PRISONS AND PROBATION OMBUDSMAN
for England and Wales

Independent Investigations

Annual Report 2010 – 2011

Prisons and Probation Ombudsman for England and Wales

Annual Report 2010-2011

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

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On accepting the challenge

to act as the Prisons and Probation Ombudsman, I identified three key tasks: to **Preserve** the work of my predecessors; to **Promote** more widely the lessons from complaints and fatal incidents' investigations; and to **Prepare** the office for the permanent Ombudsman. A fourth mantra was quickly added with the decision of the Coalition Government to review every arms-length body. The **Protection** of the office became paramount in the early months due to the uncertainty raised by the Government's review of Arm's Length Bodies.

My colleagues and I are very appreciative of the Government's decision to protect the office in recognition of the transparency which we bring to investigations in prisons, immigration detention and probation. We understand that Ministers did not make their decision in isolation, and all of the services in remit played their part. We value their continuing acknowledgement of the worth of independent investigations.

Some may say that it does not matter if a prisoner loses their property or a 70 year old prisoner dies of cancer. Because something happens frequently, it does not make it acceptable or any less worthy of investigation. In fact, how a prisoner's property is looked after may well be a measure of how the prisoner himself is treated, and a death being predictable raises questions about whether detention was still necessary as well as whether suitable care was given. Securing the future of the Ombudsman's office means that these all too common situations will continue to be independently investigated and the lessons shared. Over 2,500 complaints investigations and 200 fatal incidents investigations are testament to this, as is our research into circulatory diseases and the reminder to prisons to develop protocols with their local ambulance services. They all illustrate the importance of Protecting the office.

Stephen Shaw left the office in April 2010 at the start of this reporting year. His contribution to the wellbeing of prisoners, detainees and those under probation supervision has been chronicled elsewhere. In particular, the Perrie Award for 2010 is a well deserved tribute to his work to 'make the world a better place' by an 'accumulation of small achievements' which contribute to the decency agenda.

Preserving Stephen's legacy has been a key responsibility during 2010-11. The business plan set out our objectives for the year and, against the constraints of work pressures and wider Government policy changes, they have largely been achieved. We were helped by a budget settlement which reflected the increased workload and, more prosaically, by better office accommodation. We have also been able to invest in training and over half the investigators are on track to be awarded the Advanced Professional Certificate in Investigative Practice. This is an external qualification and means that, for the first time, the Ombudsman's investigators are recognised as meeting their approved standard.

Of course, the office's key task is to consider an individual's complaint and the circumstances of each death. Every investigation seeks lessons to be learnt and the potential for improving the arrangements for individuals. This year my office received 4,641 complaints, a rise of 14% since last year. About half of these did not meet our eligibility criteria and the total number of cases eligible for investigation

this year was 2,561, 10% higher than last year. Given this increase in workload, it is testament to the hard work of my team that we completed 20% more cases than last year, 2,496 in total.

Two hundred deaths were notified to my office this year, seven more than in 2009-10. The number of self-inflicted deaths fell slightly, but the number by natural causes increased. At the time of writing, our numbers indicate fewer deaths from illicit drug overdoses, but there remain 13 prison deaths which are unclassified, some of which await toxicology results and may be drug related. In the face of serious staffing issues, we have managed to produce nearly as many draft reports as last year, although our output of final reports has been lower this year than last. I am pleased, however, to have kept pace with incoming cases and issued 200 draft and 178 final reports during the year.

I am also pleased to report that there has been progress on meeting published timeliness targets for complaints. Over 90% of cases were assessed for eligibility within ten working days and 63% of complaints investigations were completed within 12 weeks. This compares to 82% and 47% respectively last year.

We have made some progress on improving the timeliness of fatal incidents reports, although we continue to struggle to meet the published targets of 20 weeks for natural causes and 26 weeks for other types of death. Only 15% of drafts were issued within these target times. Although the majority of cases miss the deadline, they are being completed more quickly than last year, with reports on natural causes deaths issued on average two weeks earlier than last year and self-inflicted reports seven weeks earlier.

The impact of late and inadequate clinical reviews has affected my office's performance for many years and references have been made in previous Annual Reports. The delays caused by clinical reviews are mentioned elsewhere in this report. In the coming year we will be publishing regular performance information about delays and introducing a variable target which reflects our dependence on external agencies. It gives me no satisfaction when an Independent Monitoring Board uses its own Annual Report to complain about delayed inquests. Then the Coroner lays his own delays at my door when, in reality, I am waiting for the clinical review before I can issue my report to the bereaved family and the service in remit. I am grateful that the Secretaries of State for Justice and Health have considered the issue. The Business Plan for the coming year will continue to give attention to improving the timeliness of clinical reviews.

In response to comments in last year's stakeholder survey, the target for issuing final fatal incidents reports has been extended to give families more time to comment. We issued 45% within the new target of 12 weeks after the draft report.

The recommendations made as a result of my office's investigations are key to effecting change where it is needed. This year we made 26 national recommendations from fatal incidents investigations; 18 of these have been accepted so far and we await responses to the others. Complaints investigations generated 15 national recommendations; ten have been accepted, one partially, one was rejected and three still await a response.

My recommendations lead to direct improvements for prisoners and others.

For example, my findings from deaths in approved premises have resulted in NOMS considering whether to supply safe ligature knives and defibrillators as they already do in prisons. A prison death led to NOMS agreeing that each prisoner should have a unified health record, which includes any information about substance misuse and is available for any subsequent periods in custody. A complaints investigation resulted in Prison Service Order 1250 being amended to award compensation to prisoners whose property is lost or damaged in the prison laundry.

Sharing the lessons more widely is also key to Promoting the office. One way that this has been extended is by establishing the office's weekly email alert service. The alerts let subscribers – who currently number over 1,000 – know when each Prisons and Probation Ombudsman (PPO) report is published. As I visit different regions, I am greatly encouraged by speaking to practitioners who tell me how they use the reports to improve their own services. There are still prisons which have not experienced a death in custody, as well as many approved premises and removal centres in the same happy position. I hope that those in charge also read these reports and consider whether there are lessons to be learned.

To date little has been published about complaints investigations and this will be rectified in 2011-12. This is partly because the complaints terms of reference do not require learning to be shared and partly because the complainants' confidentiality must be protected. I found in favour of the complainant in only a quarter of complaints, either by mediating a settlement or by upholding the complaint fully or partially. This suggests that the decision made by the services in remit was correct in the majority of cases and it could therefore be useful to look for ways to communicate this to them. In the coming year we will also be able to say more about the themes behind complaints with the hope that the services under investigation will use the learning to improve their systems and reduce the number of complaints.

In preparation for the appointment of a permanent Ombudsman, several key personnel policies have been introduced or revised. Our finances have been managed responsibly as has our key resource, which is, of course, the Ombudsman's staff. A Lean analysis[1] is already identifying ways in which we can remove duplication and rationalise our investigation processes. A strategic review of the work processes and numbers of staff will conclude in May.

My report considers each part of the office in turn.

Firstly, I cover our Corporate Services functions, which include office management, infrastructure, research and the wider world. There are many successes but also frustrations, especially as we remain on the Home Office IT system, which incurs far higher costs than if we transferred to the Ministry of Justice. Exclusion from standard Ministry of Justice systems some four years after the machinery of Government changes is frustrating for every member of my staff.

Next, I highlight the work of my Complaints team and illustrate the most common categories of complaints. As in previous years, these are general conditions (which include staff behaviour), property (including what can and cannot be kept in possession) and allegations that adjudications were not handled correctly.

Lastly, I look at the work of my Fatal Incidents Investigation team and consider suicides in local prisons. I go on to assess the circumstances when a prisoner dies after refusing medical treatment. We have found some good examples of palliative care for prisoners, although I am surprised that so many remain in custody. Most deaths leave a family bereaved and reliant on my

[1] Lean is a management technique to set up an organisation's processes in a way that eliminates waste and improves customer value.

reports to find out what happened to their loved one. Families tell me that they do not want other families to go through the same experience. I highlight one family's contribution to improving practice and the Department of Health guidance which was issued as a result.

Looking at the year's successes in the context of reduced budgets, it is clear that my workload must reduce if timeliness is to have any chance of improving. I talk to Governors and others about how they can reduce my office's workload: compliance with Prison Service Orders, good quality responses to complaints at Stage 1 of the internal complaints process, safer custody and good healthcare all mean that the Ombudsman's caseload shrinks. The focus for my predecessors was ensuring that there was wide and easy access to the Ombudsman. I am in no doubt that there is ready access. In the coming year the office will want to reduce its workload by encouraging the National Offender Management Service (NOMS) and others to resolve complaints at an earlier stage and consider how the number of avoidable deaths can be reduced.

Finally, I want to pay tribute to my colleagues whose work is the bedrock of this, the 16th, year of the Prisons and Probation Ombudsman office. The workload has risen yet again but they have accepted the challenge. Performance, delivery and timeliness continue to improve which has helped to secure the office's future. They have accepted the change of Ombudsman and supported me since my appointment.

It is with reluctance and regret that I decided that the budget settlement for coming years did not permit the office to retain the staff seconded from NOMS. The office owes a great deal of its success to the expertise and dedication of seconded staff as well as its permanent staff and I am sorry that the secondments have been ended. I am confident that the maturity and experience of the permanent staff will fill the gap.

I am also very conscious of the number of my staff who are taking advantage of the Ministry of Justice's voluntary early departure offers. Their departures will undoubtedly affect performance in the short term. In the longer term, it gives the office the opportunity to restructure and reinvest to meet the budget and continue to deliver the terms of reference.

In particular, I pay tribute to the other members of the senior management team. Elizabeth Moody, Tony Hall and Thea Walton have worked tirelessly with me to share the leadership of the office. Together we have Protected, Preserved, Promoted and Prepared the office for the years ahead. Recognising the challenges facing the whole public sector, we hope that sufficient resources have been allocated to allow the work to continue, albeit in a leaner and more streamlined way.

It is an honour to be responsible for independently investigating fatal incidents and complaints from people who are deprived of their liberty. I am proud to be accountable for finding out what happened and how lessons can be learned. I am especially proud to be the first woman to give her name to these investigations and I wish my successor, Nigel Newcomen CBE, well as he takes the office into the coming year.

Jane Webb
Acting Prisons and Probation Ombudsman

Corporate Services: Wider issues for the office

> Communication has improved and it seems to have raised its profile over the last 12 months. [Approved premises manager]

This Annual Report rightly focuses on my investigations and the lessons learned from them. However, the terms of reference could not be delivered without the support of many important corporate activities which are frequently hidden from view. Here I record some of the notable achievements during the year.

I deliberately gave more priority this year to managing my office's finances, in view of the continuing pressure to do more with less. As the figures at the end of this chapter show, my budget is modest in relation to many comparable organisations and it is vital to squeeze as much as possible out of it. We made many efficiencies without affecting the quality of our work. For example, we reduced spending on travel and subsistence by a third. We dispensed completely with agency staff to fill temporary vacancies. We also made a large number of housekeeping efficiencies, such as limiting refreshments at meetings, cancelling management away days, cutting down attendance at external conferences and reducing stationery and publications costs. Holding vacancies open has also contributed to the underspend, although this has had an impact on the timeliness of our work.

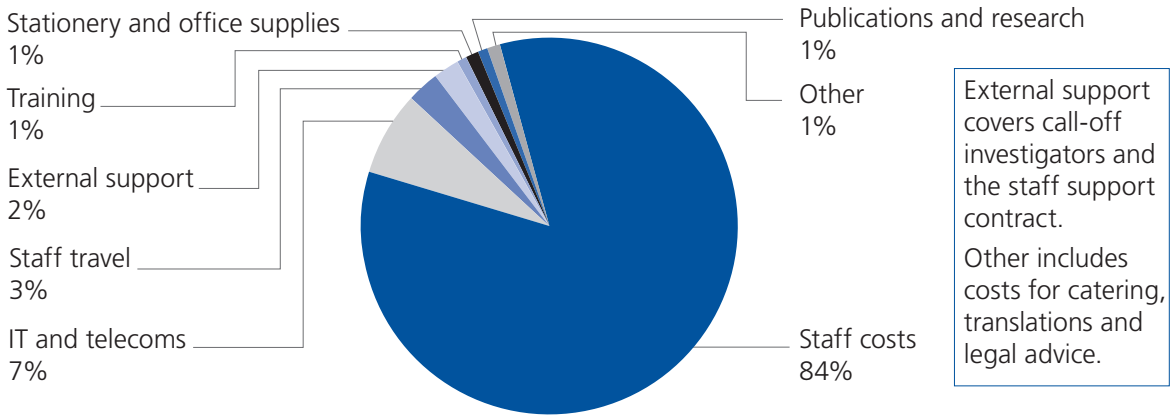
This year we spent a total of £5,851,842, 3% less than last year, and less than our budget allocation of £5.98 million. The chart below illustrates how staffing accounts for the vast majority of our costs. This has become even more marked since we reduced spend on non-pay costs such as travel.

Office management

I am fortunate that my office possesses a talented team of investigators, other staff and managers, but, as with any modern organisation, systems and processes need to work well to realise our potential and provide the best possible service.

> Very professional in their dealings with staff and they ensure that they gather all information before making a decision. (Governor)

Office costs 2010-11



For example, my office has implemented a performance scorecard which has become an indispensible tool for managing the office. It provides regularly updated data on all aspects of our performance, the output and timeliness of reports, accessibility and the effectiveness of support services. We now have an all-round perspective and can take early corrective action when necessary.

Linked to the performance scorecard is the risk register. My office has always recognised the need to manage risk, such as the health and safety risks arising from the unpredictable nature of investigation work, often requiring extensive travel, and from the nature of much of our work. These risks were managed informally but it became clear that a more rigorous approach was needed, so that key risks are reviewed regularly and corrective action taken.

Staffing

In recent years, my office has invested heavily in developing the skills of investigators and other staff. We worked with an external provider to deliver a range of courses, tailored specifically to the needs of the office. They covered effective writing, work management, interviewing skills, project management and investigative skills.

We have built on this foundation by commissioning another provider to deliver an accredited training package, Advanced Professional Certificate in Investigative Practice, for fatal incident investigators and some complaints investigators. Thirty-five of my staff have completed the training and are on track to receive an accredited qualification which provides assurance both to the office and to people outside about the professionalism of our investigations.

We put a number of new policies in place, most notably the 'Good Colleague' profile, home-working guidance, a new reward and recognition scheme and guidance on diversity and equality.

In previous years we have carried out our own internal staff survey. This year we used a specially tailored version of the Ministry of Justice's staff engagement survey, which enabled us to benchmark our results against those of other arms-length bodies. The results indicated areas where we are doing better than other similar organisations, such as giving staff regular feedback on their performance, as well as areas for improvement, such as staff not feeling that they have the tools they need to do the job well. The latter issue is addressed in the following section on office infrastructure.

Staff care is always a priority. The pressure to deliver the work is relentless, and every stakeholder would like a quicker service. Reports are subject to considerable external scrutiny. The subject matter brings its own stresses, not only for the fatal incidents investigators but a good number of our complaints investigations as well. While my staff can make use of the Ministry of Justice workplace support, that is not enough. We have an ongoing contract with an external staff care provider who undertakes an annual check of fatal incidents staff and offers counselling and advice whenever it is needed.

> "Replace the case management system with a system that is quicker and more efficient. [Staff member]"

Office infrastructure

In common with other organisations, we are heavily reliant on IT systems to manage our casework, produce management information, provide precedent information for caseworkers and analyse the themes from recommendations to enable lessons to be learned. Increasingly, to do our work efficiently, our systems need to link with others. So we need to have access to the Ministry of Justice IT network and NOMS new prisoner information system (P-Nomis).

Some four years after our sponsorship passed from the Home Office to the Ministry of Justice, we are still linked to the Home Office IT network. This is a wholly unsatisfactory situation. It means that we have only partial access to several essential Ministry of Justice services such as financial management, website maintenance, travel and subsistence payments and others. Additionally, we are charged significantly more for Home Office remote access laptops than if they came from the Ministry of Justice network. We are also prevented from having easy access to prisoner records through links to NOMS P-Nomis system. These are compelling cost and business reasons for my office to be connected to the Ministry of Justice network which will need to happen at the earliest possible time if we are to work efficiently and balance the budget in the coming year.

Things have fared better on the office accommodation front. Our accommodation in Ashley House was expanded in May 2010 after many years in unacceptably cramped conditions. However, there remain significant concerns about the commitment to maintain the infrastructure of the building to an acceptable standard. We rely on the Ministry of Justice to oversee management of the building, but the fabric is deteriorating and concerns about basic health and safety procedures are dealt with very slowly.

It was no real surprise, therefore, that the building suffered a serious power outage in June and July 2010. It could not be occupied for three days and it took a further week for the air conditioning to be restored and temperatures to be brought down to acceptable levels. Of course, these are straitened times, but my sense is that our building is considered to be the poor relation in the Ministry of Justice estate. This needs to change.

Research, analysis and learning the lessons

Three years ago my office had no research or analysis capability and very little useable data. Since then we have made considerable progress in building up an extensive database of information from our fatal incident investigations. This database, known as FIIFIS (which stands for Fatal Incident Investigations Full Information System), was developed using funding from the Department of Health and now contains detailed data on cases relating to deaths since 2007. The database continues to grow with investigators providing information on newly completed cases and interns collecting data from the more historic cases.

November 2010 saw the publication of our first thematic report[2] based on the information collected in FIIFIS. This presented the analysis of 115 deaths from circulatory diseases between 2007 and 2009. The analysis found there had been concerns with emergency response in 43% of cases where a prisoner had suffered a heart attack in prison (excluding healthcare centres). The report received a good deal of publicity and caused the Ministry of Justice and the Department of Health to reissue joint guidance to ensure that access to prisons for ambulances is not unnecessarily delayed.

> “Much better publications and information on fatal incidents. [Safer custody manager]”

[2] Learning from PPO Investigations – Deaths from circulatory diseases, November 2010.

The knowledge base we have developed for fatal incidents is now highlighting the lack of a similar resource for complaints investigations. The first steps to redress this imbalance were made over the last year, with detailed information from over a hundred property complaints being collected by an intern. The analysis of these data, from just a small proportion of the complaints cases which my office deals with, has demonstrated how useful such a resource could be if it were rolled out to cover all complaint types. I am hopeful that the analytical resources in the office can be expanded this year so that we can fully develop the knowledge base for both complaints and fatal incidents investigations. This resource will improve individual investigations by helping investigators to identify precedents. More radically, as far as this office is concerned, it will enable us to explore patterns and analyse emerging themes to generate collective learning for the services in remit.

The last Annual Report included several mentions of three stakeholder surveys which my office had undertaken during the year. The individual results from all three surveys were published on our website and a summary report[3] was published in June 2010.

This year, while the general stakeholder survey remained as an on-line survey in November, we took a slightly different approach to bereaved families. Last year's survey involved contacting 133 families at the same time, which for some meant several years after the death of their relative. In September this year we started to send a feedback form at the end of each investigation. Responses have been received from only 13 families at the time of writing and so detailed analysis is not appropriate. Two-thirds of respondents were positive about all aspects of their experience of dealing with the PPO, and all respondents rated the way they had been treated by their PPO family liaison officer as good or very good.

[3] Perceptions of PPO: What stakeholders think about the Prisons and Probation Ombudsman 2009-2010; June 2010.

Compared to previous surveys, the general stakeholder survey was more focused on the preceding 12 months rather than general impressions. One in five respondents noticed improvements since last year in the timeliness of investigations and overall quality. However, as in previous years, timeliness continues to be an area of concern for many respondents. Investigations were not completed quickly enough according to nearly half of those who had experience of fatal incidents and a third of those who had experience of complaints.

A quarter thought communications had improved and there had been a substantial increase in the proportion of respondents who had seen PPO publications. The usefulness of the publications varied but overall two-thirds found them very or quite useful. Respondents were asked to rate how 'influential', 'independent', 'accessible' and 'professional' they felt the PPO to be. Over 85% gave 'very' or 'quite' ratings on all four scales. The individual ratings are shown in the statistics section of this report.

Next year we are planning to collect feedback from governors and coroners on our fatal incident investigations on a case-by-case basis, so that respondents can focus more clearly on what happened in individual cases.

Quotes from both stakeholders and bereaved families are shown throughout this Annual Report for illustrative purposes, but they are not necessarily representative of the views of all respondents.

The wider world

A crucial part of my office's work is to communicate the lessons learned from investigations and highlight more generally the good work of my office. During the year, I made it a priority to get out and about. For example, I visited 12 prisons and probation areas. The visits are in addition to regular meetings with colleagues such as the Director-General of NOMS, the Director of Offender Health, the United

Kingdom Border Agency, the Youth Justice Board, HM Chief Inspector of Prisons, HM Chief Inspector of Probation and the Parliamentary and Health Services Ombudsman. We particularly value our continued contact with the office of the Prisoner Ombudsman for Northern Ireland and the office of the Scottish Public Services Ombudsman.

I regularly attend the Ministerial Board on Deaths in Custody and other colleagues are part of the Independent Advisory Panel's virtual stakeholder group. We are pleased to support the Board's work and value its efforts to reduce the number of deaths in custody.

Colleagues and I addressed many conferences at home and abroad, including a conference in Budapest funded by the International Helsinki Federation for Human Rights. We have welcomed visitors from Afghanistan, Argentina, the Cayman Islands, China, Ecuador, Ethiopia, Panama and Peru. They are all interested in learning how my independent investigations contribute to prisoners' wellbeing and I am pleased to contribute to improving prisoners' conditions in other countries.

This activity is in addition to more structured communications. We continue to issue a quarterly newsletter, On the Case, which highlights learning from investigations. A weekly email was introduced to alert stakeholders and other interested parties to new publications on our website. This enables us to provide a better information service to an audience of over 1,000 readers each week. New subscribers can contact PPOcomms@ppo.gsi.gov.uk to be added to the weekly alert.

> "The e-mail alerts are very good, a great improvement and easy to share with my team. [IRC Manager]"

The website[4] provides users with clear information about the work and how we do it. It is a repository for our publications and contains an anonymised version of the report of every fatal incidents investigation which I have completed. There are currently over 750 anonymised reports on the website which are a valuable source of learning as well as demonstrating accountability.

> "These reports get me thinking about our own processes and whether they need amending in the light of investigations elsewhere. [Approved premises manager]"

Independent investigations by arms-length bodies such as my office are rightly published on an independent website and I am pleased that the threat to subsume the site into a wider Justice site has, at least temporarily, been removed.

Although my office does not seek a high media profile, it is in the nature of the work that investigations occasionally attract attention, often because the incident which led to my office's involvement was newsworthy. It is difficult to measure objectively, but my perception is that media interest has increased during the year and so we have appreciated having our first press officer. I believe this attention is a welcome development, although a cautionary note should be added. Like my predecessors, I do not offer views on the issue of the day in the offender management field. That would not be consistent with my office's function or its values.

How we performed on our 2010-11 work plan

Our business plan for 2010-11 included a plan of work activities to develop the office so that it is in the best possible position to support our front-line delivery. The following table sets out the progress we made on each item. Some of our plans were particularly challenging and further work will roll forward into 2011-12, as set out in our new business plan.

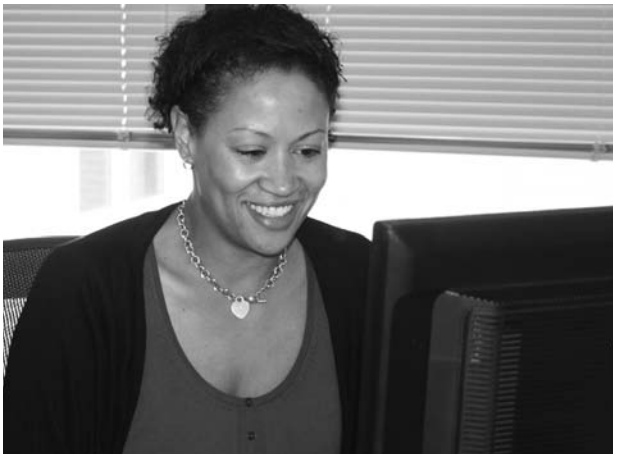
[4] www.ppo.gov.uk

Workstream	End of year assessment
1.1 Review our governance arrangements in discussion with Ministry of Justice to ensure our independence is safeguarded.	This was considered as part of the Government's review of arms-length bodies, resulting in agreement that the PPO should continue in its current form as an independent body, sponsored by the Ministry of Justice.
1.2 Undertake an annual review of our framework document with Ministry of Justice and complete protocols on specific support services.	The review of the framework document was deferred to 2011-12, pending the appointment of the new permanent Ombudsman. The protocols were agreed in principle by end July. Two remain outstanding (HR and finance) and were delayed by Ministry of Justice wider initiatives on arms-length bodies and procurement which are outside the PPO's control.
1.3 Continue to argue for legislation to be introduced to provide a statutory remit that delivers conspicuous independence.	An options paper was produced and sent to Ministry of Justice in August, and subsequently agreed with them informally. Further actions await the Ministry of Justice formal response and the appointment of the new permanent Ombudsman.
2.1 Ensure our publicity materials, in particular our three recently produced DVDs, are used to maximum effect.	NOMS gave a commitment to ensure that posters are displayed. New instructions give guidance on posters and DVDs. PPO staff are encouraged to highlight posters during visits. The complaints leaflet will be revised in 2011-12.
2.2 Undertake work to explore reasons why certain complainants groups are under-represented, such as women and young people.	Not undertaken because of the need to redeploy resources to higher priority areas. This included finding ways to reduce our workload, linked to our reduced budget.
2.3 Improve our telephone customer service.	This is being taken forward as part of the Lean work, and is ongoing through 2011-12. Some baseline information has been collected.
3.1 Develop means of measuring and assessing the quality of our investigations and reports.	The Ombudsman/Deputy Ombudsman reads all fatal incidents reports. A fatal incidents investigation quality assurance process was drafted. It recommended fundamental changes to the way we work, and it has been incorporated into the PPO strategic review. The Ombudsman/Deputy Ombudsman read all complaints reports and records of investigation and comment on quality issues. This process is now more systematised and further development work will take place in 2011-12.

Workstream	End of year assessment
4.1 Undertake a review, using Lean methodology, to streamline our processes.	The review started in September. Process mapping for complaints and fatal incidents investigations has been done. Further work is incorporated into the PPO strategic review.
4.2 Seek to reduce the number of ineligible complaints being made and the number of borderline cases that are accepted for investigation.	Pursued with NOMS, who will ensure prison staff are aware of correct procedures and that posters are displayed. A new leaflet and posters are planned. The Ombudsman has highlighted correct procedures during visits to prisons. A PPO themed Ministerial visit has been arranged which will highlight the impact which NOMS has on the PPO's workload. New complaints leaflets/posters were drafted but this work was put on hold pending the outcome of the strategic review and will roll over to 2011-12. The Business Plan for 2011-12 contains additional objectives to address the issue.
4.3 Assess clinical reviews of deaths in custody to establish whether they address the issues and follow the guidance. If not, devise an action plan for improvement.	An internal review was completed and key issues were shared with the NHS. Regional offender health leads are copied into all clinical review guidance. Regular meetings take place highlighting issues with the DH offender health team. Each team leader has responsibility for a region and escalating PCT issues. The issue of delayed clinical reviews has not been resolved and it is on the agenda for the Secretaries of State for Justice and Health.
5.1 Develop a cross-office stakeholder relations strategy.	A draft communications strategy was agreed in June. A stakeholder meetings database was set up and data collected for the performance scorecard on the effectiveness of stakeholder engagement.
5.2 Develop the complaints investigations knowledge base.	A property questionnaire was devised and tested and a database of cases was created. An analysis of property cases was carried out. Further development of the complaints knowledge base is a priority in the 2011-12 business plan.
5.3 Issue research reports highlighting lessons learned from both complaints and fatal incidents investigations.	A report on deaths by circulatory diseases was published in November. Papers on general complaints themes and an analysis of self-inflicted deaths between 2007 and 2009 are at an advanced stage of consultation and will be published shortly.

Workstream	End of year assessment
5.4 Review the effectiveness of the quarterly newsletter On the Case and the PPO website.	Website use data became available in April. Work was started to make access to anonymised reports more user friendly, although this was deferred by a wider initiative to merge arms-length bodies' websites (in the event it was agreed that the PPO could continue to operate an independent website). On the Case was revamped in December. A weekly email alert to stakeholders became operational in June and has 1,000 subscribers.
5.5 Develop and implement a research strategy, focusing on learning the lessons and establishing some underlying reasons for matters we investigate.	A draft strategy was agreed in June, focusing on improving the availability of data, producing research reports and supporting the management information system. This was intended to increase the office's influence with stakeholders.
6.1 Implement a human resources and recruitment strategy and a diversity and equality action plan which the office developed in 2009-10.	A human resources strategy was agreed in May and has been implemented during the year. Features include establishing a home-working policy, better sick leave management and better succession planning. A diversity and equality policy was published. This will be followed up with training for staff in 2011-12.
6.2 Provide development for managers in effective management, including performance and attendance management.	Development needs were assessed through a talent management exercise. A two-day event for managers in February covered change management.
6.3 Provide development for all staff, ensure we make the best use of the range of skills we have and consider an element of accreditation.	Learning and development needs/priorities were agreed in June and relevant development activities were implemented with providers. Accredited training was delivered to both fatal incidents and complaints investigators.
6.4 Develop a corporate risk register.	An initial register was agreed and baselined in November. It has since been reviewed quarterly.
6.5 Work with Ministry of Justice to develop a new electronic case management system.	A new system was identified in June, but insufficient funds meant that the alternative option of transferring the existing case management system from the Home Office to the Ministry of Justice network platform was pursued. Transfer is likely to take place in 2011-12.
6.6 Work with Ministry of Justice to achieve better office accommodation.	This was achieved in May. Expanded accommodation in Ashley House now covers the ground and 3rd floor, and includes new meeting rooms.

Complaints



> I think the work which the PPO have done during the last 12 months has been very fair in all aspects. [Prison administrator]

The number of new complaints received in 2010-11 rose to 5,291 (an increase of 14% over the previous year). As in previous years, the vast majority (88%) of complaints received were about prisons, with only 9% concerning the Probation Service and just 2% relating to immigration detention.

It is still the case that we have to turn away a lot of complaints as they are not eligible for investigation, most often because the complainant has not followed the internal complaints procedure of the relevant service. Although I am pleased that eligibility has not dropped back to the low point of 36% in 2007-08, it is frustrating that still only half the complaints we receive are eligible. My office is looking into ways of working with the services in remit to reduce the number of ineligible complaints received and the resources spent on dealing with them.

Sometimes the complainant has not been able to complete the internal complaints process through no fault of their own.

Despite reminders, Mr A had not received a final response to his complaint about missing property after six weeks. My office therefore accepted his complaint for investigation on the grounds that he had tried to use the internal process and should not be penalised because the prison had failed to respond.

Some complaints are ineligible because they are outside the Ombudsman's remit. In such cases my office will tell the complainant who they need to contact.

Mr B complained that the prison's Healthcare Department had ignored his complaints that he was suffering from withdrawal symptoms after his medication was stopped. My office told him that he should complain to the Primary Care Trust in the first instance.

Complaints received more than three months after the final response from the service in remit are also ineligible. I do, however, exercise my discretion occasionally to accept such cases for investigation where there is a good reason for the delay or where the complaint is sufficiently serious. One such case involved a complaint from Miss C, a young child, that staff at an IRC had treated her unkindly which was accepted for investigation despite being some months out of time when it reached me.

A small number of complaints meet the eligibility requirements but are not accepted for investigation.

Mr D complained that the provision of mince pies at the prison's Christmas carol concert amounted to a bribe to convert to Christianity. I declined to investigate on the grounds that Mr D's complaint did not raise a substantial issue and investigation would not be a good use of public money.

There are marked differences in eligibility between the three services in remit. While just over half (52%) of prison cases were eligible, only 14% of probation cases were. Complaints from serving prisoners about the Probation Service have particularly low eligibility. Of 502 probation cases received, only 70 were eligible. In contrast, although only 130 cases were received about immigration detention, 75 (58%) were eligible.

Overall during 2010-11 there were 2,561 cases eligible for investigation, an increase of 10% over the previous year.

Notwithstanding this increase in workload, we have focused this year on improving the service we provide to complainants and have made significant improvements, despite having fewer staff than last year.

When we receive a new complaint, we aim to assess its eligibility for investigation and write to the complainant with our decision within ten working days. In 2009-10 we did this in 82% of cases, which was a considerable improvement from 53% in the previous year. I am pleased to report that speed of assessment has continued to improve and in 2010-11 we assessed 91% of cases within ten working days. The average time taken to assess eligibility more than halved from 17 days in 2009-10 to just seven days in 2010-11.

Once we accept a complaint for investigation, we aim to complete the investigation within 12 weeks. It is pleasing that we met this target in 63% of cases, a considerable improvement from 2009-10 when only 47%were completed within 12 weeks. The average time taken to complete a complaint fell from 17 weeks last year to 14 weeks in 2010-11.

> “To be fair the timeline for complaints is often defined by us and our ability to supply your investigators with the necessary information. [Governor]”

We have also significantly reduced the number of very longstanding cases. At the beginning of the year we had 131 ongoing cases which had taken over 24 weeks, including 64 which had taken over 36 weeks. By the end of the year the number of cases still ongoing after more than 24 weeks was 29, of which just six were taking longer than 36 weeks.

We hope to maintain and build on these levels of service during 2011-12, although we recognise that this will be a challenge with a reduced budget.

As in previous years some complainants need not have sought my help if their complaints had been better dealt with internally.

Mr E had been found guilty at an adjudication hearing and submitted an application to staff in the segregation unit the following day asking for a copy of the paperwork so he could appeal. He was told – incorrectly – that he was not entitled to have a copy. He then submitted a complaint and was told in response that segregation unit staff would be asked to give him a copy. When he had still not received the paperwork 12 days later, he submitted a second stage complaint. He was told in response to ask the segregation unit staff. When he still did not receive the paperwork he completed the final stage of the complaints process. He received a reply apologising for the delay and saying that staff had been asked to give him a copy. Ten days later he wrote to me as he had still not received the papers more than a month after he had first asked for them.

My investigator contacted the prison’s discipline office where records of adjudications are kept. She was told that they had not previously been asked to copy the paperwork for Mr E but that they would do so and would forward it to Mr E immediately. Six days later Mr E contacted the investigator to say he had still not received the papers. The investigator then spoke to a governor and Mr E eventually received the papers two months after he had first asked for them. The prison discipline manual makes it clear that

prisoners must be given a copy of their adjudication paperwork on request and it is very disappointing that Mr E had to ask for my assistance before his simple and reasonable request was met.

The Prison Service are piloting a new internal complaints process which reduces the number of internal stages from three to two. I support this in principle on the grounds that it should make the complaints process simpler and quicker for complainants. In theory it should also result in complainants receiving better quality responses and therefore reduce their need to seek my assistance. It will be important, however, to ensure that these benefits are delivered. My staff will therefore be monitoring the impact on the changes in the pilot areas and feeding this back to the Prison Service.

When complaints do reach me, I attempt to achieve a mediated settlement whenever possible. Complaints about lost or damaged property in particular lend themselves to a mediated approach but other categories of complaint may also be the subject of mediation.

Mr F complained that his personal officer was refusing to answer his general applications and asked for his personal officer to be changed. The PPO investigation established that the personal officer wanted to encourage Mr F to engage by discussing problems in person rather than in writing, although he did respond in writing to Mr F's applications when his applications concerned matters that were outside his control. My investigator went to see Mr F and explained to him that there were different ways of resolving problems or asking for help and that a discussion with his personal officer would often be the quickest and most effective way to resolve problems on the wing. She suggested to the prison that some form of mediation should take place between Mr F and his personal officer. The prison agreed and suggested that this should be facilitated by the senior officer (SO) on Mr F's wing. The investigator thought that the SO might not be seen by Mr F as sufficiently impartial. It was therefore agreed that the mediation would be facilitated by a governor with no day-to-day involvement in the running of the wing.

When a mediated settlement cannot be reached, however, or where the issues complained about are particularly serious, I issue a formal report and make recommendations to the service in remit. In 2010-11 I issued 110 reports and made around 240 recommendations. They range from recommendations that compensation should be paid for lost or damaged property, recommendations that practices should be changed at individual establishments or Probation Trusts and recommendations for policy changes at a national level. I am pleased that my recommendations have invariably been accepted.

I made 15 national recommendations, nine of which have so far been accepted by NOMS and one by the UK Border Agency (UKBA); one has been partially accepted and response is awaited for the other three. They covered topics including the provision of a viewable format for CCTV footage, the handling of racist complaints, and the protocol for transferring security files between prisons. Only one national recommendation was not accepted by NOMS, relating to providing means for prisoners to make hot drinks when they are locked up for lengthy periods. Responses are awaited to a further three national recommendations.

In some cases I may uphold the complaint but conclude that no further action is required, usually because the service concerned has already accepted that a mistake has been made and offered an apology. An example of this can be seen in the case of Mr Z below.

> "An independent PPO service is crucial to the future of HMPS. [Governor]"

Who complains?

As in previous years, the overwhelming majority of complaints have come from prisoners, with prisoners in the high security estate over-represented. Although the high security estate holds only 7% of the prison population, it accounted for 37% of eligible complaints this year.

By the time this report is laid before Parliament, my office will have published an overview[5] of all the complaints we have investigated since the office opened in 1994 until the end of March 2010. Among other facts, it highlights that there are a few people who make a large number of complaints to my office. In 2009-10 the most prolific 2% of complainants (34 individuals) made 270 complaints between them (15% of the total number of complaints received). The most prolific complainant made 56 complaints.

The report also presents a demographic analysis of the people who make complaints to my office. It shows that older prisoners are particularly over-represented among those making complaints, with three-quarters of those who made a prison complaint in 2009-10 over 30 years old, compared to half the prison population as a whole. Those from a non-white ethnic background are also slightly over-represented, while women are under-represented.

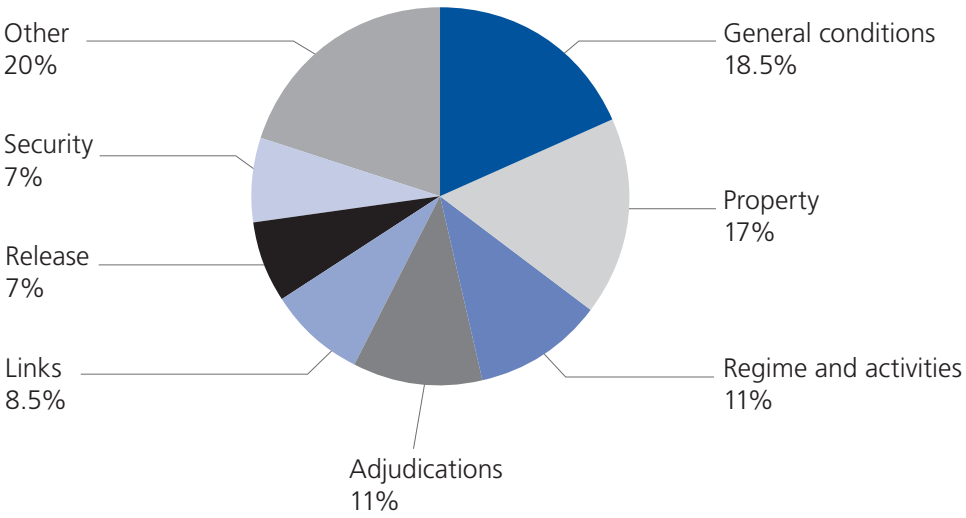
Types of complaint

The chart below shows the type of complaints received.

Again, as in previous years the most common complaint subjects were:

- general conditions (including alleged bullying and harassment by staff) – 18.5%
- property (including lost and damaged property and property not allowed 'in possession') – 17%
- regime and activities (including work and pay, education and the incentives and earned privileges scheme) – 11%

All eligible complaints 2010-11 (N=2,561)



[5] Learning from PPO Investigations: Overview of complaints, May 2011.

- adjudications (that is, disciplinary proceedings relating to breaches of the prison rules) – 11%
- links (including mail and visits) – 8.5%
- release (including release on temporary licence (ROTL) and home detention curfew (HDC)) – 7%
- security (including categorisation and re-categorisation) – 7%.

As complaints about prisons make up the majority of our cases, these common categories are dominated by prison issues. Complaints from immigration detainees are also most commonly about property or general conditions, whereas those regarding the Probation Service tend to be about the complainant's offender manager or their supervision in general. Examples are given below to illustrate the range of complaints we investigated during the year.

I am pleased to report that complaints about alleged assaults by staff and about segregation have continued to remain at a low level, together making up less than 2% of the eligible complaints. Although infrequent, they are among the most serious I receive and require a commensurate investment of my office's time.

Assaults

Being restrained by the use of control and restraint (C&R) techniques may be a painful and traumatic experience. Prisoners and staff are sometimes injured. It is not surprising therefore that some prisoners who have been restrained complain that they have been assaulted by staff. We investigated 21 cases regarding assaults in 2010-11. My role in investigating such complaints is to determine whether the use of force was necessary and proportionate in the circumstances and whether C&R techniques were used correctly. When C&R has been planned in advance, there should be video evidence (often with sound) which makes the investigative task much easier. If the use of C&R was spontaneous, it can be more difficult to investigate, particularly if there is no CCTV footage. In such circumstances it will generally be one person's word against another and it can be difficult or impossible for me to determine what actually happened. In the following case, however, I was able to reach conclusions on the balance of probabilities after the PPO investigator interviewed everyone involved.

Mr G, an immigration detainee, complained that he had been assaulted by staff taking his fingerprints at an immigration removal centre (IRC). He said that he had been tricked into going to what he thought was to be a meeting with immigration staff but that, when he arrived, immigration staff were not present and he was told that his fingerprints were going to be taken. He said that staff jumped on him for no reason, beat and tortured him and dislocated his arm. Mr G's complaint was investigated by the contractor responsible for the IRC who concluded that the complaint was unsubstantiated. Mr G then asked the Ombudsman to investigate.

My investigation established that UKBA had issued an instruction to IRCs that, if a detainee had already provided his fingerprints, it would be considered 'an excessive use of force' if force was used to take them a second time. On the day in question the IRC received a fax from UKBA requesting that Mr G's fingerprints be taken. A senior manager gave instructions that attempts should be made to persuade Mr G to give his prints voluntarily, but that no force should be used until she confirmed whether the prints were already on file. By the time she was informed that UKBA already had Mr G's prints, he had been restrained by five staff using C&R techniques.

The investigator interviewed Mr G and the staff involved. I subsequently concluded on the balance of probabilities that C&R had been used when Mr G became aggressive after being asked to provide his fingerprints, but it had not been used in an attempt to take his prints by force.

I also concluded that the injury to Mr G's arm was an old one and had not been caused by using C&R. However, although I found that the use of C&R was reasonable and proportionate in the circumstances, I also found that these circumstances only arose because Mr G had been taken to the fingerprinting area unnecessarily. I recommended that the IRC contractor should consider whether any disciplinary action should be taken against the staff concerned. I also concluded that the internal investigation into Mr G's complaint had not been sufficiently thorough and that, given the serious nature of the complaint, UKBA should have investigated it themselves rather than asking the contractor to do so.

In other cases, I have not been able to reach a conclusion about what actually happened but have still made recommendations for improvements, as in the following case.

Mr H complained that he had been assaulted by staff in reception when he arrived at a new prison. The prison accepted that C&R had been used to restrain Mr H and said that his complaint would be investigated. The prison subsequently wrote to Mr H to say that they could not take their investigation any further because he had refused to cooperate. Dissatisfied with this outcome, Mr H complained to the Ombudsman. He said he had not participated in the internal investigation because he had no confidence that the prison was interested in what had really happened.

My investigator contacted the prison and said that, because of the serious nature of the complaint, she thought the prison should complete their investigation even if Mr H chose not to participate. The prison agreed and the investigation was conducted by the senior officer responsible for reception. He concluded that C&R had been used as a last resort and that minimum force had been used. Mr H remained dissatisfied and I therefore re-opened my investigation.

My investigator found that Mr H and prison staff disagreed about the events that had led to him being restrained, disagreed about the amount of force used, and disagreed about the seriousness of his injuries. In the absence of CCTV footage or other evidence, it was not possible to determine what had happened or to uphold Mr H's complaint that he had been assaulted by staff. However, I produced a formal report expressing concern about the prison's internal investigation and recommended that future investigations into serious allegations should not be carried out by a manager from the area concerned. I also recommended that the prison should consider installing CCTV in reception since this is a part of the prison where problems can easily arise.

Segregation

The use of segregation for reasons of Good Order and Discipline (GOOD) is another source of complaints, particularly when this is based on security information which prisoners do not have access to. Here my role is to satisfy myself that segregation was justified and the proper procedures were followed. There were 12 complaints regarding segregation in 2010-11.

Mr I complained that he had been segregated for two days without good reason. My investigation established that Mr I had been segregated after information was received that suggested he might have a firearm. If this information had been correct, it would have posed a very serious threat to the safety of staff and other prisoners. Although it appears that the information may have been based on a misunderstanding and no evidence of a firearm was subsequently found, I was satisfied that the Governor had acted reasonably and proportionately in immediately segregating Mr I for a short period while further investigations were undertaken.

I was also satisfied that it was reasonable for the Prison Service to retain a record of the allegation on Mr I's file, even though it had not been found to be substantiated. However, I sympathised with Mr I's concern that his chances of re-categorisation or parole might be affected in future by such a serious allegation and I therefore recommended that a copy of my report should also be kept on his file.

Staff behaviour

Complaints about staff behaviour can also raise serious issues and we investigated 131 cases this year.

Mr J complained about the treatment he received after he alleged that he had been seriously sexually assaulted by another prisoner. My investigation found that the prison's initial response to Mr J's allegation had been appropriately swift and sensitive. Unfortunately, some of the assurances given to Mr J at that stage were not followed through.

For example, although he was told that he could be located in healthcare, he was subsequently told that this was not possible because the accommodation was full. The vulnerable prisoner unit was also full and as a result Mr J was left on a residential wing. This was unsatisfactory because other prisoners had been unnecessarily alerted to Mr J's situation when he was asked to give his clothes to the police for forensic examination. In addition, although Mr J clearly felt vulnerable and anxious after making his allegation, he was not assessed by healthcare or offered counselling until some while later.

I concluded that there had been failings in the way Mr J was treated. I therefore upheld his complaint and recommended among other things that the Prison Service should issue guidance for staff on how to deal with allegations of sexual abuse or assault.

Another worrying case was that of Mr K who complained that he had suffered homophobic abuse at his previous prison.

Following my investigator's interviews with Mr K and staff, I concluded that it was probable that he had been subjected to homophobic abuse by other prisoners.

I was concerned that the culture at the prison had not been supportive to gay prisoners. I noted that HM Chief Inspector of Prisons had reported that the prisoner diversity representatives were hostile to openly gay prisoners. The Chief Inspector said that there was a 'tacit acceptance' on the part of many managers and staff that the prison was not a suitable environment for gay men.

I was also concerned that some staff emphasised the need to respect cultural and religious objections to homosexuality when discussing whether it was safe to be 'out' at the prison. Religious beliefs should be respected but this does not mean that discriminatory or antagonistic language or behaviour should be tolerated. This could suggest that gay prisoners should keep quiet about their sexuality and are somehow 'asking for trouble' if they are open about it. This is not acceptable. Gay prisoners must have the right to be open about their sexuality if they choose, even if this offends other prisoners.

I therefore recommended that the Governor should rewrite the prison's policy on sexual orientation to ensure that it fosters a more supportive culture.

On a more positive note, some complaints reveal examples of staff behaving in a thoughtful and sensitive way to prisoners with difficulties.

Ms L complained that she had been asked to share a cell overnight with another prisoner (Ms M) who had returned from day surgery at an outside hospital. She said that the other prisoner was still unwell and it should not have been her responsibility to look after her. Although the prison accepted that Ms L had shared Ms M's cell overnight, there was no record of why this had happened. I was therefore unable to establish whether staff had asked Ms L to 'buddy up' with the other prisoner or either Ms L or Ms M had asked to share.

I was satisfied that, however it came about, the cell sharing was an entirely voluntary arrangement and Ms L was happy to do it. I was also satisfied that Ms L and Ms M shared a cell because the latter wanted emotional support, not because she required medical attention. My investigation established that Ms L and Ms M were very close and that both before and after this incident they had shared a cell on other occasions when Ms M was upset. This appeared to have been arranged at their request on at least one occasion. I did not therefore accept that Ms L had been 'traumatised' by the incident and I did not uphold Ms L's complaint. Indeed, it seemed to me that the prison had acted with sensitivity and humanity by allowing Ms M to have a close friend with her after her surgery.

I was, however, concerned that the reasons for the cell sharing were not recorded and recommended that the Governor remind staff to make regular entries in prisoners' personal records.

Not all complaints about staff behaviour are about serious matters, but they may nevertheless be important to the prisoner concerned.

Mr N complained that night staff were locking equipment away early in the morning in the cabinet next to his cell and that this was waking him up.

I investigated a similar complaint a few years ago and the prison had agreed that the equipment would not normally be put away before 7.45am. The Governor agreed to remind staff of this agreement, although he made the point that the equipment might need to be locked up earlier on some occasions for operational reasons. I was satisfied that this was a suitable resolution to Mr N's complaint.

Prisoners' property

As in previous years one of the biggest categories of complaints concerned property, particularly property that was lost or damaged. We investigated 436 property cases this year. Although the loss of a T-shirt or a couple of CDs may seem a trivial matter, prisoners have a relatively small number of possessions and these can be an important means of maintaining their identity. In addition, it often seems to me that the level of care taken with prisoners' property and the seriousness with which complaints about loss or damage are treated internally, can say something wider about the ethos and management of individual prisons.

This year I helped prisoners obtain compensation for lost or damaged items ranging in value from £15 to £433. I accept that Governors have a duty not to waste public money by offering compensation unnecessarily. This does not mean, however, that complaints should simply be dismissed without a proper internal investigation. Many of these complaints could have been resolved and need never have come to the Ombudsman if the prison had investigated with an open mind.

A particular problem arises when more than one prison is involved and, although the prisoner's property has clearly been damaged or gone missing, none of the prisons is willing to accept responsibility.

Mr O complained that when he transferred from prison A, via prison B, to prison C, a ring went missing from his valuable property bag. Prison A said that the bag had been intact when it left them and they could not be responsible for what happened in other prisons. Prison B said that the bag was not opened while it was with them. At Mr O's request prison C referred the loss of the ring to the prison's police liaison officer who declined to investigate on the grounds that they thought the ring had been lost rather than stolen. Mr O asked the Ombudsman to investigate what had happened to his ring.

My investigation established that the ring had been listed as being in Mr O's valuable property bag at prison A. There was therefore no doubt that the ring had existed and had been in the care of the Prison Service. I also established that the bag had been sealed at prison A and sent first to prison B (where records showed that it had not been opened) and then to prison C where it was noted that the ring was missing when the bag was opened. Mr O had no access to the bag during this period and it was therefore clear that the ring had disappeared while in the care of the Prison Service.

The Prison Service Order on prisoners' property says that, when two or more prisons cannot agree which is responsible for lost or damaged property, the complaint should be referred to NOMS to resolve. None of the three prisons had done this in Mr O's case and none had made any attempt to resolve his complaint. My investigator asked the Governor of prison A to consider compensating Mr O for the ring (as it seemed most likely that this was where it had gone missing), but he declined. I therefore issued a formal report recommending that the Prison Service compensate Mr O for the loss of the ring. I also drew attention to the fact that the Prison Service could and should have resolved this complaint. The Prison Service accepted the recommendation and agreed that Mr O's complaint should have been resolved without needing to approach the Ombudsman. My resources are scarce and I do not think that they need to have been used to deal with Mr O's missing ring.

It is obviously important that prisons do not spend public money unnecessarily and I am always conscious of this when deciding how much compensation would be reasonable for lost or damaged property. I only recommend compensation when there is good evidence that the property existed and was lost or damaged while in the care of the Prison Service.

Mr P complained that the Prison Service had lost a wallet which he said contained a valuable coin worth £20,000. My investigation established that the wallet had been lost while in the care of the Prison Service. However, as there was no evidence that the coin had been inside, I recommended that Mr P should only be compensated for the loss of his wallet.

Nevertheless it is also important that prisoners are fairly compensated where the Prison Service is responsible for the loss or damage.

Mr Q complained that the prison had broken his stereo which he said cost £100 two years earlier. The prison accepted that it was responsible for the damage but said that Mr Q had signed a disclaimer accepting that the prison would only be liable for a maximum of £35 in compensation if it was lost or damaged.

My investigator established that prisoners' property would only be issued to them when they signed this disclaimer and they therefore had no choice but to sign it. She also established that the limit for electronic items at other similar prisons was £50. Mr Q's prison said that they had determined the upper limit for compensation after establishing the price for stereos from

a range of mail order catalogues. The investigator pointed out that Mr Q had to buy his stereo from the sole supplier approved by the prison and had therefore not been able to take advantage of the cheaper prices available elsewhere and would not be able to buy another stereo for £35. She asked the prison to offer £50, which she considered to be the price Mr Q would have paid minus 50% for wear and tear. The Governor offered £40 compensation and Mr Q said that he still wanted the full £100. I remained of the view that as the stereo was two years old it was reasonable to take wear and tear into account and that £50 was an appropriate figure. The Governor eventually agreed to offer £50.

> "One particular complaint springs to mind where the investigator was challenging but fair. This left both staff and prisoners feeling that they had a fair opportunity to contribute and be listened to. [Governor]"

Another common source of property complaints is the items that prisoners can or cannot buy from the approved suppliers. As prisoners are restricted about what and where they can purchase, it is important that the items they buy are of the appropriate quality.

Mr R complained that he had not been provided with the original receipt for a watch he had purchased from the Argos catalogue (the approved supplier) and could not therefore activate his life-time guarantee.

My investigation established that it would not be appropriate for Mr R to be given the receipt since it included purchases made on behalf of other prisoners. Legal advice suggested that the precise nature of the legal relationship between Mr R, the prison and the supplier was unclear and might differ from prison to prison and supplier to supplier. It is therefore difficult for me to make any general recommendations.

The investigator was, however, able to agree with the prison that Mr R would be provided with confirmation of the date, place and delivery order number on Prison Service headed notepaper, and she established with Argos that this would be accepted as proof of purchase. This provided a practical, albeit not perfect, solution to Mr R's problem.

I received a number of complaints this year from prisoners about fire retardant bedding.

When Mr S transferred to a new prison, he was told that he could not retain his duvet, sheets, pillow case and duvet cover in his possession as they were not fire retardant. He complained that he had bought the bedding from the approved suppliers at his previous prison and was allowed it 'in possession' there. He therefore thought it unfair that it was not allowed it at the new prison and he was expected to pay for another set of bedding or use Prison Service issue bedding. It was clear that Mr S's bedding did not meet the prison's fire safety requirements. In these circumstances, although I sympathised with Mr S's frustration, I did not uphold his complaint because I could not say that the prison acted unreasonably by refusing to allow him to use the bedding.

I am, however, pleased that the Prison Service responded to my concerns by advising Governors to allow prisoners an amnesty period in which to acquire new bedding to the required fire safety standards. After this period, bedding that does not meet the standards will be removed and replaced with Prison Service issue bedding.

Release

There have been 178 complaints investigated this year regarding release. They have the lowest uphold rate of all the complaints which we investigate. There are clear criteria to be applied in considering requests for ROTL and HDC, and, when prisoner's applications have been refused,

it is generally clear that they do not meet those criteria.

Mr T complained that he had been refused early release under HDC arrangements. He said that he was 21 years old and wanted to see his baby daughter.

Prison Service policy requires that prisoners must be released on HDC unless there are substantive reasons why this should not happen. My investigation found that Mr T's current offence was an escalation in seriousness from his previous offences, he had a history of offending while on bail or serving community sentences, and recent adjudications in prison for fighting and possession of cannabis. In these circumstances, I did not think it unreasonable for the prison to refuse HDC on the grounds that there was an unacceptable risk that he would re-offend during the HDC period.

Although I did not uphold Mr T's complaint, I noted that his behaviour in prison had deteriorated since he moved to an establishment further from his home. I therefore suggested that the Governor should consider whether Mr T might benefit from returning to his previous prison for the remainder of his sentence.

Sometimes, it is clear that mistakes have been made in refusing applications for release.

One such case is that of Mr U who asked me to investigate why he had not received a response to his applications for ROTL for emergency reasons. He said that, when he complained to the Governor, he was told his applications had not been received.

My investigation established that, at the time of Mr U's applications, the prison's processes for tracking the movement of application forms had allowed errors to occur. This appeared to have happened twice, although his subsequent applications were processed correctly. I therefore upheld Mr U's complaint.

I was pleased to note, however, that the prison had introduced an electronic system that provides much improved tracking and reduces the possibility for human error. Therefore, there was no need for me to make any recommendations.

Regime and activities

We investigated 287 cases relating to regime and activities, of which 87 were about work and pay and 110 were about incentives and earned privileges (IEP).

Work and pay

The opportunity to earn money through work is very important to many prisoners and immigration detainees who have no other source of income.

Mr V, who is over 70, complained about the rate of 'pension' he received - £3.75 a week- which he said was not enough to live on. He felt he was being penalised for being too old to work.

I established that the Prison Service sets a mandatory minimum rate for retirement pay at £3.25 a week. I also established that retired prisoners at Mr V's prison receive a full rebate on their TV rental of 50 pence a week and the retirement pay at his prison would shortly be increased to £4.50 a week. This effectively meant that Mr V would soon be receiving £5 a week. My investigation also found that the prison also offered a number of 'environmental jobs' to elderly or disabled prisoners that involve very little physical work (for example, ensuring that all the lights are switched off) and the rate of pay for these jobs was between £7.50 and £9 a week.

Although I sympathise with prisoners in Mr V's situation who have no income other than their retirement pay, I did not uphold his complaint because he was already receiving well above the minimum rate of retirement pay and also had the opportunity to apply for an environmental job.

Incentives and Earned Privileges

Mr W had been set a target in his sentence plan to complete the sex offenders' treatment programme (SOTP). Because he denied his offence, he was assessed as unsuitable for the SOTP but it remained a target. Failure to undertake appropriate offending behaviour programmes automatically bars a prisoner from achieving enhanced IEP status at Mr W's prison. While Mr W denies his offence, he is unable to undertake the SOTP and unable to obtain enhanced IEP status. Mr W complained that it was unfair that he could not obtain enhanced status simply because he maintained his innocence.

Mr W has the right to maintain his innocence. However, I recognise that the Prison Service must accept the verdict of the court and treat convicted prisoners as guilty of their offence, and I agree that the SOTP is a relevant and realistic target for Mr W. I also support the policy of requiring prisoners to address their offending behaviour and offering them IEP incentives for doing so. I did not therefore consider that the decision to downgrade Mr W to standard was unreasonable and I did not uphold his complaint.

Mr X complained that he had been adjudicated on and given an IEP warning for the same incident (failing a mandatory drug test). He felt that this was unfair and amounted to 'double jeopardy'.

The IEP scheme is designed to encourage prisoners to reach and maintain proper standards of behaviour. It is distinct from the formal disciplinary system which deals with offences under prison rules. The IEP system can take account of other matters such as a prisoner's attitude or a refusal to undertake offending behaviour programmes that do not give rise to formal charges. However, when an incident occurs that is serious enough to warrant a formal charge, it would be irrational if this did not also have the potential to affect the prisoner's IEP status. I did not therefore think that it was unreasonable that failing a drug test resulted in both a formal disciplinary charge and an IEP warning, and I did not uphold Mr X's complaint.

Food

Thirty-two complaints about food were investigated in the course of the year.

Mr Y complained that he was only allowed to buy six pieces of fruit a week from the prison shop which would affect his ability to manage his diabetes.

My investigation found that the prison had placed a restriction on the amount of fruit prisoners could buy during the Football World Cup to reduce the risk of prisoners brewing alcohol. I did not uphold Mr Y's complaint because I was satisfied that this temporary restriction on fruit was reasonable and the prison was still providing a balanced diet (including plenty of vegetables and other important food groups) for diabetic prisoners.

Maintaining outside contact

Contact with the outside world, particularly with families, is very important for many prisoners. There were 221 investigations into complaints about contact with the outside world. When problems arise, all that is necessary in some cases is an acknowledgment that a mistake has been made and an apology.

Mr Z complained that a letter to his solicitors had been opened by staff in contravention of prison rules.

My investigation established that the letter had been opened, albeit with good intentions. The Governor accepted that this should not have happened. He therefore offered Mr Z a verbal apology in person which Mr Z accepted, and followed this up with a written apology. As the matter had been resolved satisfactorily, I upheld Mr Z's complaint without making any further recommendations.

Adjudications

When a prisoner is found guilty of a charge at an adjudication, the finding remains on his or her record and may affect future chances of re-categorisation, parole or transfer to another prison. It is not surprising therefore that I receive a large number of complaints about adjudications and 279 were investigated this year.

My role in considering such complaints is not to rehear the adjudication but to confirm that the adjudication was procedurally correct, the adjudicator heard sufficient evidence and made sufficient enquiries into the prisoner's defence to find the charge proved, and the punishment was proportionate.

Procedural failings may occur if the charge is not laid correctly.

Mr AA was charged with having cannabis in his urine following a positive drug test. The charge was found to be proved. Mr AA appealed against this finding on the grounds that the charge had not been laid within the time specified in the prison discipline manual. The manual states that failure to lay a charge within 48 hours of the alleged offence being discovered renders any subsequent hearing void unless there are exceptional circumstances. Mr AA said that he had initially been given two charge sheets in the names of other prisoners and was only given the correct charge sheet eight days later. The record of the adjudication showed that Mr AA had raised this point at the hearing when the reporting officer confirmed that he had been given the wrong sheet. However, the adjudicator did not make any further enquiries and recorded that she was satisfied that the paperwork was correct.

My investigation found that there were five different notices of report on the file but that the first one containing Mr AA's details was dated nine days after the positive drug test. This tended to support Mr AA's account. I concluded therefore that I could not be satisfied that the charge had been laid within 48 hours. I was concerned that the adjudicator had not recognised the need to enquire into this herself. I recommended that the finding against Mr AA should be quashed.

Another procedural issue that is often raised by complainants is whether they have been granted adequate time to obtain legal advice. In many cases I am satisfied that the time allowed has been reasonable, but this is not always so.

Mr BB was charged with disobeying a lawful order to move from the care and separation unit to normal location. At the first hearing Mr BB asked for a week's adjournment to obtain legal advice. The adjudicator offered him a telephone call to his solicitors which Mr BB declined. The adjudicator then proceeded with the adjudication and found the charge proved. Mr BB complained to me that the offer of a telephone call to his solicitors was not an adequate response to his request for legal advice.

I agreed. I do not think it is reasonable to expect solicitors to be able to provide advice in a brief telephone call, with no notice and without funding or access to the records. In my view the request for a week's adjournment to obtain legal advice was reasonable and should have been granted. I therefore recommended that the finding of guilt be quashed. The Governor accepted my recommendation and agreed to discuss my report with adjudicating governors at the prison to prevent any recurrence.

The prison discipline manual states that the adjudicator's role is to enquire into the events and decide whether an offence under the prison rules has been established beyond reasonable doubt. The adjudicator 'must investigate the charge ... in a spirit of impartial enquiry' and enquire fully into the prisoner's defence. Adjudicators do not always fulfil these requirements.

Mr CC was charged with failing to provide a urine sample for a mandatory drug test (MDT). The adjudicator found the charge proved (although he imposed a suspended punishment because Mr CC had previously provided negative samples on MDTs and had a good conduct record). He complained that the adjudicator had not explored his defence adequately. Mr CC said that he had provided one sample willingly but refused to provide a second sample after being told that his first sample had been rejected because the testing equipment was faulty.

My investigation found that it had been unclear from the evidence given at the hearing whether the first sample had been rejected because it was out of the correct temperature range (which might have indicated that it was a false sample that had been held outside the body) or because the equipment was faulty. If it had been rejected for the first reason, Mr CC could legitimately have been asked to provide another sample. If, however, it was rejected because the equipment was faulty, the relevant Prison Service Order makes it clear that it would be unreasonable to ask the prisoner to provide a second sample. The adjudicator should therefore have tried to establish why the first sample had been rejected and what reason Mr CC had been given when he was asked to supply a second sample. He did not do so and I therefore concluded that there was insufficient evidence to find the charge proved beyond reasonable doubt. I recommended that the finding be quashed.

Mr DD was charged with disobeying a lawful order to move to another wing and the charge was found proved. Mr DD complained to me that the adjudicator had not fully investigated his defence which was that he would be at risk if he moved.

My investigation found that the adjudicator had relied on a report from the violence reduction team, compiled after the charge had been laid, which stated that there was no reason why Mr DD could not move to the other wing. However, Mr DD had said that there were reasons which he had explained to two members of staff.

To explore Mr DD's defence the adjudicator should, therefore, have established what these reasons were, whether they were well founded, and whether Mr DD had attempted to alert staff to his fears either at the time the order was given or before. The adjudicator did not do this. He did not ask Mr DD what his reasons were and did not ask the member of staff called as a witness whether Mr DD had said anything to him about his reasons. Mr DD did not question the witness himself, but the onus is on the adjudicator to ensure that the prisoner's defence is fully explored. In these circumstances I was not satisfied that the adjudicator had made sufficient enquiries into Mr DD's defence to find the charge proved beyond reasonable doubt. I recommended that the adjudication finding be quashed and the Prison Service accepted my recommendation.

Security

There were 178 security related investigations this year. Prisoners often complain about decisions that have been made on the basis of security information which they cannot see or challenge. I understand how frustrating this must be. Nevertheless, I recognise that such intelligence plays an important part in maintaining security and good order in prisons. In such cases my role is to examine the security information reports to confirm that they have been properly recorded and evaluated.

Mr EE complained that he had been placed on closed visits as a result of unsubstantiated allegations that he had

received an article during a visit. He said that there was no CCTV footage of the alleged incident and that he had not been charged. He believed that the prison was wrong to punish him by restricting his visits when there was no evidence he had done anything wrong.

My investigation established that the prison had received reliable intelligence that Mr EE was involved in the smuggling of contraband. In the circumstances I did not uphold Mr EE's complaint as I did not consider that the prison's actions had been unreasonable.

Mr FF complained that he had been told that his solicitor could not visit him unless she was accompanied.

My investigation established that there were reports that Mr FF and his solicitor had been seen holding hands on three separate occasions and that Mr FF had been heard telling her that he loved her. I was satisfied that the number of reports, the quality of the information and the reliability of the sources gave the prison legitimate cause for concern, particularly given Mr FF's status as a category A prisoner attending court for a trial.

I was also satisfied that the prison had responded in a proportionate way by requiring that another member of the legal team should be present, rather than banning the solicitor outright, and that Mr FF's defence had not been compromised. For these reasons I did not uphold the complaint.

Mr GG complained that he had been subjected to an excessive number of cell searches.

I did not uphold his complaint but I was concerned that the prison had not replied to the letters which Mr GG's solicitors had sent on his behalf about his complaint. I thought that the prison had been wrong to draw a distinction between a complaint made directly by a prisoner and one made by a solicitor acting on the prisoner's instructions.

Mr HH complained that he had been refused Category D status. He said that he had not received any warnings or adjudications and that, as far as he knew, there were no concerns about him. Mr HH was serving a sentence for drugs and firearms offences.

My investigation found that 24 security intelligence reports had been submitted about Mr HH in the five months before he made his complaint.

I was satisfied that these reports had been properly evaluated and that, although the allegations had not been proved, the prison had reason to suspect that Mr HH was involved in moving large sums of money between individuals in the community without an obvious explanation. In these circumstances I did not uphold Mr HH's complaint as I could not say that the prison's decision to refuse him category D status was unreasonable.

Mr II, a foreign national prisoner, complained that he had been refused recategorisation to open conditions because of his immigration status. He had been issued with an intention to deport but UKBA had not yet taken a final decision whether or not to pursue deportation action. The prison told Mr II that they could not take a final decision on possible recategorisation until they knew whether UKBA intended to pursue deportation action or not, and that he would therefore remain a category C prisoner while UKBA's decision was pending. Mr II felt that the prison had acted incorrectly. He said that he had an excellent custodial record and argued that his immigration status was not relevant to the recategorisation decision.

My investigation showed that Mr II had complied with the prison regime and his sentence plan and appeared to have made positive use of his time in custody. It seemed that he would have met the criteria for open conditions were it not for his immigration status. However, open conditions are only suitable for prisoners whose risk of absconding is very low.

Because Mr II wanted to stay in the UK after completing his sentence, the prison had concluded that the threat of possible deportation increased the risk that he might abscond from an open prison, and had therefore decided that he should remain category C.

Although I sympathised with Mr II's frustration, I did not think it was unreasonable for the prison to take his immigration status into account in assessing his risk. I was, however, concerned about the length of time it was taking UKBA to make a decision on whether or not they intended to pursue deportation action in Mr II's case. Although outside my remit, I recommended that the Prison Service should copy my report to UKBA to make them aware of my concern.

Probation

Probation complaints tend to be quite distinct in character in that, whether submitted by serving prisoners or by probation supervisees in the community, they generally concern dissatisfaction with the complainant's offender manager or with the content of reports written for sentencing, sentence planning, parole or early release. Seventy were investigated in the course of the year.

Mr JJ said that his offender manager had included incorrect information about a family member in his pre-sentence report to the court. He said that he had found this extremely distressing. When he complained about this he was told that the information had been obtained from the Crown Prosecution Service and quoted in good faith. It later emerged that the information had in fact been obtained from a court liaison officer at the magistrate's court. The Probation Trust investigated Mr JJ's complaint and concluded that an error had been made. The Trust apologised both for the error and for the insensitive tone of the letter he had received in response to his original complaint.

Mr JJ complained to me that he believed the offender manager had deliberately provided him with false information about the source of the information. My investigation found no evidence that this had been anything other than a genuine error. I recognised that this had been distressing for Mr JJ but I was satisfied that the incorrect information was not relevant to the sentencing decision. Given this, and the fact that the Probation Trust had already apologised, I concluded that there was no further remedy I could recommend.

A more unusual case involved Mr KK who was subject to a Sex Offender Probation Order (SOPO) following a conviction for sexual offences against a child. He complained that he had lost his deposit on his rented accommodation (nearly £300) when he had to leave after reporting that a child was living there. He asked the Probation Trust to refund his deposit. He was told in response that it had been his choice to leave the accommodation and that the Trust was not therefore liable for his loss.

My investigation found that the existence of the SOPO meant that Mr KK had little choice about where he lived. One of the conditions of the SOPO was that Mr KK could not live in accommodation with children. He was told by his offender manager that he could not live in his own property as it was too close to an area which he was not permitted to enter. He was also told that his address had to be approved beforehand by the Public Protection Unit (PPU).

On his release from prison Mr KK moved into accommodation identified for him by his offender manager. However, he was told the very next day that he would have to move out as the PPU had not approved the address. He moved as required to another address with the same landlord which his offender manager found for him but which had also not been approved by PPU. The day after he moved in he realised that a child was staying at the new accommodation. He reported this to the duty offender manager and was told to move out immediately or he would be in breach of his SOPO. He was given emergency accommodation at an approved premises hostel. The landlord refused to return his deposit as he had broken his contract.

I did not accept the Probation Trust's argument that Mr KK was not entitled to compensation because he was the author of his own misfortunes. In my view Mr KK's difficulties arose from his offender manager's failure to clear the original release address with the PPU before he was released from prison. I considered that Mr KK acted entirely responsibly in informing the duty manager as soon as he realised there was a child in the house and he followed instructions by moving out. If he had moved back in he would have been in breach of his SOPO and would still have been required to move out.

The Probation Trust also suggested that Mr KK was pursuing the complaint as a means of avoiding having to address his offending behaviour. I recognised that there might be an element of this, but it did not affect my view that Mr KK was out of pocket through no fault of his own.

Following my intervention the Probation Trust agreed to refund Mr KK's deposit.

Immigration

Seventy-five immigration complaints were investigated this year. As in previous years, the fact that between 35-40% of immigration detainees are time-served former prisoners means that there is much common ground between complaints arising in prison and those arising in immigration removal centres (IRCs). For this reason I included some complaints from immigration detainees in the earlier section of this report. There are, however, some issues specific to immigration detainees, such as language difficulties, as the following case illustrates.

Ms LL, a Chinese speaker who spoke some English, submitted a request form asking to be allowed to '… clear my belongings. I need to get rid of some clothes'. She subsequently sorted through her clothes and handed a bag of clothes to staff who disposed of it to charity in line with what they understood to be her wishes. Ms LL complained that she had wanted to put some of her clothes into storage and had not wanted them disposed of. She asked for compensation.

My investigation found that, although a Chinese interpreter visited the IRC once a week, Ms LL had asked a friend to complete her request form. Ms LL said that her friend had misunderstood what she wanted to do with her clothes. This was unfortunate as the form stated very clearly that Ms LL wanted to 'get rid of some clothes'. I was satisfied that staff had checked this with Ms LL when she handed the bag of clothes over. In the circumstances I did not think staff at the IRC had been at fault and I did not uphold Ms LL's complaint.

> "I thank you for a fair and independent investigation. You have restored my faith in the system. [Letter from complainant]"

Fatal incidents investigations

> Since the introduction of the PPO I believe the public's faith has been restored in our processes due to the fairness and transparency the PPO provides through its investigations. [Safer Custody Manager]

A key focus for the fatal incidents team this year has been to continue to improve the timeliness of issuing reports. The longer the time taken to issue a report, the more its impact reduces. I am acutely aware that delays cause families additional distress as well as delaying the service from learning lessons, and the coroner from conducting his enquiries. I am therefore encouraged that, on average, we have issued our draft reports more quickly than last year and that we cleared nearly all the cases which had been ongoing for a very long period. However, it is disappointing that only 15% of draft reports were issued within our target of 20 weeks for natural causes and 26 weeks for self-inflicted cases.

> Difficult to compare, but have the feeling matters are being dealt with more speedily. [Journalist]

Improvements can still be made, but becoming quicker is a notable achievement in the face of considerable pressure. We have seen an increase in new cases for the second year running, at the same time as significant staff shortages. This combination led to the decision to stop taking discretionary cases from the autumn. It is regrettable, as there are often lessons to be learnt from deaths that occur in the days following release, and the decision remains under review.

Like other public sector organisations we have made considerable savings and our efforts are ongoing. Vacancies have been held pending our budget settlement and the review of the work of the office. Some experienced staff left and there have been several management changes. However, we have issued 200 draft reports and the quality of our investigations remains high.

Interim feedback letters are used to communicate concerns early in the investigation and encourage quick learning. While we also provide verbal feedback, the letters ensure that there is a written record which sets out the issues being explored. Stakeholders want to know about the progress of investigations and so we also introduced letters to tell them when a delay is likely to occur, providing the reason and likely timescale.

Since becoming responsible for investigating deaths in 2004, my predecessor and I have commented endlessly regarding the speed and quality of clinical reviews and the impact on our work. Unfortunately, this year is no exception. The clinical review is often a crucial part of our investigations. It is imperative to have a judgement about clinical practice and areas for improvement. We have worked ever more closely with regional offender health leads, and meet regularly with offender health. We have introduced more robust escalation procedures for following up when a reviewer has yet to be appointed or to complete the review. However, these

initiatives have had little impact and our reports are regularly delayed by the late arrival of the clinical review.

> "I think you are caught by the speed of other partners especially the PCTs and this does create problems in producing the learning in a timely fashion. [Regional lead for Offender Health]"

An internal study of 49 reviews received this year showed that just three were received within the agreed timescale, the majority were over two months late, with nearly a quarter arriving six months after they were commissioned. I regularly issue reports which have been delayed as a result of the clinical review, sometimes by just a few weeks but it can be over a year after the death. The reasons for delays are complex, most commonly because of delays appointing the reviewer, and some practicalities over access to paperwork and arranging interviews. Many delays were attributable to the reviewer's workload and their own quality assurance processes.

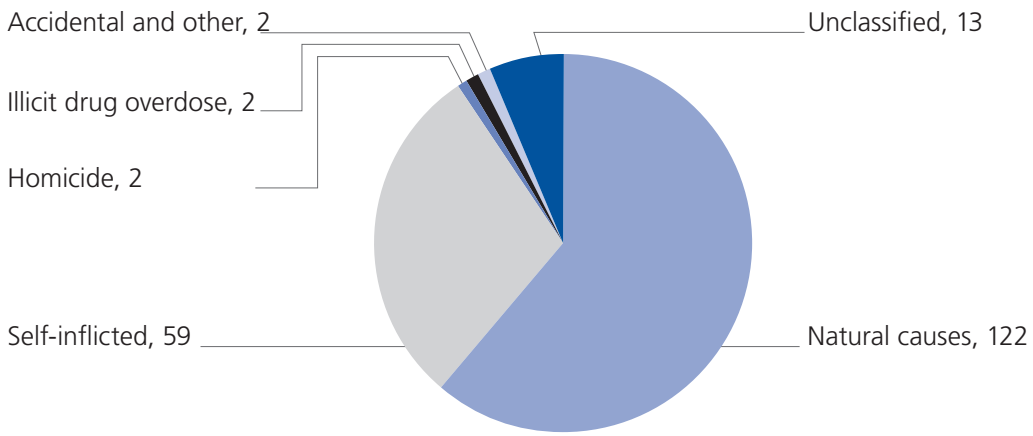
We are working with the Ministry of Justice and the Department of Health and have highlighted this problem to the Secretaries of State. I do not think that bereaved families should have to wait to hear what happened to their relative or that my office's reputation be criticised publicly because of delays which are outside my control.

New cases

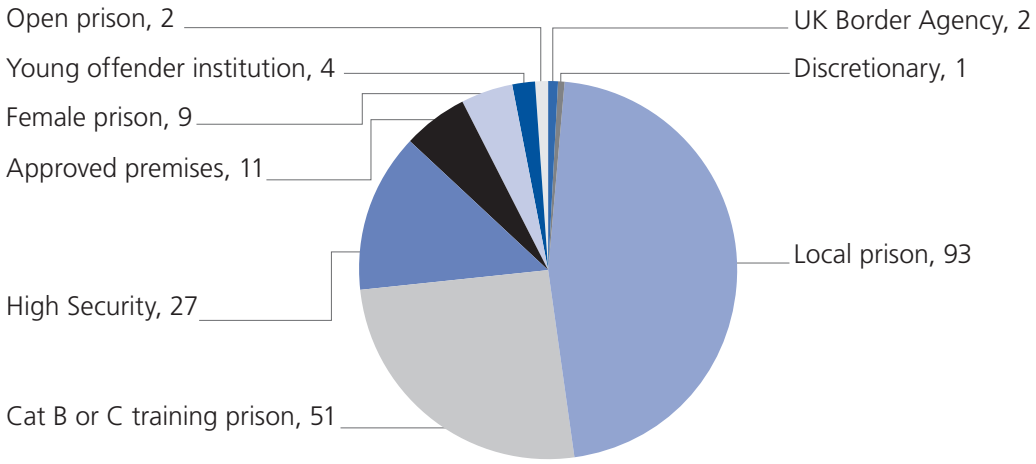
We opened investigations into 200 new cases in the last financial year, compared to 193 in 2009-10. The charts below show the type of death and where they occurred. A more detailed breakdown is provided in the statistics section of this report. As can be seen from the charts, the overwhelming majority of deaths occur in prison which explains why most of my references are to prisoners.

Two deaths occurred in the immigration estate, one on an aircraft during deportation and the other in an immigration removal centre. They are the first people to die in the immigration estate for over four years.

Fatal incidents investigated by the PPO in 2010-11: Type of death (N=200)



Fatal incidents investigated in 2010-11: Type of establishment (N=200)



There remain 13 unclassified deaths for which the immediate cause of death is unclear. I investigated five such cases in 2008-09 and eight in 2009-10. I comment later on the nature and difficulties these cases present.

With an ageing prison population and many premature deaths (in comparison with the community), I am investigating an increasing number of deaths from natural causes. An average of three recommendations is made in these cases, demonstrating the valuable learning which we identify. Broadly speaking, there are some deaths which are reasonably foreseeable, such as those of people who are receiving palliative care. When a death is expected, it is reasonable that certain actions should have taken place, such as consideration of compassionate release. In these cases we are piloting an 'issues-led approach' to investigating and reporting, which I explain later in this report.

We see many examples of good practice such as involving families in the care of terminally ill prisoners, facilitating visits, active consideration of compassionate release and many more that demonstrate the compassion that is often shown to these prisoners. However, we still have cause to comment on missed hospital appointments and the lack of respect for the prisoner's dignity by being held in restraints.

Other deaths due to natural causes are sudden, particularly those related to circulatory disease and heart attacks. Our thematic report into the learning from deaths due to circulatory diseases found that the average age of the deceased was just 53 years old with 30% aged less than 45 years. Last year's Annual Report drew attention to the lack of first aid provision and delays in emergency responses and my concerns remain. The report also highlights that the emergency response could have been better in 43% of cases. I identified several implications for practice, including a prison and Primary Care Trust review of protocols with local cardiology services, local ambulance services, and the provision of emergency first aid training for front-line staff.

I have commented more widely that NOMS policies and procedures for preventing and responding to deaths mainly focus on those which appear to be self inflicted. I suggest that there is scope to consider the implications both of long-term illness and sudden death when the policies are next reviewed, including how best to involve

families in the prisoner's care, consideration of compassionate release and emergency response training.

It is encouraging that there are slightly fewer self-inflicted deaths than last year. I have no doubt that strenuous efforts are made by staff to look after those in their care, and a great deal of effort has been made by NOMS to share learning and increase awareness of risk factors related to suicide. In a recent, as yet unpublished, analysis by my office of self-inflicted deaths during 2007 and 2009, nearly half of the deceased were unsentenced, for 39% it was their first time in custody and 14% had been recalled on licence. Although nearly a third of the deaths occurred within the first three months in prison, 16% had been in prison for two years or more. It is already known that many who take their lives have committed an offence against a relative. When we know of the victim of the offence, our study found that 49% could be described as an intimate or other family member.

Significantly, concerns were raised by investigators about the reception process in 39% of the deaths which were apparently self inflicted. There was a lack of attention to the person escort record, health screening, obtaining information from outside doctors and community psychiatric services, and documents being shared between establishments.

We also found that the most significant events in the days and weeks prior to the death include relationship breakdown (one in five), bullying or intimidation from other prisoners (one in five), and impending court appearances (also one in five). In the coming year we will develop this work and look further at reception processes and intimidation by other prisoners.

Learning the lessons

The vast majority of my recommendations are accepted by the services in remit and action plans are devised. There is evidence of collective learning from cases across instructions to approved premises, and in learning bulletins from NOMS in relation to prison deaths.

> "Focus of the report needs to be more on how improvements could be made. [Family member]"

I made 26 national recommendations in final reports published this year, 18 have so far been accepted by NOMS. Issues covered in these recommendations included health records, entering cells during night state and resuscitation procedures in approved premises.

Response to healthcare recommendations – which comprise half of all recommendations – is less systematic and often depends on initiatives in regional offender health teams. The demise of these teams risks losing much good practice and I hope that the new National Health Service structure will address this gap.

Deaths in the gym

An internal study has found that, since the Ombudsman began investigating deaths in custody in 2004, at least 20 men have died during exercise sessions or very shortly afterwards. The first such death identified was at an immigration removal centre, and a further 19 deaths were in a variety of English prisons. Four were under 35 years of age, five were in the age group 45-54 and another four were between 55 and 64 years old. Apart from the death of the immigration detainee, every one of the deceased was a sentenced prisoner, with most deaths occurring in training establishments and just four in local prisons.

Many were regular gym users but several had very significant medical conditions and/or were infrequent exercisers. Two died of cerebral haemorrhages and the rest died because of heart disease or heart attack.

In ten cases the men collapsed as they were undertaking physical education in the gymnasium or its confines. The other

men collapsed or became unwell within a couple of hours of leaving the gym. Nearly half of the emergencies became apparent after the prisoner had returned to his own cell. The recommendations flowing from the reports are, therefore, important for clinical staff and wing officers as well as their PE colleagues. Three areas of particular significance (which do not just apply to the gym) are:

1. **Emergency equipment**

   Investigations point to the need for appropriate equipment which staff are trained to use. Two PE related deaths in two different Yorkshire prisons in 2009 led to recommendations that sufficient defibrillation machines should be available and sufficient staff should be trained to use them throughout the prison.

2. **Recognising the symptoms**

   The report on deaths from circulatory diseases underlines the importance of a swift and effective response when a prisoner reports chest pain, accompanied by sweating and discomfort, especially if it is radiating down an arm. The most recent report on a PE death praises a prison officer and nurse who responded in exemplary fashion to just such a situation but the response was much less impressive in two of the earlier 19 cases.

3. **Efficient and effective emergency procedures**

   In an emergency, the ideal situation is for well-trained staff to respond quickly and effectively. Several recommendations spring from the investigator's judgement that the response to the crisis should have been faster or better co-ordinated.

   In a powerful example of such a deficiency, the prisoner had asked to be taken to the healthcare centre when his back hurt and he had pins and needles in his hands at the end of a gym session. As the doctor examined him, he fell to the ground and lost consciousness. The doctor asked for an ambulance at approximately 4.00pm but, although various staff assumed that this had been done, the ambulance service was first contacted 20 minutes afterwards at 4.21pm. No single person took responsibility for calling the ambulance and it was not until 4.37pm that the paramedics arrived at the prison.

My predecessor devoted a section of his last Annual Report to the theme of emergency response. I make no apology for returning to the theme because there are demonstrably still lessons to be learned and heart-related illness is the single largest cause of natural death in prisons.

Refusing medical treatment

A number of deaths were of prisoners who refused to cooperate with the treatment plan to address their health needs. Sometimes the prisoner was diagnosed with a terminal illness and refused to accept any treatment to prolong their life. In other cases, the death can be directly attributed to their unwillingness to accept medical treatment and their death was by no means inevitable.

Prisoners have the right to refuse medical treatment in the same way that anyone in the community has. Indeed they may have a 'Do Not Resuscitate' order or an 'Advance Directive' in place to make their wishes clear. However, refusal of treatment depends on the individual having the mental capacity to do so. Places of detention have particular obligations under the Mental Capacity Act 2005 to assess the individual's mental capacity to refuse treatment. One of the key principles in the Act is that, even when an individual makes what appears to be an unwise decision, they should not be treated as lacking the capacity to make that decision. When a prisoner refuses life-saving or life-prolonging treatment, the prison should make arrangements for their capacity

to be assessed by a relevant expert. If the prisoner's capacity is sound, then an Advance Directive may be drawn up to allow them to stipulate what treatment they will and will not accept.

A prisoner's reasons for refusing treatment can be complex. Access to specialised hospital care involves being escorted from the prison and some prisoners resent having restraints applied and officers being in attendance. Other prisoners want to be able to smoke, which they can do in their cell, but cannot in hospital.

Mr MM had a considerable medical history before his arrival in custody, most notably significant kidney disease. He had been refusing treatment by his consultant prior to arriving in custody but the prison was provided with a report into his medical history and likely needs in future. The report noted that aggressive control of Mr MM's blood pressure would play an important part in slowing down the progression of his kidney disease.

During his imprisonment Mr MM regularly refused to have his blood pressure taken or to provide blood samples. He also refused to take his prescribed medication most of the time. Because of his lack of cooperation, Mr MM was eventually removed from the consultant's list. He also failed to attend appointments with doctors at the prison. Following a significant deterioration in his kidney function, Mr MM saw another consultant. By this point he needed kidney dialysis and, after much persuasion, agreed to accept the treatment although he only went to two sessions before refusing any more.

Mr MM gave a variety of reasons why he would not take his medication or undertake any other treatment, saying that he did not feel it was helping him and did not want any more interference. As well as refusing treatment, Mr MM's behaviour was sometimes described as bizarre. This could have been linked to his kidney function but also he had been diagnosed as suffering from an antisocial personality disorder before coming into prison and his behaviour towards female staff was often said to be inappropriate and aggressive.

My investigation found that considerable efforts were made by staff to encourage Mr MM to cooperate and accept his medical care. A multi-disciplinary team delivered a complex medical management plan so that the prison was able to deliver a high level of care. Healthcare worked closely with Mr MM's hospital consultant who visited him in prison to discuss his treatment, an example of good practice in delivering high-level care to a patient with complex needs.

Mr MM's capacity to refuse treatment was assessed by a number of specialists and he was visited by an independent mental capacity advocate who advised him how the Mental Capacity Act applied to his circumstances. He was also visited by a local solicitor with a view to preparing an Advance Directive to determine what treatment he would be willing to accept in the future. He had sufficient mental capacity to make decisions about his treatment. I found that the prison took all reasonable steps to persuade Mr MM to accept life-saving treatment, while respecting his right to refuse to consent.

Escorts and restraints

In most prisons, the NHS commissions health services which are delivered in partnership with NOMS. The aim is to ensure prisoners are given a service similar to what they would expect if they were living in the community. When the problem cannot be dealt with properly at the prison, the prisoner is usually taken to an outside hospital where they remain in the custody of the prison.

In several cases, I found that a shortage of staff resources, poor communication and the logistics of facilitating several escorts has led to hospital appointments being cancelled. My research found that over half those with heart disease were referred to an NHS hospital for out-patient care. Although access to secondary care was generally very good, several prisoners had appointments

cancelled as no escort was available and in one instance the deceased had 16 separate appointments rearranged due to poor protocol between secondary care providers and the prison. Similar difficulties occurred in the following case.

Mr NN was 68 years old and had been diagnosed with angina, high blood pressure and raised cholesterol, as well as three previous heart attacks, before going into prison. He had served six months of his sentence when the prison doctor referred him to a consultant cardiologist. Mr NN eventually saw the consultant cardiologist for the first time almost two years later. In the interim, 14 appointments had been cancelled or rescheduled. Most had been deferred by the hospital, but several by the prison.

In common with other prisons, there was a policy limiting the number of prisoners able to go out for hospital appointments each day as uniformed staff had to escort them. At this prison, in the event of more appointments than places on any given day, priority was based on clinical need and the staff would contact the hospital to rearrange the necessary appointments. However, in other cases, I found no systems for prioritising prisoners and occasions when the prison failed to notify the hospital that the prisoner could not attend until after the appointment had passed. Although missed appointments were not often a contributory factor to the deaths, they can be significant and recommendations have been made for Governors to instruct staff to avoid cancelling important appointments, particularly for prisoners needing urgent medical care.

Every prisoner taken to hospital, whether for out-patient or in-patient treatment, is subject to security risk assessments to protect the public. The assessment addresses issues such as prevention of escape, the location of the ward, possible escape routes as well as current and historical risks relating to the prisoner's offence. Staff exercise their discretion and judge whether or not restraints should be used and, if so, the level of restraint required and the number of escort staff.

In addition to ensuring that the clinical care is appropriate, I strive to satisfy myself that prisoners are treated decently. I have commented in strong terms on the inappropriate use of restraints when prison staff are escorting sick or dying prisoners. In one such instance, prison staff applied restraints to a prisoner who was found hanging, demonstrably unconscious and 'lifeless' during the journey to the hospital on the basis that he had not been pronounced dead. This was a rather extreme circumstance, but demonstrates the need for prison staff to have the confidence to exercise discretion in a manner which allows for the compassionate treatment of seriously ill and dying prisoners.

Mr PP was remanded into custody at the age of 57 and was already in poor health. Due to his physical disability and difficulty climbing stairs, healthcare staff arranged for him to have a ground floor cell. He was admitted to the healthcare unit ten days before his death. He collapsed and staff quickly intervened and requested an ambulance. After administering treatment in his cell, he was taken to hospital where an emergency medical team continued resuscitating him, unfortunately without success.

In this case, the views of healthcare staff were sought by prison managers before deciding whether restraints were required. As a result, he was not subjected to the indignity of being restrained and emergency treatment was carried out unhindered. The prison was commended for ensuring that the views of healthcare professionals were considered as part of the decision about using restraints.

I know that NOMS does not condone prisoners dying with restraints in place or retaining them during medical consultations or when the person is incapable of movement and close to death. However,

I suggest that a formal revision of their policy is long overdue as, until up-to-date formal guidance is issued, staff may not feel protected when they allow prisoners to die with dignity.

Palliative care

My investigations find that palliative care services for terminally ill prisoners continue to improve. Most prisons now have access to specialist clinical services to provide advice and support to healthcare staff. The hospice movement, together with Macmillan nurses and the NHS, now work in prison healthcare units across England and Wales. These palliative care services are often from the voluntary sector and their provision of specialist care is notable given their limited resources.

Nevertheless, many prisoners are still dying in prison healthcare units and hospitals. Several of my investigations examine the decision to grant compassionate release for prisoners diagnosed with a terminal illness. I appreciate the difficulty of striking a balance between security and dignity. The protection of the public must remain at the centre of these decisions, but I am surprised at the number of prisoners in the advanced stages of a terminal illness who remain in custody.

I know that predicting life expectancy is not an exact science and doctors are more often than not unable to indicate how long a patient has left to live. Applications for compassionate release must be made to a central office at the Ministry of Justice when it can be proved that the prisoner is in the last stage of their illness. Senior prison staff have to judge when to make a timely application so the prisoner can be with their family at the end of their life, but without compromising public protection. I do not think that one or two high- profile cases should hinder a holistic assessment of every other terminally ill prisoner.

Prisoners who present a lower risk to the public can be released on temporary licence for the duration of in-patient hospital treatment. This means that no officers are assigned to bed watch, which allows the prisoner some privacy while undergoing treatment and families can visit to be involved in their medical care. The licence can be reassessed as treatment progresses and may be revoked if they are able to return to custody. Release on temporary licence (ROTL) is also used for those prisoners in the last stage of their lives when compassionate release is not possible.

I have no doubt that effective palliative care improves a prisoner's quality of life. I have mentioned that I am piloting a new method of reporting to improve the timeliness and consistency of investigations into deaths from terminal illness. The investigation remains largely the same, but the reports will assess the care received against the same standard list of criteria, which will include the diagnosis through to security, consideration of release and the use of restraints and bed watch arrangements. I hope that this approach will help to raise standards across the estate as prisons become aware of the key areas which my investigations will consider.

Self-inflicted deaths

In 2010-11, I opened 55 investigations into self-inflicted deaths in prisons, and three such investigations into those living in NOMS approved premises. I also exercised my discretion to investigate the death of

a man who had been recently released from both prison and court custody before taking his life in the community shortly afterwards. Over the seven years that my predecessor and I have investigated deaths in custody, it has been clear that certain groups of prisoners are at a heightened risk of self-harm and suicide. Those in custody for the first time, on remand, charged with violent offences or those having significant mental health or substance misuse needs are all at particular risk. As in previous years, nearly two-thirds of all self-inflicted deaths I investigated occurred in adult male local prisons (including the three core locals in the High Security Estate), where many of these risk factors are particularly concentrated.

Mr QQ had been in custody many times and was familiar with prison life and routine. He told staff that he was concerned about encountering two prisoners who he knew had reason to be upset with him. He was only in custody for two days before taking his own life and, as he was on the induction wing, he did not come into contact with the two prisoners. The staff who spoke with Mr QQ during his induction said that he did not seem especially low or anxious. When asked directly if he was thinking about harming himself, he said that he was not. He spoke of having tried to harm himself approximately eight years previously and had been monitored as part of self-harm procedures during previous custodial sentences, but he had not done anything similar since.

Mr QQ spoke with officers and medical staff as part of the induction process. He had been misusing drugs and alcohol in the community and was prescribed withdrawal medication. However, he declined to engage in any substance misuse treatment at that time. He talked with the safer custody officer about his concerns regarding two other prisoners, but told the officer that he did not want the matter investigated as he was worried this would alert the other prisoners that he was in the establishment. Although he mentioned an act of self-harm some years previously, none of the staff who came into contact with Mr QQ felt that he showed any signs of distress or that he planned to take his own life. Due to the way in which he presented, staff did not identify him to be at risk of harming himself and so they did not start the assessment, care in custody and teamwork (ACCT) self-harm monitoring procedures.

Mr QQ shared a cell with a prisoner who was subject to these procedures. An officer checked Mr QQ's cellmate at 8.00pm and spoke briefly with Mr QQ. When the officer returned at 9.35pm to conduct another check, he found Mr QQ hanging in the cell. Despite a quick response by staff who tried to resuscitate him, he was declared dead a short while later.

Like other deaths that I investigated, Mr QQ took his life soon after he arrived on the induction wing. Many examples of good, well-considered yet routine practice were identified during this investigation and, although Mr QQ gave no indication that he planned to take his life, it highlighted a number of areas where practice could be improved.

I was satisfied that the weekend did not detract from Mr QQ's induction, he was asked appropriate questions and steps were taken to deal with his anxiety regarding other prisoners in the prison. Staff took appropriate, timely action on finding Mr QQ and I did not think that his death was foreseeable. His cellmate was looked after and staff took every step possible to keep him safe. Areas where practice could be improved included ensuring that electronic medical records are available to nurses and doctors over the weekend so that they are able to see comprehensive information about prisoners who have been in custody before, and reviewing the provision of prison family liaison officers and the guidance that they require. Other recommendations dealt with training healthcare staff in self-harm monitoring procedures and giving refresher training to staff who regularly work night shifts.

While these risk factors remain constant and can help practitioners to focus on the prisoners who are most in need of support, they can fail to provide the full picture of self-inflicted deaths in prisons. Between January 2007 and December 2009, 16% of all self-inflicted deaths in prisons were of those who had been in custody for two years or more, 18% were in Category B or C training prisons and nearly a quarter had no apparent mental health needs. This echoes the sentiment expressed in the then Chief Inspector of Prisons thematic report some 12 years ago: *Suicide is everyone's concern*.

Mr RR was convicted and sentenced to life imprisonment in 2005 at the age of 61. He was initially sent to HMP Manchester, where he told staff that he was upset about his conviction, but did not intend to harm himself. Mr RR transferred to a training prison two years later where he told staff that he was worried about being in prison, but did not want any support from the mental health team.

Suicide and self-harm monitoring procedures were put in place in the following year (three years after his conviction) when prison staff realised that Mr RR had been sent documents relating to suicide. He was adamant that the procedures were unnecessary as he was not going to harm himself and they were closed later that month. Some months later, Mr RR's appeal against his conviction was rejected. Other prisoners spoke to staff as they were concerned that he might harm himself. Suicide and self-harm monitoring procedures were put in place again the following day and Mr RR was moved into the healthcare centre. The monitoring procedures were ended again a month later.

During the following year, Mr RR did not often come to the attention of staff. He worked in the gardens party and attended education classes. Staff said that there was no discernible change in his behaviour or demeanour. He kept himself to himself and at no time voiced anything which concerned staff. However, when staff unlocked the cells one morning (nearly five years after his conviction), Mr RR was found with a plastic bag over his head and a cord around his neck. Prison and healthcare staff attended but Mr RR had already died. My investigation did not consider that the prison missed opportunities to see Mr RR was at risk of harming himself, although recommendations were made in other areas.

Unclassified deaths

This year has seen a sharp rise in the number of deaths which are 'unclassified' at the time they are notified to us. In 2010-11 I was notified of 35 deaths where the cause of death was not immediately clear, and currently 13 remain unclassified. In the majority of cases, a cause is eventually found but the difficulty of doing so can make it harder to identify the issues for investigation, causing delays and further distress to the bereaved family and the staff who looked after the deceased.

A large proportion of the unclassified deaths are those where there is evidence of drugs (whether prescription or illicit) in the person's system. Over the coming year I will be examining how deaths are classified and investigated by my office to establish where improvements can be made.

Mr SS had no significant medical history and, aside from some restricted movement and pain in his right knee and arm following an accident, was generally fit and well when he came into prison. He had little involvement with healthcare staff during the short period of time that he was in custody. On the day of his death, Mr SS did not go to work in the morning as he felt unwell. He attended the workshop in the afternoon although he later said that he still felt unwell.

During the afternoon he was involved in a brief altercation with another prisoner in the workshop. Before staff had the chance to defuse the disagreement, Mr SS and the other prisoner fell to the floor. Healthcare staff were called as Mr SS had pain in his

knee and difficulty walking. A wheelchair was used to take him to the healthcare centre. His condition deteriorated and by the time he arrived he had collapsed and was cold and clammy. Mr SS's blood pressure was low and his pulse was weak. An electrocardiograph was carried out to determine whether there were any abnormalities with his heart rate and rhythm and it showed that his heart rate was abnormal. Mr SS complained of tightness in his chest and arm and an ambulance was requested. His condition initially appeared to stabilise and, after a number of tests were carried out, he was assessed as fit to return to prison. His condition then suddenly deteriorated as he was preparing to leave the hospital and he died shortly afterwards.

The death was initially treated as suspicious. However, the cause of Mr SS's death was confirmed as a heart attack following a blockage in his coronary artery. The pathologist's opinion was that Mr SS's collapse following the altercation in the workshop was coincidental and not directly linked to his death. I found no evidence that prison staff could have done anything to prevent his death. He did not report any symptoms before he collapsed and staff responded quickly. The care that he received was equitable with that which he could have expected in the community.

Deaths such as Mr SS highlight the difficulty of investigating unclassified deaths until a clear cause of death is known. My office works closely with coroners in such circumstances but the complexity of some such deaths can result in long delays before a pathologist can confirm a specific cause and all the likely issues can be explored.

Possible drug combinations

I am also investigating an increasing number of deaths in which the cause of death cannot be determined until toxicology tests have been conducted – and in a number of cases when different combinations of drugs could potentially be the cause of death.

This occurs when multiple drugs (either prescribed or not) are taken and the combined effects are damaging or lethal. The reasons for toxicity vary depending on the mixture of drugs involved. The death can also be dependant on the individual, pre-existing medical conditions and general heath. Therefore, what could prove lethal for one individual can differ from another. It is a particularly complex issue, which generates different views even between experts. There are often delays before toxicology reports are received.

The introduction of the integrated drug treatment system (IDTS) across the prison estate ensures, among other interventions, that methadone maintenance programmes are in place for drug-dependent prisoners. IDTS aims to improve the quantity and quality of treatment available to prisoners, particularly in the early days in custody. Importantly, it also aims to reinforce consistent care from the community into prison, between prisons, and when returning to the community. Such individually focused support is a welcome feature and should ensure that those with drug issues in prison have access to the same quality of treatment as those in the community, and therefore the same chances to rebuild their lives.

Many prisoners have complex needs (for example drugs, alcohol and depression) which are supported by a variety of treatments. Prisoners may over or under report their drug use to healthcare staff and it is clear that determining a therapeutic dosage, acting on the symptoms presented, is not an exact science. Often multiple medications for different detoxification regimes (for example drugs and alcohol) and maintenance dosage are prescribed. In addition, prisoners may obtain illegal drugs and/or get hold of drugs that have been prescribed for other prisoners. Investigating a death in these circumstances can identify a complicated and difficult picture.

Mr TT was a man in his thirties who came into prison with a history of significant long-term drug and alcohol dependency. He

had been there for just five days when he was found dead in his cell. The post mortem concluded that Mr TT died of 'mixed drug (methadone and benzodiazepine) toxicity'. On arrival at the prison Mr TT had told healthcare staff that he had asthma and a mental health condition. He also said that he had both alcohol and drug addictions, for which he had been receiving treatment from his general practitioner. He tested positive for opiates and benzodiazepine and was therefore seen by the prison detoxification team as well as the prison doctor.

Mr TT was prescribed a range of medication for his medical needs as well as the standard level of detoxification medication including 20ml methadone (initially for three days, then increased to 30ml) and varying doses of chlordiazepoxide (a benzodiazepine for the treatment of alcohol withdrawal). Both detoxification medications were administered in line with the latest National Institute for Health and Clinical Excellence guidelines and Mr TT was appropriately monitored by healthcare staff. Mr TT was also prescribed zopiclone (a short acting sedative) to help him sleep (sleep disturbance is a side effect of opiate and alcohol withdrawal).

On his fifth day in prison, Mr TT was found dead in his cell by an officer at 8.20am and it appeared that he had died during the night. The toxicology results showed a number of different medications present, including the prescribed methadone and chlordiazepoxide, but also temazepam which was not prescribed. Consideration was given to the possibility that Mr TT had obtained temazepam through illicit means. Subsequently, a professor in bio-analysis, an expert witness called for the coroner, stated that the temazepam was a metabolic by-product (produced naturally in the body) of chlordiazepoxide. The professor confirmed that the prescribed medication would not have caused his death. The narrative verdict at the inquest found that Mr TT had died from 'mixed drug toxicity caused by the synergistic action of an unknown combination of prescribed medication'.

It was not possible for my investigation to throw any more light on the circumstances surrounding Mr TT's death. It is clear that he was being treated appropriately for his clinical needs and within national guidelines for his drug and alcohol withdrawal – indeed the clinical reviewer said that the care Mr TT received was satisfactory.

Foreign national prisoners

About 13% of the prison population are foreign nationals, although many will have lived in the UK for years. In 2010-11, there were 19 deaths of foreign national prisoners, 16 of which were due to natural causes and three were apparently self inflicted. This is considerably lower than in 2007-08, when there were 37 foreign national deaths, 23 of which were apparently self inflicted, a quarter of all self-inflicted deaths investigated by the Ombudsman that year.

In addition to the concerns faced by prisoners generally, foreign national prisoners often face further difficulties while in custody. Many can be anxious about their immigration status or their ability to communicate with prison and healthcare staff. Recognising the impact of these anxieties is essential, as is good communication with other agencies so that prisoners can understand their treatment and express their concerns.

Mr UU was born in the United Kingdom (UK), but had lived abroad with his family for many years. He regarded his home as abroad but worried about political unrest in his adopted country and its impact on his family, who still lived there. When he was taken into prison, he was not regarded as a foreign national as he had the right to live in the UK. Therefore, the foreign nationals officer was not aware of him. His particular needs as a person from abroad, such as the entitlement to a higher telephone allowance, were not recognised at first. Mr UU asked his peers whether he would be allowed to serve the non-custodial portion of his sentence abroad and

received conflicting and possibly inaccurate information. He received a longer sentence than he expected and took his own life a week afterwards. He had expressed his concerns about the safety of his family and told his cellmate that he could not survive being parted from them.

NOMS defines a foreign national as a person who is not a British citizen and who does not have the right of abode in the UK. Although Mr UU was a British national, he had lived abroad for many years and, in many respects, fitted the criteria of a de facto foreign national. However, he was not classed as such and was in many ways an anomaly. Mr UU was not well educated about the criminal justice system in this country, particularly regarding his eligibility for early release. I found that his ignorance and the prison's failure to address his needs earlier led in part to him taking his life. Had his fears been recognised sooner, staff would have been able to put additional monitoring in place under the suicide prevention and self-harm management procedures. NOMS accepted the recommendation that, when a prisoner is a British national but lives abroad, the foreign nationals section of the induction document should be completed and their details given to the foreign nationals officer.

Mr VV was 46 years old, had a long history of illicit drug use and had been receiving treatment for liver disease for some time. At his reception health screen when he first went into prison, it was recorded that he spoke little English and interpreters might be needed during future consultations. Throughout his time in prison, interpreting services were used to assist him on a number of occasions, including during medical consultations. Mr VV was regularly treated at external hospitals and, prior to being admitted as an inpatient, the prison doctor wrote to advise the hospital that an interpreter might be required. Mr VV was admitted as an emergency to hospital, where he remained until he died.

The interpreting services used by prison and healthcare staff ensured that Mr VV could communicate his needs. The prison doctor's efforts to arrange these services when Mr VV went to hospital appointments was an impressive example of good practice.

Approved premises

In 2010-11, there were 11 deaths of approved premises residents which is similar to the number in the last two reporting years, 11 in 2009-10 and ten in 2008-09. Of these, four deaths were due to natural causes, three were self inflicted and two were the result of drug overdoses. One death remains unclassified although it appears to be drug related, and a further death occurred in a road traffic incident. While the number of deaths in approved premises remains relatively low, the incidence of probable drug overdoses is proportionally much higher than in the rest of the office's caseload, reflecting wider access to sources of supplies.

Mr WW was released to an approved premises after being granted bail while on remand for serious offences. He initially settled well, but soon reported being bullied. Staff challenged the alleged bully and Mr WW later told them that the bullying had stopped. Several times over the next few months, Mr WW consumed more alcohol than he was permitted under the terms of his bail, including the night when he died.

That evening, he argued with a fellow resident and threatened him. He was sent to his room by staff and the on-call manager advised that he should be checked regularly. However, Mr WW was found hanging at the first check.

My investigation found that staff had not taken sufficient action to address either the breach of bail conditions or the bullying by other residents. Staff should have been aware of the Assessment, Care and Teamwork (ACT) procedures (used by approved premises staff to monitor and support residents thought to be at risk of

harming themselves). It is clear that they were concerned about Mr WW but they missed an opportunity to provide structured support.

Family contributions to investigations

The views of bereaved families are an integral part of the PPO investigation and each family is offered the opportunity to be involved at an early stage and at key points throughout. My family liaison officer (FLO) contacts the family and friends by telephone, letter or occasionally face to face. It is the earliest opportunity for a relative to become involved and the FLO explains their role and the investigation process. This early contact gives the family the chance to express their concerns and issues and provide vital information to be considered as part of the investigation.

> "The FLO was sympathetic and understanding. [Family member]"

The FLO is a consistent point of contact for the family who are encouraged to get in touch with any further questions or issues. When the draft report is available, the FLO invites the family to comment on the issues in the report, identify any factual inaccuracies and satisfy themselves that their concerns have been taken into account. They have eight weeks to comment and their views are given to the investigator for consideration. If requested, the family will be sent a copy of the final report with an explanation of any amendments and why some comments may not have been investigated or the original draft changed.

Following the inquest, the final report is anonymised by removing any information within the report that could identify individuals. The family have an opportunity to receive a copy of the anonymised version as a final check to ensure their relative cannot be identified within the report. The anonymised version of the report is then published on the PPO website.

In many cases, families are instrumental in influencing changes to policies and processes within the prison and probation services as a result of their involvement in my investigation.

Mr XX was a young man who died suddenly of a brain haemorrhage. He was heard snoring in a loud and unusual way before being found unconscious in his cell the following morning. Officers had taken his snoring as a sign that he was sound asleep and were unaware that loud and unusual snoring can be a sign of a more serious underlying health condition. A national recommendation was accepted by the Department of Health and guidance was issued to prison staff regarding loud heavy snoring from people who do not normally snore and who cannot be roused.

Mr XX's family were instrumental in ensuring that this matter was followed up and positive action was taken to educate prison staff. The family's commitment paid off and the topic was featured in an article entitled 'Indicators of serious illness' in Safer Custody News (no longer produced by NOMS). The family told my FLO that they were delighted that something positive came from Mr XX's death and it reassured them that NOMS takes these issues seriously.

Statistics

(Percentages are rounded and therefore may not total 100%)

Corporate statistics

Finance	2009-10	% of total	2010-11	% of total	Change 09/10-10/11	% change
Budget allocation	5,822,000		5,980,000		158,000	3%
Staffing costs	4,922,590	82%	4,889,589	84%	-33,001	-1%
Non-pay costs	1,112,414	18%	961,953	16%	-150,461	-14%
Total spend	**6,035,004**	**100%**	**5,851,542**	**100%**	**-183,462**	**-3%**

Stakeholder ratings	Influential (N=283)		Independent (N=311)		Professional (N=319)		Accessible (N=292)	
Very	85	30%	160	51%	177	55%	114	39%
Quite	162	57%	130	42%	131	41%	150	51%
Not very	34	12%	15	5%	7	2%	25	9%
Not at all	2	1%	6	2%	4	1%	3	1%
Total	**283**	**100%**	**311**	**100%**	**319**	**100%**	**292**	**100%**

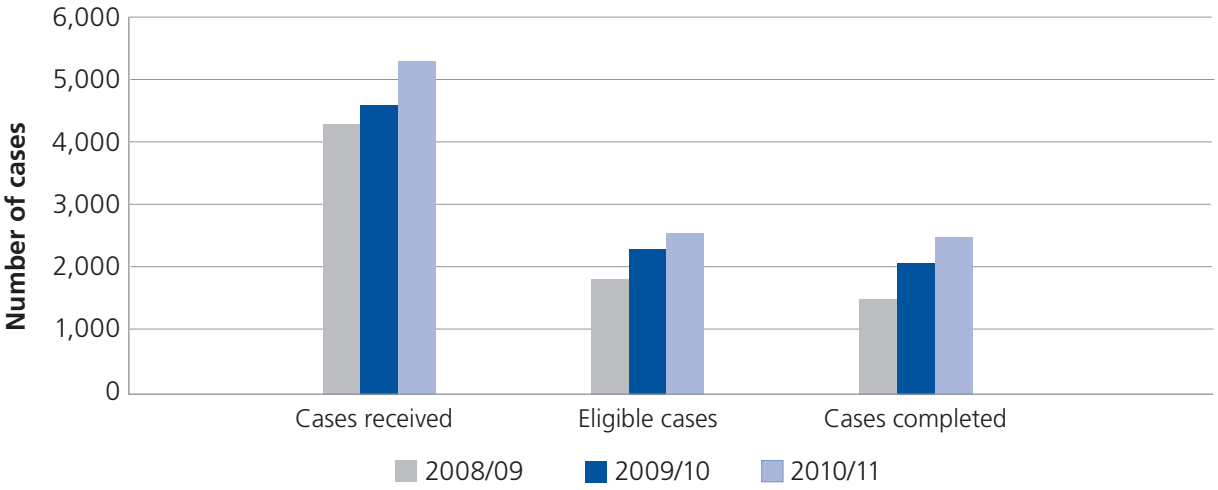
Complaints statistics

Cases received	Total 09/10	% of total	Total 10/11	% of total	Change 09/10-10/11	% change
Prison	4,050	87%	4,659	88%	609	15%
Probation	488	11%	502	9%	14	3%
Immigration	103	2%	130	2%	27	26%
Received	**4,641**		**5,291**		650	14%

New eligible complaints (Investigations started)	Total 09/10	% of total	Total 10/11	% of total	Change 09/10-10/11	% change
Prison	2,173	94%	2,416	94%	243	11%
Probation	82	4%	70	3%	-12	-15%
Immigration	69	3%	75	3%	6	9%
Eligible cases	**2,324**	100%	**2,561**	100%	237	10%

Investigations completed	Total 09/10	% of total	Total 10/11	% of total	Change 09/10-10/11	% change
Prison	1,944	93%	2,362	95%	418	22%
Probation	72	3%	67	3%	-5	-7%
Immigration	67	3%	67	3%	0	0%
Completed	**2,083**		**2,496**		413	20%

Complaints cases over the last three years



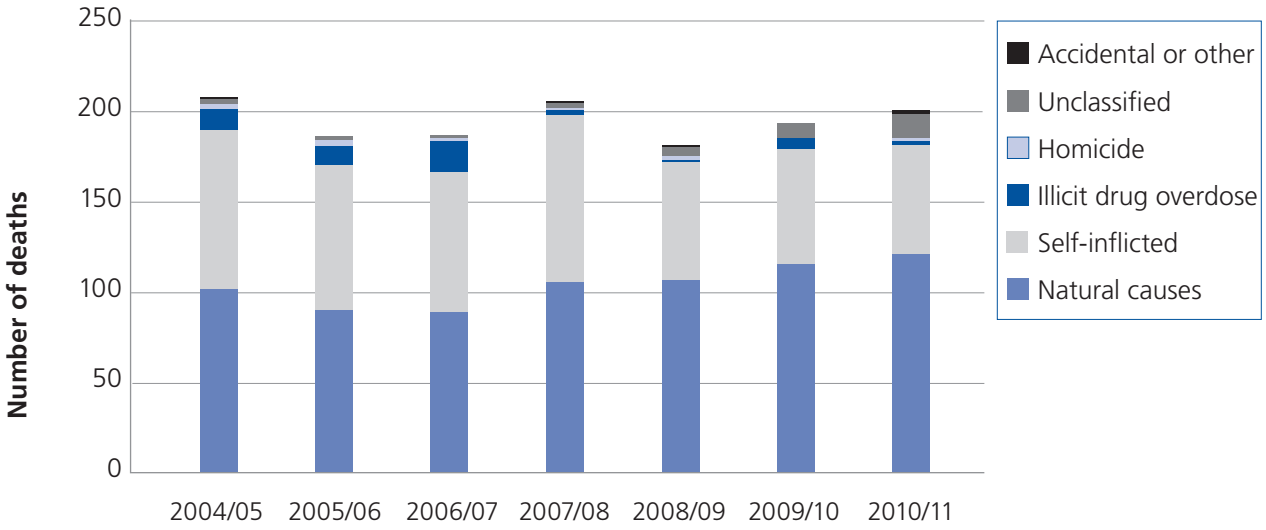
Fatal incidents statistics

Deaths in 2010-11	Male prisons	Female prisons	Young offender institutions[6]	Approved premises	Immigration removal centres	Discretionary investigations	Total
Natural causes	114	3	0	4	1	0	122
Self-inflicted	49	2	4	3	0	1	59
Homicide	2	0	0	0	0	0	2
Illicit drug overdose	0	0	0	2	0	0	2
Accidental and other	1	0	0	1	0	0	2
Unclassified	7	4	0	1	1	0	13
Total	173	9	4	11	2	1	200

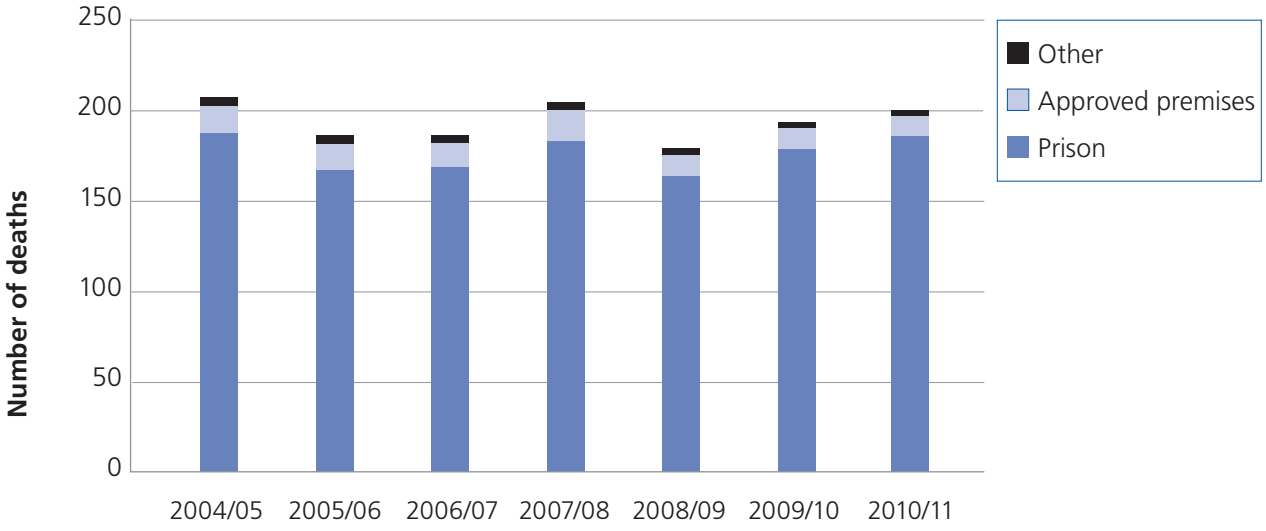
[6] All deaths in young offender institutions were of young offenders aged 18 and over.

Reports issued	2009-10	2010-11	change	% change
Drafts	203	200	-3	-1%
Finals	213	178	-35	-16%
Anonymised reports	135	174	39	29%

Fatal incidents investigated since 2004: Type of death



Fatal incidents investigated since 2004: Establishment type



Statement of purpose

The Prisons and Probation Ombudsman's office exists to carry out independent investigations into deaths and complaints. Our service is in respect of prisoners, those supervised by probation and immigration detainees.

The purpose of our investigations is to understand what has happened, to correct injustices, and to identify learning for the organisations whose actions we oversee.

Statement of values

1. **Accessible:** We will provide a service that meets the needs of the people who use our services and their expectations. We will promote awareness and understanding of the services we provide using plain language and in a range of formats.
2. **Professional:** We will be sensitive to the needs of bereaved relatives and share the information that we gather in our investigations. We will be open, honest and fair in the way we treat all complainants, relatives and witnesses. We will treat the organisations that we work alongside professionally and cooperatively.
3. **Impartial:** We will act independently and ensure that we investigate all our cases objectively. We will be transparent and consistent in our decision making and will set out clearly the reasons for our decisions which will be sound and justified.
4. **Efficient:** We will use our time, money and resources effectively and efficiently. We will listen to customer feedback and look to continuously improve our processes and the service we provide.
5. **Influential:** We will seek to improve the performance of services within remit by advising our stakeholders on scope for improvements which have been identified in the course of our investigations.
6. **Accountable:** We will take responsibility for our actions and be open to learning from constructive criticism.

PPO Terms of Reference[7]

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[8]. 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 costs of the office.

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

[7] The PPO Terms of Reference were last revised in 2009. Since then the title Secretary of State for Children, Schools and Families has changed to Secretary of State for Education.

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

classified material and information 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 enquiries 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 act on the basis only 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; and

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 to 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 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 Primary Care Trust 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 Primary Care Trust 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
Stephen Shaw *(to April 2010)*
Jane Webb (Acting Ombudsman)

Senior Personal Secretary
Jen Buck

Deputy Ombudsmen
Tony Hall
Elizabeth Moody
Penny Snow *(career break from June 2010)*
Thea Walton

Personal Secretary
Janet Jenkins

Assistant Ombudsmen
Louise Baker *(career break from July 2010)*
Karen Cracknell
John Cullinane
Kate Eves
Sarah Hughes *(to May 2010)*
Karen Johnson
Wendy Martin
Gordon Morrison
Olivia Morrison-Lyons
Colleen Munro
Louise O'Sullivan *(to February 2011)*
Dionne Spence
Nick Woodhead

Human Resources and Communications
Steve Turnbull (Manager)
Ries-William Lamont *(to March 2011)*
Samantha Rodney

Central Services
Eileen Mannion (Manager)
Henry Lee (Finance Manager)
Geoff Hubbard *(to April 2010)*
Mark Chawner
Jay Mehta

Research and Analysis
Sue Gauge (Manager)
John Maggi
David Ryan Mills

Senior Investigators and Investigators
Terry Ashley
Tamara Bild
Tracey Booker
David Cameron
Karen Chin
Althea Clarke-Ramsey
Deborah Clarkson
James Crean
Anthony Davies
Lorenzo Delgaudio
Rob Del-Greco
Angie Dunn
Susannah Eagle
Andrew Fraser
Ann Gilbert
Kevin Gilzean
Alan Green
Christina Greer
Natasha Griffiths
Helena Hanson
Diane Henderson
Ruth Houston

Senior Investigators and Investigators cont.

Joanna Hurst
Razna Khatun
Madeleine Kuevi
Lisa Lambert
Anne Lund
Steve Lusted
Kirsty Masterton
Lisa McIlfatrick
Steven McKenzie
Beverly McKenzie-Gayle
Mark McPaul
Tracy Mulholland
Anita Mulinder
Vidia Narayan-Beddoes
Peter Nottage *(to July 2010)*
Amanda O'Dwyer
Emma Range
Ben Rigby
Andrea Selch
Anna Siraut
Tina Sullivan
Amanda Steyn *(to March 2011)*
Sarah Stolworthy
Rick Sturgeon
Anne Tanner
Jonathan Tickner
John Unwin
Louisa Watkins
Nicola Weir
Marc Williams
Karl Williamson
Jane Willmott
Bryan Woodward *(to July 2010)*
Sharon Worth
Sajjda Zafar

Complaints Assessment Team

Rebecca Sanders (Manager)
Veronica Beccles
Clare Bond
Sarah Buttery
Zainab Hasan *(to February 2011)*
Ranjna Malik
Emma Marshall
Verna McLean
Ewelina Nocun
Alison Stone
Ibrahim Suma
Melissa Thomas
Nimmi Virdee *(to February 2011)*
Tracy Wright *(to June 2010)*

Fatal Incidents Support Team

Marta Rodrigues (Manager)
Durdana Ahmed
Catherine Costello
Rowena Evans
David Gire-Mooring
Katherine Hutton
David Kent
Esther Magaron
Tony Soroye

Senior Family Liaison Officer

Joanne Howells

Family Liaison Officers

Rindee Dale
Abbe Dixon
Rachel Gyford
Laura Spargo
Laura Stevenson

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