legally enforceable powers of access or interview of some equivalent bodies, although I am pleased that my terms of reference ensure this is more of a presentational issue than a substantive one.

It has been argued that this lack of a statutory basis weakens the visible independence of my office and I ignore these criticisms at my peril. Indeed, the Justice Select Committee, when endorsing my appointment, called on the Government to 'proceed to put the Ombudsman on a statutory basis at an early opportunity'.[2] I am pleased that the Secretary of State for Justice has confirmed that he remains committed to reinforcing my independence, although no legislative slot has yet been found. Meanwhile, I will continue to ensure that my office remains robustly independent of the services I investigate and the departments responsible for them – anything less would be to diminish the role.

Nigel Newcomen

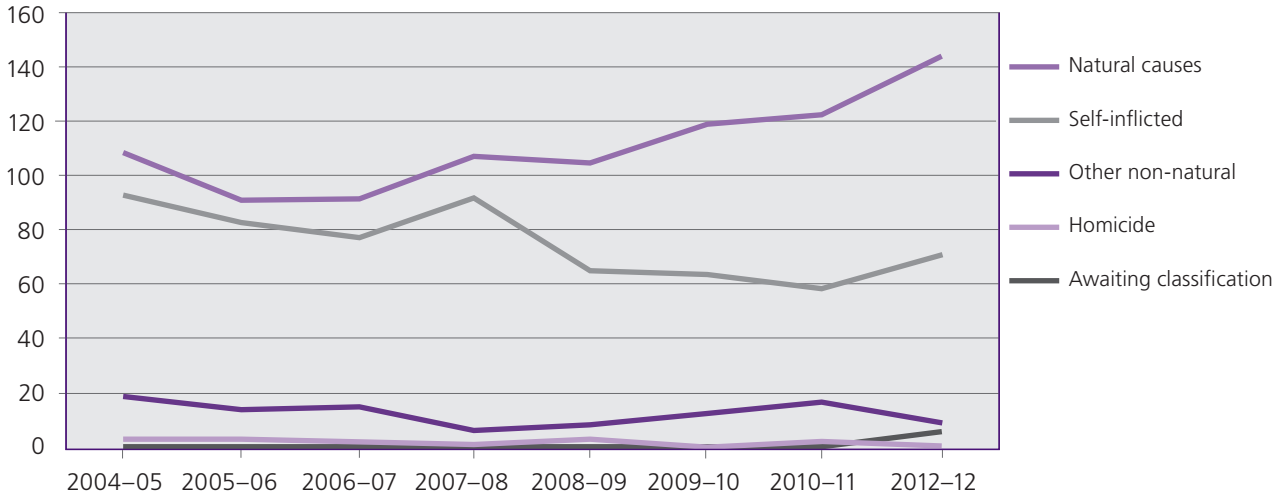
[2] House of Commons Justice Committee, Appointment of the Prisons and Probation Ombudsman for England and Wales, *Fourth Report of Session 2010–12*, 17 May 2011.

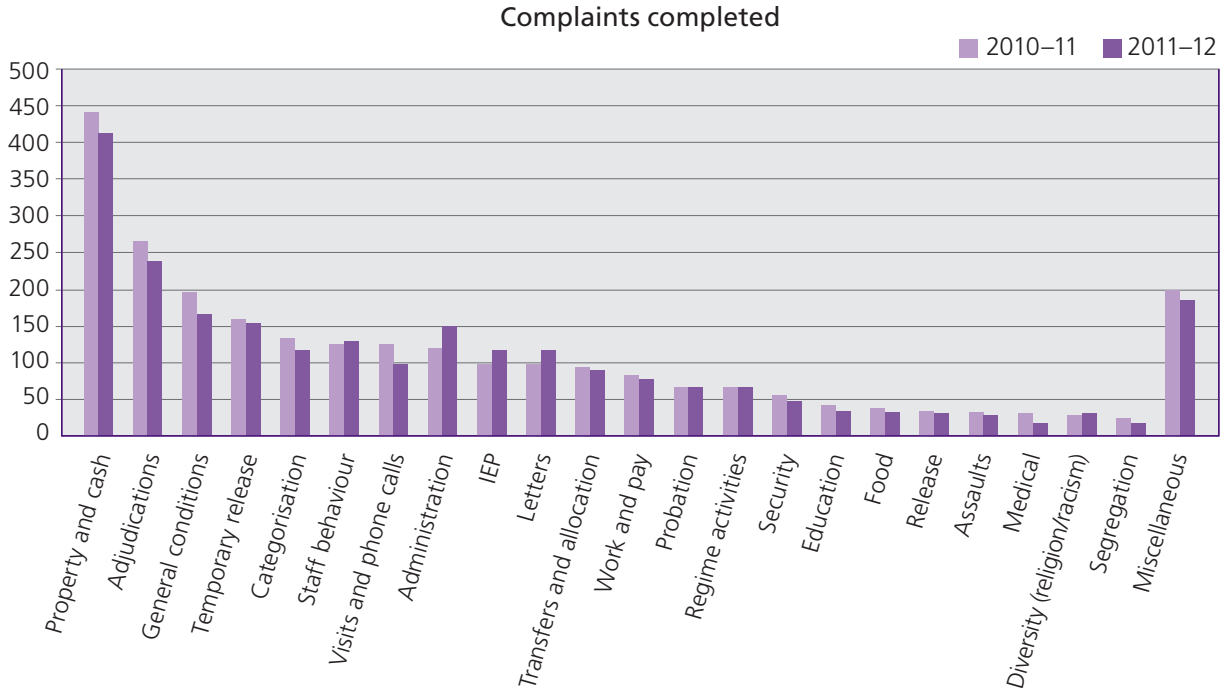
THE YEAR IN FIGURES

Fatal incidents

- **229** investigations into fatal incidents were started this year, an increase of **15%** compared to last year – the highest annual figure since we took on this work in 2004.
- **142** deaths were from natural causes – **20** more than last year – continuing the upward trend of recent years.
- **71** were apparently self-inflicted – **13** more than last year – reversing the downward trend of the last few years.
- **9** were from some other non-natural cause, mostly drug-related.
- **1** was homicide and **6** cases are still awaiting classification at the time of writing this report.
- As in previous years most fatal incident investigations were in prison.
- **15** deaths were investigated in probation approved premises (four more than last year) and **4** in immigration removal centres (two more than last year).
- **24%** of natural causes draft reports were issued within the target of 20 weeks. **22%** of self-inflicted draft reports were issued within the 26-week target. This was an improvement on last year's figures – 16% and 14% respectively.
- **86%** of clinical reviews usually commissioned by Primary Care Trusts were not received within the 10-week deadline.
- **196** final reports were issued, 10% more than last year.
- **143** anonymised reports were published on our website.

Fatal incident investigations

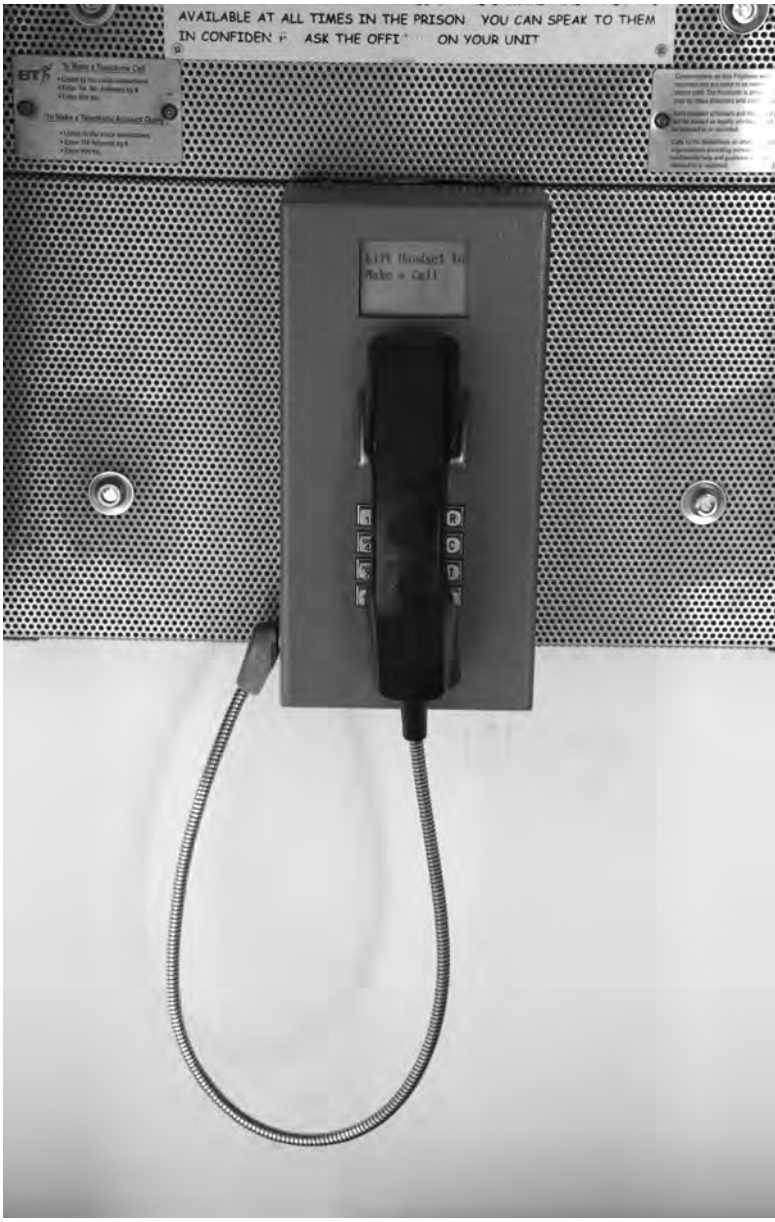




Complaints

- **5,294** complaints were received, three more than last year. Of these, **4,726** complaints were about the Prison Service, **433** were about the Probation Service and **135** were about UKBA.
- Overall, only around **half** the complaints received were eligible for investigation.
- **79%** of ineligible cases were not eligible because the complainant had not completed the internal complaints process before coming to the PPO.
- At **13%**, eligibility of probation cases was much lower than prison or immigration detention cases. Only **58** of the 433 probation cases received were eligible for investigation.
- Although we received fewer cases about UKBA than about probation, we investigated more cases – **76** – because their eligibility rate was much higher – **55%**.
- A record **2,667** investigations were started, an annual increase of 4%.
- **37** people made more than seven eligible complaints each and collectively made up **20%** of our entire caseload.
- **A third** of complaints completed were about the high security estate, although it accounts for only 4% of the prison population, a similar figure to previous years.
- **2,360** investigations were completed in total, a drop of **5%** compared to last year.
- Complaints covered a wide range of subjects, with property being the largest single category, making up **17%** overall and **a third** of UKBA cases.
- Over **a third** of probation complaints were about the complainant's offender manager and **a quarter** were about reports which had been written about the complainant.

- We found in favour of the complainant in **23%** of prison cases and **22%** of those about probation and UKBA.
- Timeliness in dealing with complaints deteriorated due to staff shortages. **40%** of cases were assessed for eligibility within our 10-day target compared to **94%** last year. **53%** of complaints completed were within our 12-week target compared to **63%** last year.
- There was no change in the average time to complete a case, which was **14 weeks**.



PRISONS AND PROBATION OMBUDSMAN FOR ENGLAND AND WALES

INVESTIGATING FATAL INCIDENTS

"20% of our investigations into self-inflicted deaths found evidence of bullying or intimidation from other prisoners in the three months before their death."

Learning lessons: thematic findings

As part of our commitment to ensuring that individual investigations into fatal incidents result in wider lessons being learned, we produced three thematic publications this year based on our findings.

The first brought together key facts and figures from over 200 reports into self-inflicted deaths.[3] Some of the findings substantiate what we already know about deaths in custody, showing that remand prisoners and those in the early days of custody account for the greatest proportion of self-inflicted deaths. Nearly two-thirds of deaths took place in local prisons which informs us that there is a need for greater vigilance in those prisons. It shows that those charged with violent offences, particularly against a family member, are at high risk of suicide. While these risk factors are well known, they bear repeating and in a number of investigations in the year we found that they were overlooked when assessing risk. Where suicide and self-harm monitoring procedures were in place at the time of the death, there were a number of concerns and deficiencies in their implementation, and we assessed monitoring arrangements as correct in only 40% of cases, some poor recording of significant issues, absence of key staff from case reviews and a lack of family involvement in the process.

The figures, when brought together in this way identified new evidence, such as the impact of bullying and intimidation, with as many as 20% of our investigations into self-inflicted deaths finding evidence of bullying or intimidation from other prisoners in the three months before their death.

This new learning led to our second thematic report on violence reduction, bullying and safety.[4] This looked closely at 42 self-inflicted death investigations and found that in 17, staff responses to allegations of bullying, assaults and other related incidents could have been better. The report identified three specific areas for learning: the importance of recording and sharing information about bullying or victimisation; the need to understand violence reduction and improve prisoners' feelings of safety; and the importance of protecting prisoners at specific risk of victimisation.

Our third thematic publication was an overview of 402 deaths from natural causes.[5] Natural cause deaths have increased markedly in recent years as the prison population ages. One of the key questions for our investigations is whether the health and social care provided is equivalent to that which the individual could have expected to have received in the community. The study found that equity of care improved with the age of the prisoner

[3] PPO (2011) *Learning from PPO investigations: Self-inflicted deaths in prison custody 2007–2009.*

[4] PPO (2011) *Learning from PPO investigations: Violence reduction, bullying and safety.*

[5] PPO (2012) *Learning from PPO investigations: Natural cause deaths in prison custody 2007–2010.*

and the length of time in custody. Care was more inequitable for the youngest age group, those between 18 and 34, where we found that only just over half received care equivalent to that which they could have expected in the community. This has helped us to identify an area where more work is needed: what lessons can be learnt from natural cause deaths involving younger prisoners.

The report also looked at emergency arrangements in cases where the individual's clinical condition required an emergency response. In such cases we found there was room for improvement in just over a third of the cases.

There is much still to be gleaned from our investigations when looked at collectively. Families often tell us that the most important thing for them is that the agencies involved should ensure that the same thing does not happen again and we are determined to help ensure that more lessons are learned from our cases in the coming years.

> "It is the third year in a row where the number of deaths has risen and the highest number since this office began investigating deaths in custody in 2004."

Individual investigations

Not all the lessons to be learned from investigations into deaths in custody are directly related to preventing deaths. The Ombudsman's terms of reference require the investigation of the circumstances of the deaths of detainees and investigations include a review of the general care of people in custody or in approved premises leading up to the time of their death. In addition, families will often raise matters that we try to answer in the course of the investigation. This year we made a number or recommendations arising out of deaths in custody reports about the general treatment of prisoners with disabilities and older prisoners and these are discussed below.

The vast majority of deaths we investigate continue to be those of prisoners. Overall, numbers of deaths rose significantly compared to the previous year – the third year in a row where the number of deaths has risen and the highest number since this office began investigating deaths in custody in 2004. This growth is disturbing – and also a significant challenge to a demand led investigative body facing squeezed resources.

We started investigations into 229 fatal incidents this year – a 15% increase on the year before. Of these, 142 were from natural causes, continuing the upward trend of such deaths in recent years. There were also 71 apparently self-inflicted deaths this year, 13 more than the previous year and reversing the downward trend of recent years. January was particularly tragic with 34 deaths, the highest number ever recorded in one month.

Thirty deaths were not able to be classified when they were reported. These cases required toxicology reports before the cause of death could be established, often delaying the investigations. Of these, nine turned out to be drug related and we are still awaiting classification in a further six.

Proportionality

We continued to focus on improving performance and, during the year, reviewed many of our procedures to improve efficiency. This has included the introduction of a more risk-based approach to investigating reasonably foreseeable deaths, where we now cover a range of common issues to ensure that appropriate care has been provided rather than a chronological approach. We have also changed the way we allocate cases to investigators to ensure a more even workload and introduced new quality assurance and case management methods so that investigators and managers review cases at regularly defined intervals to agree the scope of investigations and keep them on track towards their target dates. There are signs that improvements are beginning: 24% of natural causes draft reports were issued within our target of 20 weeks of the death and 22% of our draft reports for self-inflicted cases within our 26-week target, compared to 16% and 14% respectively last year. There is a long way to go and the challenge for next year will be to improve this still further.

As mentioned in the introduction, part of the problem in meeting our targets for completing draft reports is that we are reliant on obtaining independent clinical reviews commissioned by Primary Care Trusts (or the Healthcare Inspectorate Wales). This is a requirement of our terms of reference and is an essential part of our process if we are to take an informed view of the standard of healthcare that prisoners and others received before their deaths. This year, getting the clinical reviews on time has continued to be the seemingly intractable problem reported in previous annual reports – only 14% were received within the 10-week target. In the longer term, it is hoped that new national commissioning arrangements for offender health services will help. In the meantime, we have begun two new pilot programmes to seek to improve delivery under current arrangements by working more closely with our NHS partners and escalating cases within our organisations where problems are encountered.

Assessment of risk

In their guidance documents, the Prison Service recognises a number of factors for identifying those at risk of suicide and self-harm. While a number of them are broad, such as low socioeconomic status and childhood adversity and cover many prisoners, others are more specific and crop up repeatedly in our investigations. These include: being in the early days of custody, suicidal thought, previous attempts at self-harm or suicide, and offence – particularly those charged with violence against another person, especially murder, and particularly if the victim was a family member or partner.

Mr A entered custody with a number of factors indicating that he was at a much increased risk of harming himself. It was his first time in custody, he was accused of the murder of his partner and his person escort record (PER) contained information that he had said he wished to kill himself. At the time of his death, guidance said that 'prisoners charged with homicide are a particularly high-risk group, and within this, prisoners charged with homicide against a partner or family member are at an exceptionally high risk of suicide'. It mandated prisons to: 'make provision for additional risk assessments and care to keep safe prisoners who have been charged with domestic violence and/or domestic murder/murder of a family member. Such provision must include ensuring a record is maintained to show what action has been undertaken'.

There was no evidence that there had been a specific assessment about Mr A's risk factors. The investigation noted that, before the introduction of electronic medical records, the previous paper-based health screen process required a mandatory mental health referral in the case of a domestic murder. NOMS was unable to explain to our satisfaction why this requirement had been removed in the transition to the electronic system. A mental health assessment provides an important opportunity for trained staff to assess such a prisoner's state of mind. In this case, we made a national recommendation to NOMS that all prisoners charged with domestic homicide should be referred for a mental health assessment.

A concerning feature of our investigations in the last year is that many prison staff are not aware of known high risk factors and too much reliance is placed on how a prisoner presents on the day. Prison officers are often experienced at dealing with troubled people and making assessments. How someone is presenting, their level of eye contact, their mood and what they say is important and should not be underestimated. However, it is recognised in other measurements of risk that the best indicator of future behaviour is past behaviour. All information needs to be assessed and known risk factors need to be balanced against presentation.

In the case outlined above, a reception officer was asked whether the charge Mr A was facing would impact on his assessment of risk. He replied:

> 'No, not particularly, I would go on the individual in front of me rather than what he's done because, you know, by the grace of God everybody's done something stupid in their life and it could have been just one of those things, so I tend to take the person in front of me rather than the offence that he's committed.'

This is not an uncommon response.

Mr B arrived at prison charged with the murder of his ex-partner. It was recorded on his PER that he had attempted suicide 14 months previously. He was found hanging in his cell six days after his arrival at prison.

Again, the investigation found that no extra monitoring was put in place to reflect the extra risk attached to the charge Mr B was facing. It was alarming that none of the prison officers interviewed by the investigator – all of them based either in reception or in the first night centre and some of them very experienced – were aware that prisoners charged with the murder of a partner or relative presented a particularly high risk of suicide. The nurse who conducted his first reception health screen, knew that he had been charged with murdering his ex-girlfriend and was aware of the statistically high risk of suicide or self-harm. However, because he gave no particular reason to suggest he was likely to harm himself she did not take any further steps to assess the risk.

There were also other factors that made Mr B at high risk of suicide. He was in prison for the first time and he was a foreign national prisoner, likely to be deported. This, like the nature of his offence, was information which was known to staff and ought to have alerted them to the need to put in place monitoring procedures irrespective of how he presented himself.

In the case of Mr C, prison staff did not assess him as at risk of self-harm even though he had a range of static risk factors. He had a known history of self-harm, a family history of suicide and was in prison for the first time. In addition, Mr C was withdrawing from alcohol – usually regarded as a particularly risky time. Despite all these factors, he was not subject to any monitoring and was found hanging in his cell on his second day at the prison.

> “Over 6% of all deaths we investigated in the year will have been drug related.”

Drug toxicity

We continue to investigate a significant number of deaths which, following toxicology tests, are found to be a result of drug or mixed drug toxicity. As identified in the introduction to this report, together with a number of HM coroners, we raised concerns about the number of such deaths with the Chief Executive of NOMS, who has commissioned an investigation into the issue. In 2011–2012, nine fatal incidents were confirmed as being due to drug or mixed drug toxicity, and there are a further six cases likely to be drug related awaiting toxicology results. This will mean that over 6% of all deaths we investigated in the year will have been drug related.

We found a number of recurring factors in these deaths, not least prisoners trading in prescribed or smuggled drugs, such as Subutex (buprenorphine prescribed for the treatment of heroin and methadone withdrawal) which is widely used illicitly for its ability to create the same effects as other morphine-based medications. Similarly, pregabalin (an anti-convulsant used to treat partial seizures and for pain relief) is sought for the ‘high’ it can produce when taken in conjunction with other medications. Indeed, there is a trade in many prescribed medications, with some prisoners seeking all manner of substances to achieve a ‘high’. Other factors add to the problem, including the hoarding of prescribed medication by prisoners to take in excess at a later date and the combined effects of prescribed medication and illicit drug use.

Mr D was 30 years old when he was found slumped over the table in his cell with drug paraphernalia on the table beside him (burnt foil and a smoking implement). Post-mortem and toxicology tests confirmed the cause of Mr D’s death as fentanyl toxicity. Fentanyl is a very strong opiate based pain killing drug (said to be over one hundred times stronger than morphine) often prescribed in the form of patches. Such patches are not prescribed in prisons, but can be smuggled in and the drug ‘smoked’ in a similar way to crack cocaine.

Mr D was a known drug user, had been in prison before and was suspected of using illicit drugs in custody. He had an old injury which he claimed caused him considerable pain and he was able to convince doctors at the prison to prescribe him strong pain killers, including co-codamol, tramadol and trazodone (used to treat depression, but sometimes also used for chronic pain). Mr D continued to be prescribed high doses of pain relief, although officers on his wing said that he never mentioned having any pain or showed any signs of injury. Mr D was later also prescribed dihydrocodeine (a synthetic version of the opiate codeine) alongside the co-codamol and trazodone.

Although an orthopaedic surgeon confirmed that Mr D’s injury was repaired and should not cause him any pain, his medication regime remained unchanged. Furthermore, he was prescribed pregabalin. Intelligence suggested that as well as his prescribed medication Mr D took various drugs illicitly including carbamazapine (a mood stabiliser), gabapentin (epilepsy medication) and smoked fentanyl. Cell searches failed to substantiate this information.

We concluded that improvements were required in relation to assessing and

monitoring prisoners with known drug habits, prescribing medications, sharing information and more broadly the need to tackle the supply and use of illicit drugs in the prison.

In the last annual report, we commented on the introduction of the Integrated Drug Treatment System (IDTS) and the aim of IDTS to improve the quantity and quality of treatment available to prisoners, particularly in the early days of custody and to reinforce consistency of care between the community and prisons. It is disappointing therefore, that we investigated a number of deaths where the care of a prisoner under IDTS had fallen short.

Mr E was found unconscious in his cell at morning unlock. Staff carried out cardio-pulmonary resuscitation (CPR) and he was taken to hospital. He was pronounced dead shortly after arriving. He was 38 years old and had been in custody for only five days. The post-mortem and toxicology tests showed that Mr E died from methadone toxicity.

Mr E had a significant history of drug and alcohol dependence, self-harm and depression. On arrival at prison, Mr E was appropriately assessed and housed in a specialist detoxification unit. The following morning he told the substance misuse doctor that he used a substantial amount of heroin or illicit methadone daily. Mr E also said that he used crack cocaine and injected speedballs (a combination of heroin or morphine with cocaine) into his groin. He also reported drinking a significant amount of alcohol each day. He said that he had been prescribed methadone before entering custody, but the prison did not attempt to obtain his community medical records, which would have confirmed this.

The doctor prescribed a programme of supervised methadone to be given once a day starting at 20ml and increasing by 10ml a day up to a maximum of 50ml. In addition, Mr E began an alcohol withdrawal programme of supervised, daily decreasing amounts of chlordiazepoxide.

Our investigator was told that IDTS staff should monitor detoxifying prisoners twice a day and no further medication with sedative effects should be prescribed for five days. However, just three days later, Mr E was prescribed mirtazapine (an anti-depressant) by a visiting psychiatrist. The psychiatrist was unaware that Mr E was undergoing alcohol detoxification. Mr E was not clinically observed as often as he should have been under the IDTS policy and we found that this, together with the prescribed anti-depressant medication that enhanced the sedative effects of the detoxification medication, contributed to his death.

Mr F was 31 when he was found dead in his cell at morning unlock. The post-mortem and toxicology tests showed that he had died of respiratory depression, regurgitation of food particles and methadone intoxication. He had a long history of misusing drugs both in the community and in custody and had begun an IDTS methadone programme. He was suspected of being involved in the misuse of drugs in the prison and was often seen as being unsteady on his feet, which might have been as a result of the combined effect of his prescribed medication, which included mirtazapine, pregabalin and methadone, or possibly illicitly taken non-prescribed medication. Mr F had been on the IDTS programme for some time and his methadone dose had gradually increased to 100ml, but it was not clear from the records why the dosage had been set at such a high level.

The day before his death, Mr F was prescribed clonazepam (used to treat seizures and panic attacks) after he complained that he had had an epileptic fit and had a family history of epilepsy. No tests were carried out to confirm whether Mr F actually had epilepsy and there was nothing in his medical record to suggest it, nor any family history of epilepsy. Our investigator was told that Mr F had been advised by another prisoner to 'fake' an epileptic fit in order to obtain clonazepam. Clonazepam is a potent benzodiazepine (tranquilliser) and there is a risk of respiratory depression when taken in combination with methadone.

Our investigation found a lack of staff awareness of the risks and side effects of medication and other substances, which increased the chances of misuse going undetected. Mr F often seemed to be intoxicated when his prescribed medication was administered. The investigation also uncovered a number of deficiencies in relation to IDTS and detoxification procedures and we were particularly concerned about the level of methadone he was prescribed.

Disability

During the year we investigated a number of cases involving the deaths of prisoners with disabilities. In none of the cases was the disability itself the direct cause of death but the investigations identified a number of concerns about the treatment of those with disabilities in prisons.

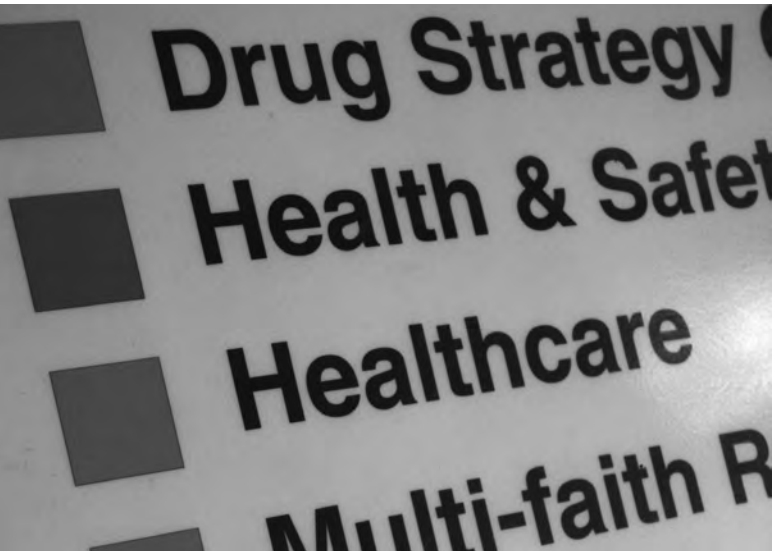
All prisons should have their own local policy to ensure they manage prisoners with disabilities in line with the Equality Act 2010. Prisons must encourage prisoners to disclose any disability and make reasonable adjustments to avoid placing the prisoner at a 'substantial disadvantage'. Each prison has a disability liaison function, responsible for identifying how best to support prisoners with disability and ensuring that they can fully access the regime.

In their national guidance, NOMS suggest that 'it is not normally appropriate' to accommodate disabled prisoners in the healthcare centre, unless their medical needs require it. Nevertheless, in some of the cases we investigated we found that healthcare centres were used as the default to accommodate those with disabilities.

Mr G was located in the healthcare centre, despite having no clinical need for inpatient treatment. He was a wheelchair user and staff assessed that he could not be accommodated safely on a residential wing. He received no medical intervention related to his disability and was not referred to the disability liaison officer.

We recognise that there will be times when prisoners with disabilities are best looked after in an inpatients' unit, if their medical needs require close monitoring, but otherwise their location in the healthcare centre may marginalise them and restrict their access

> "Investigations identified a number of concerns about the treatment of those with disabilities in prisons."



to the normal regime. Sadly, in two of our investigations this year, the disability liaison function operated so distinctly from the healthcare team that neither took responsibility for delivering the basic support for disabled prisoners.

In Mr H's case, lack of staff knowledge of the prison's disability policy, combined with poor communication between healthcare and disability liaison staff resulted in him being held in conditions that we described as 'degrading'. Due to serious mobility problems, Mr H found it difficult to use the toilet in his shared cell. Despite staff recording his difficulties, no action was taken to enable him to use the toilet for six months because neither the disability liaison officer nor healthcare staff took responsibility for resolving the problem. At night Mr H had to use a bottle to urinate.

Following the investigation, the prison accepted recommendations to strengthen the disability policy and to ensure the needs of prisoners with complex disabilities are identified when they arrive at the prison.

However, in some cases we found that even where reception arrangements effectively identified prisoners with disabilities, poor communication and lack of awareness seriously undermined subsequent care.

Mr I arrived in prison with documents outlining his medical needs and completed the disability questionnaire. His mother contacted the prison with information about how to manage her son's disability. Despite this information, the extent to which Mr I's disabilities would affect his life in prison and whether he needed any reasonable adjustments to be made, were never properly assessed. No personal emergency evacuation plan was prepared. No one took responsibility for ensuring Mr I's needs were being met and, as a result, he was located inappropriately and did not have access to the most basic comforts, including appropriate footwear that his mother had sent to the prison. He was not a man to complain about his treatment and we were concerned that this, combined with his existing physical conditions, meant that staff failed to identify how unwell he was before he died very suddenly.

Although his death could not have been foreseen, we made a number of recommendations aimed at improving the prison's care of men with disabilities.

Governors and directors need to ensure that staff are aware of their personal responsibilities and duty of care towards prisoners with disabilities. Specifically, there is also a clear lesson from these cases that only by working together, can discipline and healthcare staff effectively meet the needs of disabled prisoners.

> “Prisoners aged 60 and over are now the fastest growing age group in the prison estate and this rose 128% between 2000 and 2010.”

Older prisoners

In June 2011, there were 9,000 prisoners aged over 50 across England and Wales, 10.5% of the population. Prisoners aged 60 and over are now the fastest growing age group in the prison estate and this rose 128% between 2000 and 2010. It is perhaps unsurprising that this office has investigated more natural cause deaths of older prisoners (aged over 50) proportionately than any other age group.

This does not mean that prisons do not provide appropriate care for prisoners at the end of their lives. As we reported last year, palliative care provision has improved and some prisons now have specific palliative care suites to manage the needs of prisoners who are dying. A more planned approach to managing terminal illness is reflected in our investigations and we found that older prisoners who have died, are more likely than those who die at a younger age, to have received medical care that is equivalent to what they could have expected in the community.

One of the measures used to support elderly prisoners with complex medical needs, is the use of other prisoners as carers. Caring may involve physical help such as washing, dressing and personal care or providing social support to those who cannot mix easily with others as a result of their medical condition. The Prison Reform Trust has called for more use of trained prisoners to support other prisoners. We have seen this work well in practice, but without the appropriate support structures, the prisoner-carer system can be misused.

Mr X volunteered to act as a carer for an elderly prisoner with complex medical needs. He had cared for his parents in ill health, but had no formal experience or healthcare qualifications. However, he was expected to shower Mr J, and often had to clear up his incontinence, among other difficult duties. He told the investigator that he felt isolated and unsupported by staff. Officers and healthcare staff did not take responsibility for Mr J’s complex and demanding needs. The carer was an excellent source of support for the elderly man, but was left vulnerable himself.

In this case, we recommended formal training and support for prisoners acting as carers. In order to protect the older prisoner being cared for, and the individual acting as carer, such arrangements must be formalised with clear parameters and structured staff support. Prisoner-carers need to be a supplement to the care that staff provide, not a replacement.

Inevitably, older prisoners will need to attend hospital for medical intervention more often than younger ones. When any prisoner leaves the prison, they must be risk assessed by medical and security staff to determine what level of restraint is needed to manage their risk appropriately.

In last year’s annual report, we called for a formal revision of restraints policy relating to seriously ill prisoners in order to promote less risk averse decisions and enable more prisoners to die with dignity. Such a review

has not taken place and we continue to investigate deaths where elderly people with limited mobility have been restrained with handcuffs and chains, even when they had been assessed as a low escape risk and a low risk to the public. In some cases, restraints had restricted their access to appropriate healthcare intervention.

Mr K was reliant on crutches for his mobility. Staff completed an escort risk assessment for a hospital appointment, the medical section of which was completed only by an administrator who said that there was no medical reason not to restrain Mr K. In fact, the double cuffs that were used for his restraint meant that Mr K could not use his crutches and therefore was not able to attend his appointment.

When completing an escort risk assessment, staff should take into account a prisoner's health and physical condition at the time of the escort. Often there is too much reliance on the static risk suggested by the original offence even though there has been substantial physical change since, meaning the actual likelihood of escape or capability of causing harm has reduced significantly. In one investigation, we found there was no medical contribution to the risk assessment and, restraints were used on an elderly, frail man until the day he died. In a similar case, an older prisoner was restrained until hours before his death because the risk assessment had not been completed appropriately.

According to Mr L's escort risk assessment, he was a low risk to the public. The medical contribution to the assessment was not signed or dated and provided no clear consideration of the risk that Mr L posed at the time of the assessment. Despite minimal detail of the prisoner's physical condition on the risk assessment, Mr L was restrained and accompanied by two officers when he was taken to hospital. As his condition deteriorated, the prison reviewed the risk assessment and removed restraints so as not to interfere with Mr L's clinical care, but his restraints were not permanently removed until just hours before his death.

An escort risk assessment must strike the appropriate balance between protecting the public and ensuring the humane treatment of the individual prisoner. We continue to see too many examples where prisons restrain frail and elderly prisoners even when their physical condition renders it implausible that they could present any risk.

Approved premises

There are around 100 approved premises (formerly known as probation and bail hostels) in England and Wales. Their purpose is to provide an enhanced level of residential supervision in the community, within a supportive and structured environment, for offenders assessed as presenting a high risk of harm and also unconvicted people on bail. Although deaths in approved premises represent a small proportion of

our investigations, some valuable lessons can be learnt from these cases. Many staff in approved premises will not have the experience of previous deaths to draw on. It is therefore important that the learning from our investigations is shared across probation trusts through NOMS.

The number of deaths in approved premises was significantly higher this year than in previous years. Of the 15 deaths investigated, seven were due to natural causes, four were self-inflicted, two were due to other non-natural causes and two are so far undetermined. In two of the cases of self-inflicted deaths in approved premises, information sharing between the prison and probation trust was poor.

Mr M was arrested and remanded to prison. He had taken an overdose of medication in police custody so suicide and self-harm monitoring procedures were put in place. He told staff that he would kill himself if given the chance but lacked the ability to do so in prison. One of the potential triggers for his self-harm was the prospect of homelessness. Mr M was bailed to an approved premises a few days later but the referral forms used were incorrect and incomplete, with no reference to either his mobility problems or his risk of self-harm and suicide. There was no suitable accommodation when he arrived at the approved premises and it was subsequently decided to withdraw his place. Mr M took his life on the morning that this decision was due to be communicated to him but it was not established whether he had somehow become aware of this. From comments made by Mr M, staff had become aware that he had some thoughts of self-harm but only provided limited, informal monitoring.

“In two of the cases of self-inflicted deaths in approved premises, information sharing between the prison and probation trust was poor.”

The Offender Risk Assessment System (OASys) is an assessment tool which is used as part of sentence planning and provides an assessment of offenders’ risks and needs. It allows automatic sharing of data and operational information between probation and prison staff. The aim of the system is to improve the consistency of offender assessment, provide courts with better informed sentencing advice and support informed decisions about discretionary release and the interventions necessary to reduce the risk of reoffending.

In Mr N’s case there were deficiencies in sharing relevant information between agencies. The prison did not sufficiently complete the escort documents which accompanied Mr N between criminal justice agencies or attach the documents relating to his self-harm monitoring; the escort contractor did not pass on those documents to the probation trust, who, in turn, failed to request them. Therefore, none of the prison documents about Mr N’s risks were sent to the approved premises. Mr N’s referring officer failed to comply with the policy to provide the approved premises with either a full OASys risk assessment or, as a minimum, an OASys risk of harm screening assessment and he did not see Mr N personally.

Our findings included recommendations to the prison and a national recommendation to NOMS about the need to complete documents to the required standard, pass on information about ongoing risk and revise guidance so that approved premises have all the information they need to make an informed decision as to whether their accommodation is appropriate for the individual.

The circumstances of Mr O's death in a different probation trust had some similarities. He was bailed to approved premises four months after his arrest. At Mr O's induction, the day after his arrival, he told staff that he wanted to end his life and subsequently repeated this. Although this was acknowledged and discussed by staff, crucially, they decided not to implement the suicide and self-harm prevention procedures. He continued to express feelings of depression as well as other concerns and hanged himself two weeks later.

Again, the mandatory requirement for an OASys risk of harm screening had not been carried out and relevant information about Mr O's health problems was not sent to the approved premises. We considered that the outcome for Mr O might have been different had there been continuity of treatment between prison and the community. The investigation also identified that the approved premises staff lacked the confidence to apply self-harm and suicide prevention monitoring procedures. We made several recommendations, including the need to improve the referral process for people on bail and repeated a previous one that staff should be properly trained to use the monitoring procedures for those at risk.

The circumstances of both these deaths demonstrate the continuing need for the various parts of the criminal justice system to coordinate their efforts to ensure that relevant and important information is shared when people transfer within them. Referral systems to approved premises need to be more robust and full information about risk and relevant health issues provided.

Immigration removal centres (IRCs)

In 2011–12, we investigated the deaths of four detainees in IRCs (one man died after he was released). Of these, three deaths were from natural causes, and one was apparently self-inflicted. This is an increase from 2010–11, when two detainees died. In the four years prior to that, there had been no deaths in IRCs.

Two of the natural cause deaths occurred in the same IRC, although both these detainees had transferred from a different IRC shortly before their deaths. In both cases, we found that healthcare provision at the first IRC was deficient. Deficiencies were identified in the emergency response arrangements in two cases. In three cases, we found that elements of the immigration casework had not been progressed as well as they might have been. While deaths in IRCs remain relatively rare, it is clear that similar issues recur across the estate and we hope that UKBA and the IRCs will seek to learn the lessons from deaths no matter where they occur.

Mr P was an illegal entrant who was arrested trying to leave the UK using a forged document. After claiming asylum, he was taken to an IRC for his application to be processed. However, he then withdrew his application, deciding he wanted to return home.

While waiting for UKBA staff to arrange his return, he complained of headaches but was unable to see healthcare staff. He was transferred to another IRC, but three days later his roommate pressed the cell bell as Mr P was having chest pains. Healthcare staff attended and gave him Gaviscon, and told him he would see a doctor later that morning. However, two hours later his condition deteriorated and, despite attempts by staff to resuscitate him, Mr P died.

We made 14 recommendations as a result of this investigation. Among these, we made three recommendations directly related to the emergency response, including further training for staff in recognising the signs of possible emergencies such as heart attacks and training in the use of defibrillators. We also recommended that UKBA ensured that the cases of those who wanted to leave the UK are expedited.

Mr Q was a failed asylum seeker who was also arrested trying to leave the United Kingdom. After serving a prison sentence, he was released but immediately arrested by the police. He was returned to immigration detention but, when it was realised that there were still outstanding police enquiries, arrangements were made for him to be released. However, shortly before his release (when he was to be arrested again for different matters), he was found hanging.

We made six recommendations. Two of these related to the quality of the emergency response and recommended that further training be provided. Another related to the circumstances of Mr Q's detention. In common with Mr P's case, we also recommended that further efforts were made to obtain details of next-of-kin when detainees were received into IRCs.

Liaison with families

Throughout the year our family liaison officers (FLOs) have continued to contact bereaved families to ensure their views are considered as an integral part of our investigations. The FLOs provide families and their representatives with a consistent point of contact and help to ensure they are provided with explanations and insight into the death of a family member. There was some family contact in 95% of the fatal incident investigations carried out in the past year and nearly 25% involved a personal visit or meeting. Feedback received from families about FLOs has been very positive.

In some cases, we have investigated concerns raised by families which have led directly to positive changes.

Mr R was admitted to hospital from prison with a serious illness and died a few days later. Following our contact with his family, a number of issues were highlighted relating to prison family liaison. His family felt no consideration had been given to contacting them until a very late stage, a few hours before his death, and even then they had only been notified by telephone. A prison family liaison officer was not appointed until after his death and did not contact his family until three days later. A follow up visit to the family, in person was not made at the earliest opportunity.

We made two recommendations to the prison Governor: to ensure sufficiently trained prison family liaison officers and to appoint a family liaison officer when a prisoner is assessed as seriously ill, so that appropriate and timely arrangements are made for early contact with families.

INVESTIGATING COMPLAINTS

Learning lessons: thematic findings

Our investigation reports and their recommendations enable investigated bodies to learn from individual cases and make important changes and improvements. However, with nearly 5,300 complaints received and nearly 2,400 investigations completed in 2011–12, it is also important that we use our findings to identify general lessons to be learnt. We are still at an early stage but, in May 2011, we published the first thematic learning lessons report concerning complaints.[6] This provided baseline information about the huge number of complaints dealt with since this office was established in 1994. It gave an overall picture of complaints, including the increase in numbers over time, the high numbers of complaints received from the high security estate and the disproportionate number of complaints from a small number of prolific complainants. It also provided numbers of complaints about individual establishments for comparison purposes. This baseline will be built upon in the coming year with a further focus on thematic learning from our cases.

Individual complaints

In 2011–12 the volume of complaints received remained similar to the previous year, as did the high proportion of ineligible cases. While 4% more cases were started than in the previous year, timeliness deteriorated, largely due to a significant number of vacancies at both investigator and assessor level and a freeze on new recruitments while clarity was sought on our budget. Despite continuing work to streamline processes, carrying vacancies inevitably had an impact on our ability to assess new complaints and complete investigations quickly. On the positive side, the average number of complaints completed by each investigator increased, and timeliness began to improve by the end of the year. This puts us in a good position to improve performance in 2012–13.

[6] PPO (2011) *Learning from PPO investigations: Overview of complaints*.

Proportionality

Alongside this streamlining of processes are efforts to ensure proportionality and to target our resources as effectively as possible. So, in line with our terms of reference, we are increasingly declining to investigate complaints that raise no substantial issue or where no worthwhile outcome can be achieved. Examples include cases where a prison has already acknowledged that a mistake has been made and has apologised, and where there is nothing further this office would be able to achieve; and cases where, since making a complaint about a relatively minor matter, a prisoner has transferred to a different establishment where the complaint is no longer relevant.

Where we do investigate, we try to ensure that our responses are proportionate to the seriousness of the complaint. For example:

Mr A complained that his prison had breached Prison Rule 28 (1) by failing to provide prisoners with 'toilet articles necessary for...health and cleanliness'.

Our investigation found that the prison had run out of shower gel following a problem with its supplier, but had provided prisoners with soap instead, and that shower gel was now available again. In the circumstances, all that was required was a short letter informing Mr A that his complaint had not been upheld as we considered soap was an acceptable alternative.

Serious complaints

On the other hand, we are putting more resources into the investigation of serious complaints, including carrying out more interviews with complainants and staff. Among the most serious complaints received are allegations of assault by staff. Unless there is clear CCTV evidence, these are difficult complaints to investigate, partly because they often boil down to one person's word against another's, and partly because, if there has been an internal investigation, the alleged incident may have happened a year or so before the complaint reaches us. For example:

Ms B complained that she had been sexually assaulted on three occasions by a male nurse at an immigration removal centre (IRC). Ms B's complaint had been investigated by the UK Border Agency's (UKBA) Professional Standards Unit who had concluded that the allegations were unsubstantiated and that Ms B's desire to remain in the United Kingdom had encouraged her to formulate the allegations against the nurse.

Our investigation found that there was no independent evidence to prove or disprove Ms B's allegations. On the one hand, the nurse vigorously denied them, there had been no previous complaints about him, and his managers and colleagues considered that such behaviour would have been wholly out of character. On the other hand, Ms B's account was detailed and had remained consistent over time, and it was plausible that she had not complained earlier for fear of jeopardising her appeal against deportation. Against this, it was difficult to understand why she had deliberately placed herself in a situation where she would be alone with the nurse in the early hours of the morning if he had already assaulted her, and there was some evidence that she may have thought a complaint of this nature would aid her appeal against removal.

We concluded that, although UKBA's investigation had been prompt and thorough, there was insufficient evidence to uphold their conclusion that Ms B had fabricated her allegation. We also found, however, that there was insufficient evidence to enable a conclusion as to whether she had been assaulted. We recommended that IRCs make it clear to female detainees before appointments that they can see a female nurse or doctor if they prefer (other than in emergencies) or can be accompanied by a friend or chaperone. UKBA accepted this recommendation in principle.

Not all serious complaints are about assaults.

Ms C, a young offender, complained, among other things, that she was unable to complete her Detention and Training Order (DTO) because she was transferred to an adult establishment on her eighteenth birthday.

The investigation found that, once Ms C transferred to the adult establishment, she was no longer engaged in a DTO regime and followed the normal regime for adult sentenced offenders. In our view this effectively subverted the court's intentions and substituted a different, less therapeutic, form of sentence. We also found that different procedures are followed for male and female young offenders. The presumption is that, on turning 18, a male young offender will remain where he is and continue with his DTO. Female young offenders, however, are routinely transferred to adult establishments because of lack of space and are, therefore, unable to complete their DTOs in any meaningful sense. The Chief Executive of NOMS accepted our recommendation that he carry out a review of national policy on the transfer of 18-year-old

women serving a DTO, to ensure that they are not treated any less favourably than young men and continue to experience a regime that is consistent with the intentions and ethos of a DTO.

There have been other serious complaints concerning the prison's responsibility to care for prisoners appropriately.

Ms E, a prisoner in a male high security prison who regards herself as transsexual, complained that she was not being allowed to live in role as a woman. The prison accepted that they had refused to allow Ms E to wear female clothes. They said that Ms E did not yet have a diagnosis of gender dysphoria and that she was a vulnerable individual who would be at risk of sexual exploitation by other prisoners if she was allowed to live and dress as a woman.

Our investigation found that Ms E's medical diagnosis was extremely complex and that she was a vulnerable person who did not always show good judgement in relation to her personal safety. We accepted that, in refusing to allow Ms E to live and dress as a woman, the prison believed that they were acting in her best interests. We found no evidence that prison staff were pursuing a personal vendetta against her, as she believed. On the contrary, we were satisfied that she had been treated with sensitivity and that staff had invested considerable time in trying to ensure her safety and wellbeing.

However, the Prison Service's own policy on the care and management of transsexual prisoners (set out in PSI 07/2011) says that a formal diagnosis of gender dysphoria is not required and that establishments must permit prisoners who consider themselves to be transsexual to live permanently in their acquired gender. This will include allowing prisoners to dress in clothes appropriate to the acquired gender. The policy makes it clear that any risk to and from a transsexual prisoner must be identified and managed.

In this case, it was clear that the prison was not complying with Prison Service policy. We fully recognise the challenges that a transsexual prisoner living in role can pose in a male high security prison. Nevertheless, prisons have to manage many prisoners whose offence, sexuality, personality or behaviour puts them at particular risk. The risks of dressing as a woman must be managed in the same way as any other vulnerability. We, therefore, upheld Ms E's complaint and recommended that the prison put plans in place to manage transsexual prisoners in line with PSI 07/2011. It was also recommended that the Prison Service take account of our report in their training for staff on the care and management of transsexual prisoners.

Mr F broke his leg playing sport and subsequently complained that his accident was caused by a poor playing surface. He also complained that prison staff left him in pain and did not ensure he received medical attention. He said that he was not able to attract the night patrol officer's (NPO) attention, despite calling out for help during the night, and he suggested that the NPO had in fact failed to visit the wing.

After the accident Mr F was seen almost immediately by a nurse who said that his leg was not broken and that he did not need to go to hospital. She advised that he should keep his weight off his leg overnight and she would arrange for him to be seen by a doctor in the morning. The judgement of medical professionals is not within our remit and the investigation, therefore, focused on the actions of the non-medical staff.

> "The care establishments take with prisoners' property may also say something about their attitude to prisoners more generally."

We found no evidence that the injury was caused by the playing surface. On the contrary, all the evidence, including Mr F's own account at the time, pointed to this being nothing more than the kind of accidental injury that can occur in sport. We were satisfied that it was entirely reasonable for prison staff to accept the nurse's judgement that Mr F did not need to go to hospital. We accepted that Mr F had been in pain and that he had probably had a broken night. However, we were satisfied that the NPO carried out regular patrols as this was verified by the electronic record (which could not have been made unless the NPO had walked the length of the wing), and that he would have been able to hear Mr F if he had called for help. We also accepted the NPO's account that Mr F was asleep each time he checked on him, as Mr F would have been able to hear the NPO if he had been awake. Finally, we were satisfied that medical help was summoned promptly when the day staff came on duty and realised that Mr F was in pain. We did not, therefore, uphold Mr F's complaint.

Property

Other complaints may seem relatively minor to many people, but are nevertheless significant to detained complainants. For example, as in previous years, one of the biggest causes for complaint was lost or damaged property. Although the sums involved are often small, most prisoners have very few possessions and those they do have may be an important source of personal identity. The care establishments take with prisoners' property may also say something about their attitude to prisoners more generally.

Property cases have the highest uphold rate of all complaints, with over a quarter either fully or partially upheld and a further 16% where mediated settlements are achieved. This high uphold figure reflects the fact that many property complaints need never reach this office and should have been resolved locally. It is often clear, for example, that the property has gone missing or been damaged in transit between two or more prisons, but none of the establishments involved are prepared to accept responsibility and the prisoner is simply passed backwards and forwards between them. Other complaints arise because prisons fail to follow Prison Service policy.

> "One of the biggest causes for complaint was lost or damaged property."

In Mr G's case, for instance, he complained that a number of items had been wrongly confiscated from him. The investigation found that the items probably belonged to Mr G and the Governor had agreed to send them on to Mr G at his current prison. The complaint seemed to have been settled satisfactorily. However, Mr G then contacted us again to complain that, when his property arrived at his current prison, it had been destroyed. The prison accepted that it had destroyed the property, but said it had done so, in line with local policy, because they had been told that the items had been confiscated at Mr G's previous prison.

This was concerning because, since March 2010, Prison Service policy has reflected the Coleman ruling[7] which established that Governors may confiscate a prisoner's property temporarily, but have no power to destroy it or deprive them of it permanently. The prison's local policy was, therefore, not in line with national policy – or the law. We upheld Mr G's complaint and recommended that he be paid £100 in compensation.

Mr H complained that money sent in to him in a letter had not been credited to his account. When he first complained the prison told him that there was no record of any money being received. Mr H pointed out that the envelope in which his letter had arrived had been stamped by the prison's Finance Department to show that it had contained a £25 postal order. The prison then advised him to contact the Post Office to find out who had cashed the postal order.

As the prison had lost the postal order, it was unfair to place the burden of resolving the problem on Mr H. The prison agreed to our request to credit £25 to Mr H's account – but it is disappointing that they had not done this before we became involved.

It is also a concern that prisoners are still being refused compensation for items that have been lost or damaged in prison laundries. For example:

Mr I complained that several items of clothing had gone missing in the laundry. The prison had refused to compensate him on the grounds that he had signed a disclaimer saying that he held property in his possession at his own risk.

However, following a previous Ombudsman's case, Prison Service policy makes it quite clear that it is not reasonable to expect a prisoner to bear responsibility for any loss or damage to items that have been handed over to the prison laundry. We, therefore, upheld Mr I's complaint and recommended that he be paid £100 in compensation.

The majority of property complaints concern small sums of money. One particularly worrying case, however, concerned a valuable item.

Mr J complained that a jewelled cross had been lost during the seven days he had spent on remand (on a charge of which he was subsequently acquitted). The prison offered Mr J £150 in compensation. Mr J refused this. He said the cross was worth about £1500, but that what he really wanted was for it to be found and returned to him because it had been blessed by the Pope and had been a present from his late father.

[7] R(Coleman) v SSG, High Court, 2009

The investigation found that, when he first arrived at the prison, Mr J had been advised to put his cross into stored valuables for safe keeping, and had done so. This meant that it should have been stored securely by the prison. We also found that other valuable items of prisoners' property had gone missing at the prison around this time. We, therefore, upheld Mr J's complaint. Although he had no receipt for the cross, his detailed description of it was entirely credible. We found that similar items by the same maker retailed at about £1500 and recommended that the prison pay Mr J this in compensation. We also recommended that the Governor should review how and where valuable items are stored, and should refer all losses of valuable property to the police for investigation.

Adjudications

Adjudications are another significant cause for complaint. As with property complaints, many of these complaints need never reach this office if Prison Service policy is correctly followed. The Ombudsman's role in considering complaints about adjudications is not to rehear the evidence, but to decide whether, based on the evidence presented at the hearing, it was established beyond reasonable doubt that the prisoner did what he was charged with doing, that the correct procedures were followed, and that a fair and just decision has been reached. In about 20% of complaints about adjudication, we concluded that the finding of guilt was unsafe – most commonly because the adjudicator had failed to call witnesses without good reason, or to enquire fully into the prisoner's defence, or to record the reasons for decisions.

> "In about 20% of complaints about adjudication, we concluded that the finding of guilt was unsafe."

Mr K was charged with using threatening, abusive or insulting words or behaviour. The adjudicator found the charge proven and Mr K received a punishment of seven days cellular confinement. Mr K complained that the adjudicator had refused to call his witnesses.

The investigation established that the adjudicator had indeed refused to call Mr K's witnesses. He may or may not have had justifiable grounds for doing so, but it was impossible to know because he had not recorded his reasons, beyond saying, 'I do not propose to have a parade of prisoner witnesses who will all tell me the same thing'. As a result, we could not be satisfied that the adjudicator had made sufficient inquiries into Mr K's defence to find the charge proved beyond reasonable doubt. We, therefore, upheld Mr K's complaint and recommended that the finding of guilt be quashed. This was the second poorly conducted adjudication in a short space of time from the same prison and we, therefore, recommended that the Governor remind adjudicators that they need to ensure the prisoner's defence is fully explored and that a clear record is made of the hearing. We then investigated a third very poor adjudication from the same prison

making the same errors, and have now recommended that adjudicators at the prison are given refresher training.

Family ties

The ability to maintain links with family and friends through letters, phone calls and visits is key to resettlement and obviously important to many prisoners. A sign of the times is that we had our first complaints from prisoners about email contact this year.

Mr L complained that he had not received two emails sent to him by a relative via the 'email a prisoner' facility. The investigation established that the emails had been sent and that the prison should have printed them off and given them to him. However, there were no records in the prison to show that this had happened, and we accepted that Mr L had not received them.

We concluded that this was due to teething problems with the new facility, and recommended that the Governor should either use a different system for receiving emails or put procedures in place to maintain an audit trail.

Mr M complained that his prison had opened his legally privileged mail on several occasions and had lost recorded delivery letters he had placed in the external post. He believed his post was being deliberately targeted by prison staff.

Our investigation was unable to establish what had happened to individual items of Mr M's mail. However, we found that some staff involved in handling prisoners' mail did not have a good understanding of the processes to be followed, there was poor communication between departments and there was a lack of structure and direction. In these circumstances, it was easy to imagine errors occurring.

We, therefore, upheld Mr M's complaint on the balance of probabilities, although we concluded that the problems with his mail had been caused by systemic problems at the prison and he had not been deliberately targeted. We recommended that the prison carry out a review of their procedures for handling prisoners' mail. This review has been completed and, if its conclusions are implemented, there should be no further grounds for such complaints.

We investigated other family ties issues this year.

Mr N had been convicted of serious sexual offences against the young daughters of his previous partner. After being released on licence, he had formed a relationship with another woman with young daughters. He was subsequently recalled to prison and then applied to marry his new partner. The prison was concerned that she was a vulnerable individual and that her children would be at high risk of harm if she married Mr N. They, therefore, delayed taking a decision on his application while they consulted the Multi Agency Public Protection Panel. Mr N complained that this amounted to an unlawful refusal.

The investigation established that Mr N's partner had been told about his convictions and that she still wished to marry him. It was also established that Social Services had been made aware of the situation. We found that the prison's delay had in effect amounted to a refusal of Mr N's application. We recognised that the prison had acted in what it believed to be the best interests of Mr N's partner and her children. However, Governors have no

authority to refuse a prisoner's application to marry on the grounds that the marriage is undesirable. We, therefore, upheld Mr M's complaint. He had by then transferred to another prison where the marriage had gone ahead.

Incentives and earned privileges

As in previous years, we received a number of complaints from prisoners who were unable to achieve the enhanced level of the incentives and earned privileges (IEP) scheme because they were not taking part in accredited offending behaviour programmes. Such complaints generally come from prisoners convicted of sexual offences who have been assessed as being unable to take part in the Sex Offender Treatment Programme (SOTP) because they deny their guilt.

The Prison Service is obliged to accept the verdict of the courts and we consider that it is appropriate for the most important aspects of a prisoner's time in custody – risk reduction work, pro-social behaviour and compliance with sentence plan objectives – to be rewarded by the IEP scheme. Conversely those who do not engage with this work should not expect to receive the same rewards as those who make the often painful steps towards confronting and changing their offending behaviour.

We upheld the following complaint.

Mr O had been convicted of serious sexual offences, which he denied. He complained that he was downgraded to standard because he was not undertaking any offending behaviour work. We were concerned to find that, although Mr O had been in custody for two years, he did not have an OASys risk assessment or a sentence plan (apparently because of a disagreement about which probation trust had responsibility for him). As a result, although he had been told that he needed to do the SOTP, he had never been assessed to determine whether he was suitable for it.

We did not consider that it was reasonable to penalise Mr N for not undertaking a programme for which he had never been assessed. We, therefore, upheld Mr O's complaint and recommended that his enhanced status be restored. The report was also copied to the Chief Officer of the relevant probation trust so that a sentence plan could be put in place for him.

Mr P's complaint was an unusual variation on the SOTP theme. He complained that he was unable to take part in the SOTP programme because, as a Muslim, he could not discuss his sins with others. He wanted the SOTP removed from his sentence plan.

We sought advice from the Muslim Adviser to the National Offender Management Service who said that some Muslim scholars took the view that individuals cannot divulge their sins to anyone, while others took the view that it was acceptable to divulge sins to others in certain contexts (for example, court hearings, therapy, when seeking spiritual guidance) where the intention was to overcome the sin. The adviser went on to say that there was, therefore, a legitimate Islamic opinion that would enable Mr P to participate in the SOTP if he chose to.

We did not uphold Mr P's complaint. The Prison Service has a duty to address prisoners' offending behaviour and reduce their risk before they are released back into the community. One important means of doing this is to identify suitable offending behaviour courses as part of a sentence plan. We were satisfied that the SOTP was a relevant programme for Mr P and that it was reasonable for it to remain on his sentence plan. It was for Mr P to decide whether he wished to undertake it or not. He had the right to choose not to participate. If that was his choice, he would need to accept that it would then be difficult for him to demonstrate that he had addressed his offending behaviour and reduced his risk.

Religious issues

Mr P's complaint was one of an increased number received about religious issues this year (17 cases compared to eight). Although there were complaints from Christians, Rastafarians, Sikhs and Pagans, the majority were from Muslims. For example:

Mr Q complained that he had been stopped from reading the Qur'an out of his cell window in the segregation unit.

The investigation found that the prison had a general policy that it was unacceptable for a prisoner to make a noise that could be heard outside of his cell as it disturbed others. The prison's Muslim minister told us that there was no religious reason for Mr Q to have been reading the Qur'an out of his window in this way. We did not, therefore, uphold his complaint.

Another Muslim prisoner, Mr R, complained that his religious items were not exempt from the volumetric controls on property. Prison Service policy provides that prisoners must be allowed to have items that are essential to the practice of their religion. However, because these items were not exempt from the volumetric controls, Mr R was being obliged to choose between his religious items and other items (such as food and cooking utensils).

We considered this was unfair and upheld Mr R's complaint in so far as it related to *essential* religious items.

Recommendations that cost money

Almost all the recommendations made by the Ombudsman are accepted by NOMS and UKBA. However, as budgets are cut, there may be less willingness to accept recommendations that come with a price tag. We are conscious that recommendations need to be realistic, but at the same time this will not stop us making recommendations which are right and necessary.

"As budgets are cut, there may be less willingness to accept recommendations that come with a price tag."

Mr S complained that he was not able to make a hot drink when he was locked up overnight (for between 12 and 15 hours depending on the day of the week).

This was out of line with Prison Service policy and practice in most prisons. In our view, both health and decency require that prisoners are provided with the means to make a hot drink when they are locked up for such long periods. Commendably, the Prison Service accepted the recommendation – and the cost implications – that the prison should provide prisoners with vacuum flasks or in-cell kettles for this purpose.

Mr T complained that prison staff would not support a move to a prison closer to his family. He said that it was very difficult for his wife and young children to visit him as they lived 250 miles away. The investigation established that Mr T was a category A prisoner who was serving a life sentence for serious sexual offences. He had, therefore, been allocated to a high security prison that specialises in providing the SOTP and other suitable offending behaviour programmes. He had not participated in these programmes because he was maintaining his innocence. He had not, therefore, demonstrated any reduction in risk.

We were satisfied that Mr T's allocation was the most appropriate one for him given his security needs and the nature of his offence.

It was also established that he had been transferred to a prison nearer his home for a period to enable him to receive accumulated visits from his family, and that it was open to him to apply for this again. For these reasons, we did not uphold Mr T's complaint. However, the investigation also found that the financial assistance available to Mr T's family, through the assisted prison visits scheme, did not adequately cover the cost of petrol for the trip as the mileage rate had not been increased since 2005 and petrol prices have risen by 60% since then. While the assisted visits scheme is not intended to cover all costs, the value of the mileage allowance has been eroded significantly since it was last increased in 2005, and this does make it more difficult for families to visit. We, therefore, recommended that the mileage rate should be increased. The recommendation was not accepted, however, on the grounds that it would cost too much.

Young offenders and female prisoners

As in previous years, young offenders and women have made a disproportionately small number of complaints. Only 3% of complainants were women and only 2% were under 21, although they make up 5% and 11% of the prison population respectively. These complaints tend to be different in nature from the complaints made by adult male prisoners. Fewer are about property, for example and a higher percentage about regimes, family ties and control and restraint incidents.

Ms U, an adult female prisoner, complained about being transferred out of a mother and baby unit (which meant that her three-month-old baby had been removed from her three months earlier than planned). The investigation found that Ms U had thrown a large stone at a window in the unit. She had known that a mother and baby were in the room at the time. The window had smashed and broken glass had fallen into the baby's empty cot. At the subsequent adjudication Ms U pleaded guilty to throwing the stone at the window, but said she had not meant to break it.

We established that the decision to remove Ms U from the unit had been taken by a review board chaired by an independent person from Social Services, and that Ms U had been able to attend the board and give her side of the story. The board found that Ms U had acted without regard for the consequences and had shown no remorse or appreciation of the seriousness of what she had done. It concluded that Ms U posed an unacceptable risk to the safety of women and children in the unit and should be removed. We could not say that this was an unreasonable conclusion in the circumstances and we did not uphold Ms U's complaint. We were pleased to see that Ms U was given a week to prepare for the separation from her baby and that she was immediately transferred to a prison nearer her home to make visits easier.

Probation

We received only 58 eligible complaints about probation supervision. These complaints were very different in nature from complaints about prison. Over a third were about the complainant's offender manager, and a quarter were about reports that had been written about the complainant.

Ms V complained about the licence conditions that her offender manager proposed to impose following her release: that she would be required to live in a hostel, rather than returning home to live with her partner and her 15-year-old son, and that she would not be permitted to live with anyone under the age of 18.

"Only 3% of complainants were women and only 2% were under 21, although they make up 5% and 11% of the prison population respectively."

The investigation found that Ms V had been convicted of violence in a domestic setting, including the false imprisonment and serious, prolonged assault of a 14-year-old girl, and that she had been assessed as presenting a high risk of harm to others. She was considered to have only limited insight into her issues with drugs and alcohol (which had been a contributory factor in all her offences) and it was thought that her partner's alcohol dependency would make it difficult for her to remain abstinent. Social Services were concerned about her son's wellbeing. We did not consider that the proposed licence conditions were unreasonable in the circumstances and did not uphold Ms V's complaint.

Mr W complained that the Probation Trust had refused to consider his complaints about his offender manager. The investigation established that Mr W had complained to the Trust about a number of alleged inaccuracies in his offender manager's report to the Parole Board.

The Trust initially told Mr W that no changes would be made to the report. However, when Mr W continued to complain, an internal investigation was carried out which concluded that, although most of Mr W's complaints were unfounded, the report did contain two, potentially quite significant errors. As a result the Trust apologised to Mr W. Mr W remained dissatisfied because he believed that the Trust had failed to implement the findings of the internal investigation. He, therefore, asked for his complaints to be reviewed by an appeal panel (in line with the Trust's policy). The Trust refused on the grounds that Mr W had raised no new information. When Mr W wrote repeatedly asking for his complaints to be reviewed, and making derogatory remarks about staff, the Trust categorised him as a vexatious and persistent complainant and told him that they would no longer respond to his letters.

We concluded that the Trust had contravened its own complaints policy by refusing to arrange a review of Mr W's complaint. Whether or not he had raised any new points, Mr W was entitled to have his complaint reviewed by an appeal panel, and it was not appropriate to categorise him as a vexatious and persistent complainant because he continued to ask that this be done. We upheld the complaint and recommended that the Trust apologise to Mr W and arrange for his complaint to be reviewed.

Immigration detention

We investigated 76 complaints from immigration detainees during the year. Many were similar to those from prisoners, with a third being about property.

But we have also investigated some serious complaints of assault by staff. There was the case of Ms B on page 32 and the following investigation into assault.

Ms Y complained that she had been assaulted by escorting staff[8] and left with her hands cuffed behind her back for over five hours.

An investigation carried out by UKBA's Professional Standards Unit found that Ms Y had been handcuffed as she described because the escorting staff had lost the key to the cuffs, and recommended that she receive an apology. It went on to find that CCTV was not working in the escort van when the alleged assault occurred, and concluded that Ms Y's allegation of assault could not be substantiated.

[8] The escort contractors have since changed.

We took the view that UKBA's investigation had been inadequate for such a serious complaint in that neither Ms Y, nor the staff involved had been interviewed. We were extremely concerned to learn that the CCTV in the escort van did not function when the engine was turned off, since, in the nature of things, most incidents that may give rise to complaint – restraints and the application of handcuffs – will take place when the vehicle is stationary. We were also disappointed to find that the escort contractors had refused to apologise to Ms Y for the fact that her hands were cuffed behind her back for five hours. They argued that, even if the escort staff had not lost the key, she would have been handcuffed anyway because of her behaviour. We did not accept this – the evidence from the escorts themselves was that Ms Y was asleep for most of the time. We recommended that UKBA ensure that CCTV operates in escort vehicles for the whole time a detainee is in them and this has been accepted. We also recommended that UKBA apologise to Ms Y for the shortcomings in their investigation and we await a response.

Mr X complained about his security risk assessment. The investigation found that Mr X had been transferred to the IRC after serving a 12-month prison sentence for wounding with intent. He was initially assessed as requiring the highest level of security. His security risk was reassessed three months later (when it was reduced to medium) and again after another four months (when it was reduced to the lowest level).

We were satisfied that Mr X's initial categorisation was not unreasonable given his history of violence, and that his categorisation had been reviewed regularly in line with UKBA policy. We were also satisfied that the security reviews had taken account of his good behaviour in the IRC, and that it had not been unreasonable to reduce his categorisation progressively over a period of seven months.

APPENDICES

Statistical tables

Please note: the percentages in the tables below are rounded and therefore may not add up to 100%.

Fatal incident investigations started	Total 2010/11	% of total (10/11)	Total 2011/12	% of total (11/12)	Change 10/11–11/12	% change year on year
Natural causes	122	61%	142	62%	20	16%
Self-inflicted	58	29%	71	31%	13	22%
Other non-natural	17	9%	9	4%	-8	-47%
Homicide	2	1%	1	0%	-1	*
Awaiting classification	1	1%	6	3%	5	*
Total	**200**	**100%**	**229**	**100%**	**29**	**15%**

* The % changes in small numbers are not meaningful.

Fatal incident investigations started	Total 2010/11	% of total (10/11)	Total 2011/12***	% of total (11/12)	Change 10/11–11/12	% change year on year
Male prisons	173	87%	198	87%	25	14%
Female prisons	9	5%	4	2%	-5	*
Young offender institutions	4	2%	8	4%	4	*
Approved premises	11	6%	15	7%	4	36%
Immigration removal centres	2	1%	4	2%	2	*
Discretionary	1	1%	0	0%	-1	*
Total	**200**	**100.0%**	**229**	**100.0%**	**29**	**15%**

* The % changes in small numbers are not meaningful.
*** One female prisoner and one approved premises resident were under 21.

Fatal incident investigations started 2011/12	Male prisons	Female prisons	Young offender institutions	Approved premises	Immigration removal centres	Total
Natural causes	130	2	0	7	3	142
Self-inflicted	57	1	8	4	1	71
Other non-natural	7	0	0	2	0	9
Homicide	1	0	0	0	0	1
Awaiting classification	3	1	0	2	0	6
Total	**198**	**4**	**8**	**15**	**4**	**229**

* The % changes in small numbers are not meaningful.

Fatal incident reports issued	Total 2010/11	% in time*	Total 2011/12	% in time*	Change 10/11–11/12	% change year on year
Draft reports	201	15%	210	24%	9	4%
Final reports	178	45%	196	39%	18	10%
Anonymised reports	173		143		-30	-17%

* In time is 20 weeks for natural causes draft reports, 26 weeks for other draft reports, 12 weeks for final reports. This is based on their classification at the start of the investigation.

Complaints received	Total 2010/11	% of total (10/11)	Total 2011/12	% of total (11/12)	Change 10/11–11/12	% change year on year
Prison	4,659	88%	4,726	89%	67	1%
Probation	502	9%	433	8%	-69	-14%
UKBA	130	2%	135	3%	5	4%
Total	**5,291**	**100%**	**5,294**	**100%**	**3**	**0%**

Complaints investigations started	Total 2010/11	% of total (10/11)	Total 2011/12	% of total (11/12)	Change 10/11–11/12	% change year on year
Prison	2,416	94%	2,533	95%	117	5%
Probation	70	3%	58	2%	-12	-17%
UKBA	75	3%	76	3%	1	1%
Total	**2,561**	**100%**	**2,667**	**100%**	**106**	**4%**

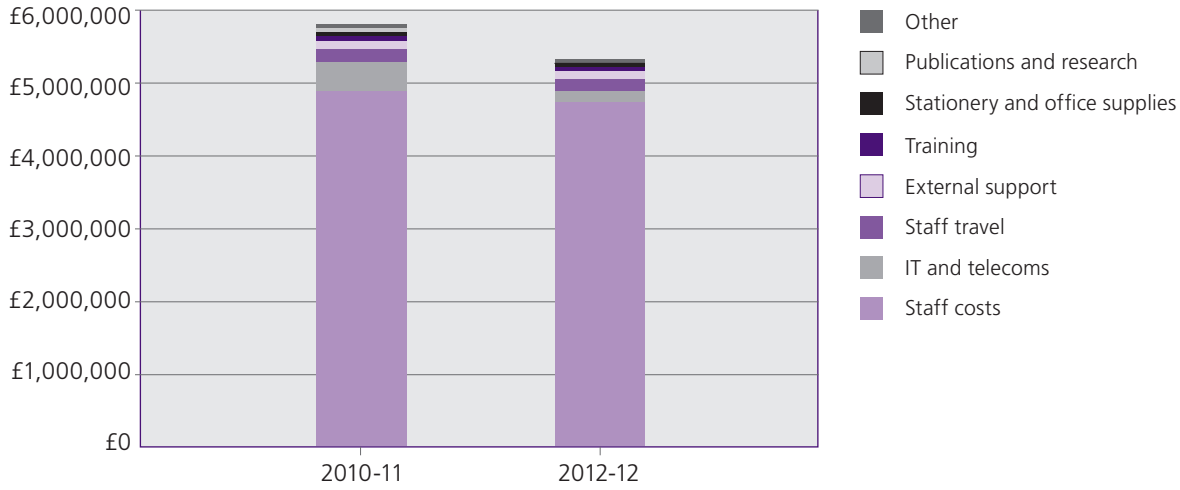
Complaints investigations completed	Total 2010/11	% of total (10/11)	Total 2011/12	% of total (11/12)	Change 10/11–11/12	% change year on year
Prison	2,362	95%	2,248	95%	-114	-5%
Probation	67	3%	67	3%	0	0%
UKBA	67	3%	45	2%	-22	-33%
Total	**2,496**	**100%**	**2,360**	**100%**	**-136**	**-5%**

Financial data

Finance	2010/11	% of total (10/11)	2011/12	% of total (11/12)	Change 10/11–11/12	% change year on year
Budget allocation	£5,977,000		£5,496,000		-£481,000	-8%
Staffing costs	£4,889,589	84%	£4,703,240	89%	-£186,349	-4%
Non-pay costs	£961,953	16%	£603,394	11%	-£358,559	-37%
Total spend	**£5,851,542**	**100%**	**£5,306,634**	**100%**	**-£544,908**	**-9%**

Finance	2010/11	% of total (10/11)	2011/12	% of total (11/12)	Change 10/11–11/12	% change year on year
Staff costs	£4,889,589	84%	£4,703,240	89%	-£186,349	-4%
IT and telecoms	£429,435	7%	£156,704	3%	-£272,731	-64%
Staff travel	£164,636	3%	£148,528	3%	-£16,107	-10%
External support	£138,472	2%	£109,018	2%	-£29,454	-21%
Training	£61,855	1%	£77,631	1%	£15,776	26%
Stationery and office supplies	£61,097	1%	£42,710	1%	-£18,387	-30%
Publications and research	£55,121	1%	£24,033	0%	-£31,088	-56%
Other	£51,336	1%	£44,770	1%	-£6,566	-13%
	£5,851,542	**100%**	**£5,306,634**	**100%**	**-£544,907**	**-9%**

Office costs – budget outturns for 2010–11 and 2011–12



Performance against Business Plan 2011–12

	Key deliverable	End of year assessment
1	Implement the findings of the strategic review which was commissioned in March 2011. The findings of the review will be presented to the senior management team by the end of May. Key issues include timeliness targets, quality assurance and staffing structures.	**Achieved.** The strategic review was completed by May 2011 and a series of work streams commissioned to implement the agreed recommendations. Progress was reviewed monthly with most work streams delivered by the end of March 2012. The impact of the new processes and procedures will be reviewed in 2012–13.
2	Continue to seek a more independent status, through reviewing our framework document with the Ministry of Justice and arguing for a statutory remit, so that the office's reputation for independence is maintained and enhanced.	**Ongoing.** The appointment of a new Ombudsman led to the initiation of a review of the Ombudsman's terms of reference and framework document with the Ministry of Justice. This will conclude in 2012–13. The Ombudsman has raised his lack of a statutory footing with Ministers who have repeated a commitment to find an early legislative slot.
3	Against a wider background of seeking to amalgamate public bodies' websites, ensure that our website's content and appearance continue to reflect our independent status.	**Achieved.** The office retains a dedicated website. An internal review of content was conducted in March 2012 and recommendations were made for change which will take place in 2012–13.
4	Review the provision of our information online to ensure that it contains the right balance of fatal incidents, complaints and corporate information.	**Achieved.** Addressed by the website working group (see 3 above).
5	Work with Ministry of Justice and Department of Health to achieve a step change improvement in the timeliness and effectiveness of clinical reviews of fatal incidents.	**Ongoing.** The Ombudsman has raised the matter with Ministers and senior officials in the Ministry of Justice who have raised this with their counterparts in the Department of Health. Two joint Ombudsman/Department of Health pilot projects have begun, one in the South and one in the North, to improve the commissioning of clinical reviews. Impact will be reviewed in 2012–13. Already, a slight improvement has been achieved.

	Key deliverable	End of year assessment
6	Develop and implement timeliness targets for producing fatal incidents reports which reflect joint accountability with the Department of Health/NHS for clinical reviews. This will be linked with a number of initiatives to improve performance on clinical reviews (see item 5 above).	Achieved. Addressed as part of the Strategic Review with new processes and key milestones identified. Changes implemented October 2011. Already, a slight improvement has been achieved.
7	Increase our influence, such as through developing structures and processes to provide more data from investigations and communicate learning to influence behaviours.	Ongoing. Addressed by the Ombudsman's new Learning Lessons Strategy 2012–15, produced in November 2011 for implementation in 2012–13.
8	Produce and publish a number of thematic research reports, highlighting key learning from our investigations.	Achieved. *Learning Lessons* reports published 2011–12: • Overview of complaints (May 2011) • Self-inflicted deaths in prison custody 2007–9 (June 2011) • Violence reduction, bullying and safety (October 2011) • Natural cause deaths in prison custody 2007–10 (March 2012)
9	Work with NOMS to reduce our complaints workload, such as through revising complaints leaflets in order to better educate complainants about complaints procedures and so reduce the number of ineligible complaints received.	Ongoing. A new complaints leaflet and associated posters intended to reduce the number of ineligible complaints were designed as part of the strategic review and produced by the end of March 2012. Distribution will take place in the coming financial year. Relevant publicity has also been sought in prisoner newspapers.
10	Deliver diversity/equality training for staff.	Achieved. Equality and diversity training was delivered at the full staff meeting in November 2011. A new Equality and Diversity Group, chaired by the Ombudsman, has been established to drive and monitor progress on the equality and diversity agenda. An equality and diversity action plan has been added to the Ombudsman's business plan 2012–13.

	Key deliverable	End of year assessment
11	Carry out a skills analysis of staff to ensure that skills are used in the best way to deliver the office's business. Provide training where skills gaps are identified.	Achieved. A learning and development plan 2011–12, based on a skills gap analysis, was produced. This identified priorities which were delivered during the year.
12	Work with Ministry of Justice (MoJ) to move the office onto the MoJ IT network (DOM1) and provide access to the NOMS prisoner database (p-NOMIS) and MoJ applications such as travel and subsistence and human resources. This will deliver substantial savings to the office's budget in the cost of remote access laptops.	Not achieved. A full transfer to DOM1 has been deferred by MOJ on a number of occasions and is now put back to 2012–13.
13	Continue to introduce the Lean approach to the office in order to ensure it operates in the most efficient and effective way possible.	Ongoing. Efficiencies in process were agreed and implemented as part of the strategic review, reducing spend by 9%. An organisational re-design exercise was initiated to create an affordable and effective staff structure, partly in response to further budget cuts amounting to at least 21% sought by the Ministry of Justice by 2014–15.
14	Address the issues identified by the staff survey, such as improving cross-office communication, tackling poor performance and reviewing procedures for reporting and investigating staff grievances.	Ongoing. A staff survey was conducted at the end of 2011 and change mapped against previous responses. Identified actions have been included in the Ombudsman's business plan 2012–13.
15	Provide staff training in information security.	Achieved. All staff attended information assurance sessions in September/October 2011 and were required to complete the mandatory e-learning by the end of the financial year.

PPO Terms of Reference

1. The Prisons and Probation Ombudsman is wholly independent of the National Offender Management Service (including HM Prison Service and Probation Services in England and Wales), the UK Border Agency and the Youth Justice Board.[9] The Ombudsman is appointed following an open competition by the Secretary of State for Justice.

2. The Ombudsman's office is operationally independent of, though it is sponsored by, the Ministry of Justice. The Ombudsman reports to the Secretary of State. A framework document sets out the respective roles and responsibilities of the Ombudsman, the Secretary of State and the Ministry of Justice and how the relationship between them will be conducted.

Reporting arrangements

3. The Ombudsman will publish an annual report, which the Secretary of State will lay before Parliament. The report will include:

- anonymised examples of complaints investigated;
- recommendations made and responses received;
- selected anonymised summaries of fatal incidents investigations;
- a summary of the number and type of investigations mounted and the office's success in meeting its performance targets;
- a summary of the office's costs.

4. The Ombudsman may publish additional reports on issues relating to his investigations, which the Secretary of State will lay before Parliament upon request. The Ombudsman may also publish other information as considered appropriate.

Disclosure

5. The Ombudsman is subject to the Data Protection Act 1998 and the Freedom of Information Act 2000.

6. In accordance with the practice applying throughout government departments, the Ombudsman will follow the Government's policy that official information should be made available unless it is clearly not in the public interest to do so.

7. The Ombudsman and HM Inspectorates of Prisons, Probation and Court Administration, and the Chief Inspector of the UK Border Agency, will work together to ensure that relevant information, knowledge and expertise is shared, especially in relation to conditions for prisoners, residents and detainees generally. The Ombudsman may also share information with other relevant specialist advisers, the Independent Police Complaints Commission, and investigating bodies, to the extent necessary to fulfil the aims of an investigation.

8. The Head of the relevant authority (or the Secretary of State for Justice, Home Secretary or the Secretary of State for Children, Schools and Families where appropriate) will ensure that the Ombudsman has unfettered access to the relevant documents. This includes classified material and information

[9] NOMS (including HM Prison Service and Probation Services in England and Wales) and UKBA are referred to throughout the Terms of Reference as 'the authorities'.

entrusted to that authority by other organisations, provided this is solely for the purpose of investigations within the Ombudsman's terms of reference.

9. The Ombudsman and staff will have access to the premises of the authorities in remit, at reasonable times as specified by the Ombudsman, for the purpose of conducting interviews with employees and other individuals, for examining documents (including those held electronically), and for pursuing other relevant inquiries in connection with investigations within the Ombudsman's terms of reference. The Ombudsman will normally arrange such visits in advance.

Complaints

Persons able to complain

10. The Ombudsman will investigate complaints submitted by the following categories of person:

i) prisoners who have failed to obtain satisfaction from the prison complaints system and whose complaints are eligible in other respects;

ii) offenders who are, or have been, under probation supervision, or accommodated in approved premises, or who have had reports prepared on them by NOMS and who have failed to obtain satisfaction from the probation complaints system and whose complaints are eligible in other respects;

iii) immigration detainees who have failed to obtain satisfaction from the UKBA complaints system and whose complaints are eligible in other respects.

11. The Ombudsman will normally only act on the basis of eligible complaints from those individuals described in paragraph 10 and not on those from other individuals or organisations. However, the Ombudsman has discretion to accept complaints from third parties on behalf of individuals described in paragraph 10, where the individual concerned is either dead or unable to act on their own behalf.

Matters subject to investigation

12. The Ombudsman will be able to investigate:

i) decisions and actions (including failures or refusals to act) relating to the management, supervision, care and treatment of prisoners in custody, by prison staff, people acting as agents or contractors of NOMS and members of the Independent Monitoring Boards, with the exception of those excluded by paragraph 14. The Ombudsman's terms of reference thus include contracted out prisons, contracted out services including escorts, and the actions of people working in prisons but not employed by NOMS;

ii) decisions and actions (including failures or refusals to act) relating to the management, supervision, care and treatment of offenders under probation supervision by NOMS or by people acting as agents or contractors of NOMS in the performance of their statutory functions including contractors and those not excluded by paragraph 14;

iii) decisions and actions (including failures or refusals to act) in relation to the management, supervision, care and treatment of immigration detainees and those held in short term holding facilities by UKBA staff, people acting as agents or contractors of UKBA, other people working in immigration removal centres and members of the Independent Monitoring Boards, with the exception

of those excluded by paragraph 14. The Ombudsman's terms of reference thus include contracted out establishments, contracted out services including escorts, and the actions of contractors working in immigration detention accommodation but not employed by UKBA.

Further provisions on matters subject to investigation

13. The Ombudsman will be able to consider the merits of matters complained of as well as the procedures involved.

14. The Ombudsman may not investigate complaints about:

i) policy decisions taken by a Minister and the official advice to Ministers upon which such decisions are based;

ii) the merits of decisions taken by Ministers, save in cases which have been approved by Ministers for consideration;

iii) actions and decisions (including failures or refusals to act) in relation to matters which do not relate to the management, supervision, care and treatment of the individuals described in paragraph 10 and outside the responsibility of NOMS, UKBA and the Youth Justice Board. This exclusion includes complaints about conviction, sentence, immigration status, reasons for immigration detention or the length of such detention, and the decisions and recommendations of the judiciary, the police, the Crown Prosecution Service, and the Parole Board and its Secretariat;

iv) cases currently the subject of civil litigation or criminal proceedings;

v) the clinical judgement of medical professionals.

Eligibility of complaints

15. The Ombudsman may decide not to accept a complaint otherwise eligible for investigation, or not to continue any investigation, where it is considered that no worthwhile outcome can be achieved or the complaint raises no substantial issue.

16. Where there is some doubt or dispute as to the eligibility of a complaint, the Ombudsman will inform NOMS, UKBA, or the Youth Justice Board of the nature of the complaint and, where necessary, NOMS, UKBA or the Youth Justice Board will then provide the Ombudsman with such documents or other information as the Ombudsman considers are relevant to considering eligibility.

17. Before putting a grievance to the Ombudsman, a complainant must first seek redress through appropriate use of the prison, probation or UKBA complaints procedures.

18. Complainants will have confidential access to the Ombudsman and no attempt should be made to prevent a complainant from referring a complaint to the Ombudsman. The cost of postage of complaints to the Ombudsman by prisoners, detainees and trainees will be met by the relevant authority.

19. If a complaint is considered ineligible, the Ombudsman will inform the complainant and explain the reasons, normally in writing.

Time limits

20. The Ombudsman will consider complaints for possible investigation if the complainant is dissatisfied with the reply from NOMS or UKBA or receives no final reply within six weeks (or 45 working days in the case of complaints relating to probation matters).

21. Complainants submitting their case to the Ombudsman must do so within three calendar months of receiving a substantive reply from the relevant authority.

22. The Ombudsman will not normally accept complaints where there has been a delay of more than 12 months between the complainant becoming aware of the relevant facts and submitting their case to the Ombudsman, unless the delay has been the fault of the relevant authority and the Ombudsman considers that it is appropriate to do so.

23. Complaints submitted after these deadlines will not normally be considered. However, the Ombudsman has discretion to investigate those where there is good reason for the delay, or where the issues raised are so serious as to override the time factor.

Outcome of the Ombudsman's investigation

24. It will be open to the Ombudsman in the course of a complaint to seek to resolve the matter in whatever way the Ombudsman sees most fit, including by mediation.

25. The Ombudsman will reply in writing to all those whose complaints have been investigated and advise them of any recommendations made. A copy will be sent to the relevant authority.

26. Where a formal report is to be issued on a complaint investigation, the Ombudsman will send a draft to the head of the relevant authority in remit to allow that authority to draw attention to points of factual inaccuracy, and to confidential or sensitive material which it considers ought not to be disclosed, and to allow any identifiable staff subject to criticism an opportunity to make representations. The relevant authority may also use this opportunity to say whether the recommendations are accepted.

27. The Ombudsman may make recommendations to the authorities within remit, the Secretary of State for Justice, the Home Secretary or the Secretary of State for Children, Schools and Families, or to any other body or individual that the Ombudsman considers appropriate given their role, duties and powers.

28. The authorities within remit, the Secretary of State for Justice, the Home Secretary or the Secretary of State for Children, Schools and Families will normally reply within four weeks to recommendations from the Ombudsman. The Ombudsman should be informed of the reasons for any delay. The Ombudsman will advise the complainant of the response to the recommendations.

Fatal incidents

29. The Ombudsman will investigate the circumstances of the deaths of:

i) prisoners and trainees (including those in young offender institutions and secure training centres). This includes people temporarily absent from the establishment but still in custody (for example, under escort, at court or in hospital). It generally excludes people who have been permanently released from custody;

ii) residents of approved premises (including voluntary residents);

iii) residents of immigration reception and removal centres, short term holding centres and persons under managed escort;

iv) people in court premises or accommodation who have been sentenced to or remanded in custody.

However, the Ombudsman will have discretion to investigate, to the extent appropriate, other cases that raise issues about the care provided by the relevant authority in respect of (i) to (iii) above.

30. The Ombudsman will act on notification of a death from the relevant authority and will decide on the extent of the investigation, depending on the circumstances of the death. The Ombudsman's remit will include all relevant matters for which NOMS, UKBA and the Youth Justice Board are responsible (except for secure children's homes in the case of the YJB), or would be responsible if not contracted elsewhere. It therefore includes services commissioned from outside the public sector.

31. The aims of the Ombudsman's investigations are to:

- establish the circumstances and events surrounding the death, especially regarding the management of the individual by the relevant authority or authorities within remit, but including relevant outside factors;
- examine whether any change in operational methods, policy, practice or management arrangements would help prevent a recurrence;
- in conjunction with the NHS where appropriate, examine relevant health issues and assess clinical care;
- provide explanations and insight for the bereaved relatives;
- assist the Coroner's inquest fulfil the investigative obligation arising under Article 2 of the European Convention on Human Rights ('the right to life'), by ensuring as far as possible that the full facts are brought to light and any relevant failing is exposed, any commendable action or practice is identified, and any lessons from the death are learned.

32. These general terms of reference apply to each investigation, but may vary according to the circumstances of the case. The investigation may consider the care offered throughout the deceased's time in custody or detention or subject to probation supervision. The investigation may consider other deaths of the categories of person specified in paragraph 29 if a common factor is suggested.

Clinical issues

33. The Ombudsman's investigation includes examining the clinical issues relevant to each death in custody – such deaths are regarded by the National Patient Safety Agency (NPSA) as a serious untoward incident (SUI). In the case of deaths in public prisons and immigration facilities, the Ombudsman will ask the local Primary Care Trust (PCT) or, in Wales, the Healthcare Inspectorate Wales (HIW) to review the clinical care provided, including whether referrals to secondary healthcare were made appropriately. Prior to the clinical review, the PCT will inform the NPSA of the SUI. In all other cases (including when healthcare services are commissioned from a private contractor) the Ombudsman will obtain clinical advice as necessary, and may seek to involve the relevant PCT in any investigation. The clinical reviewer will be independent of the prison's healthcare. Where appropriate, the reviewer will conduct joint interviews with the Ombudsman's investigator.

Other investigations

34. The Ombudsman may defer all or part of an investigation, when the police are conducting a criminal investigation in parallel. If at any time the Ombudsman forms the view that a criminal investigation should be undertaken, the Ombudsman will alert the police.

35. If at any time the Ombudsman forms the view that a disciplinary investigation should be undertaken by the relevant authority in remit, the Ombudsman will alert that authority. If at any time findings emerge from the Ombudsman's investigation that the Ombudsman considers require immediate action by the relevant authority, the Ombudsman will alert the relevant authority to those findings.

Investigation reports

36. The Ombudsman will produce a written report of each investigation. A draft report will be sent, together with relevant documents, to the bereaved family, the relevant authority, the Coroner and the PCT or HIW. The report may include recommendations to the relevant authority. Each recipient will have an agreed period to respond to recommendations and draw attention to any factual inaccuracies.

37. If the draft report criticises an identified member of staff, the Ombudsman will normally disclose an advance draft of the report, in whole or part, to the relevant authority in order that they have the opportunity to make representations (unless that requirement has been discharged by other means during the course of the investigation).

38. The Ombudsman will take the feedback to the draft report into account and issue a final report for the bereaved family, the relevant authority, the Coroner and the PCT or HIW and the NPSA. The final report will include the responses to the recommendations if available.

39. From time to time, after the investigation is complete and the final report is issued, further relevant information may come to light. The Ombudsman will consider whether further investigation is necessary and, if so, whether the report should be re-issued.

40. Following the inquest and taking into account any views of the recipients of the report, and the legal position on data protection and privacy laws, the Ombudsman will publish an anonymised report on the Ombudsman's website.

Follow-up of recommendations

41. The relevant authority will provide the Ombudsman with a response indicating the steps to be taken by that authority within set timeframes to deal with the Ombudsman's recommendations. Where that response has not been included in the Ombudsman's report, the Ombudsman may, after consulting the authority as to its suitability, append it to the report at any stage.

Staff list

Ombudsman

Nigel Newcomen CBE *(started 5 September 2011)*

Jane Webb (Acting) *(left 16 June 2011)*

Senior Personal Secretary

Jennifer Buck

Deputy Ombudsmen

Louise Falshaw *(started 19 September 2011)*

Tony Hall *(left 16 June 2011)*

Michael Loughlin *(started 27 February 2012)*

Elizabeth Moody

Penny Snow *(career break since June 2010)*

Personal Secretary

Janet Jenkins

Assistant Ombudsmen

Louise Baker *(left 31 October 2011)*

Karen Cracknell

John Cullinane

Michael Dunkley *(started 27 September 2011)*

Karen Johnson

Wendy Martin

Gordon Morrison *(left 29 June 2011)*

Olivia Morrison-Lyons

Colleen Munro

Dionne Spence

Thea Walton

Nick Woodhead

Central Services (now Strategic Support Team)

Mark Chawner

Sue Gauge (Research and Analysis Manager)

Henry Lee (Finance Manager)

John Maggi

Eileen Mannion (Manager) *(left 27 April 2012)*

Jayant Mehta *(left 5 April 2012)*

Samantha Rodney

David Ryan Mills *(left 28 March 2012)*

Steve Turnbull (HR and Communications Manager) *(left 30 September 2011)*

Senior Investigators and Investigators

Terry Ashley
Tamara Bild
Tracey Booker
David Cameron
Karen Chin
Althea Clarke-Ramsey
Debbie Clarkson
Vicki Cole *(started 30 January 2012)*
Paul Cotton
James Crean
Anthony J Davies
Lorenzo Delgaudio
Rob Del-Greco
Nick Doodney *(started 9 February 2012)*
Angie Dunn
Susannah Eagle
Kate Eves
Andrew Fraser
Ann Gilbert *(left 31 March 2012)*
Kevin Gilzean
Alan Green
Christina Greer
Natasha Griffiths *(left 30 November 2011)*
Rachel Gyford
Helena Hanson
Diane Henderson
Siobhan Hillman *(started 31 October 2011)*
Ruth Houston
Joanne Hurst
Katherine Hutton *(started 3 January 2012)*
Mark Judd
Razna Khatun
Madeleine Kuevi
Lisa Lambert
Anne Lund
Steve Lusted
Lisa McIlfatrick *(left 30 April 2011)*
Steve McKenzie
Beverley McKenzie-Gayle
Mark McPaul
Kirsty Masterton
Tracey Mulholland
Anita Mulinder
Vidia Narayan-Beddoes *(left 30 April 2011)*
Mandi O'Dwyer
Jade Philippou *(started 9 January 2012)*
Emma Range *(left 30 April 2011)*
Ben Rigby
Rebecca Sanders
Andrea Selch
Robin Shone *(left 16 June 2011)*
Anna Siraut
Sarah Stolworthy
Rick Sturgeon
Tina Sullivan
Anne Tanner *(left 30 April 2011)*
Jonathan Tickner
John Unwin
Louisa Watkins
Nicola Weir *(left 31 December 2011)*
Marc Williams
Karl Williamson
Jane Willmott
Sharon Worth
Sajjda Zafar *(left 22 July 2011)*

Family Liaison Officers

Narinder Dale

Abbe Dixon

Joanne Howells (Senior FLO)

Laura Spargo

Laura Stevenson

Complaints Assessors

Veronica Beccles

Claire Bond *(left 6 January 2012)*

Sarah Buttery

Antony Davies *(started 16 May 2011)*

Agatha Eze *(started 23 May 2011)*

Ranjna Malik *(left 30 April 2011)*

Emma Marshall

Verna McLean *(left 30 November 2011)*

Chris Nkwo *(started 5 September 2011)*

Ewelina Nocun *(left 8 April 2011)*

Alison Stone

Ibrahim Suma

Melissa Thomas

Fatal Incidents Support Team

Durdana Ahmed

Katherine Costello

Rowena Evans

David Gire-Mooring

Katherine Hutton *(Investigator from January 2012)*

David Kent *(left 30 April 2011)*

Esther Magaron

Umar Patel *(left 17 November 2011)*

Marta Rodrigues (Manager)

Tony Soroye