PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Annual Report

2006–2007

Prisons and Probation Ombudsman
for England and Wales

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Contents

Tough choices in tough times

This Annual Report reflects upon the Prisons and Probation Ombudsman's (PPO's) work in a year that presented a succession of challenges. It was of course a year in which the prison population hit new records, overflowing into police and court cells. A year in which the performance of other parts of the Home Office was rarely immune from public, political and media scrutiny and criticism. A year in which budgetary pressures bore down severely upon our ability to meet the demands placed upon us.

In turn, those circumstances have caused us to look closely at the way we organise our work and our relationship to the services in remit. In this introductory essay, I will say something about both of these issues and the tricky choices we face. However, on the plus side I also wish to record the significant achievements of this office despite the unfavourable climate.

Complaints

The raw numbers on the office's complaints role do not make happy reading. The number of complaints received has risen in every year since 1999 (this year was unusual only in that the percentage rise was single digit). Although we have done all we can to maintain service levels (identifying cases that are 'quick-wins', and maximising the resources devoted to complaints work), these measures have not proved sufficient. As a consequence, our performance in terms of timeliness of investigations has deteriorated further, and we have been adding cases to a backlog virtually every week.

No office can claim 100 per cent efficiency, and we were able to simplify our complaints procedures further this year when the Prison Service agreed we could strip out a routine security check. But most of the productivity gains achievable through the simplification of procedures were realised years ago. In light of the restrictions on my budget, to which I refer below, I have told those responsible that I can no longer defend our published output targets.

The principal reason for the increased caseload is that more of the complaints received now pass the critical sift for 'eligibility'. As with all Ombudsman systems, complainants to PPO must first have exhausted the internal remedies. In the past, a large proportion of complainants simply 'jumped the gun' and brought their problems to us without trying to resolve them with the prison or probation authorities. At least so far as prison is concerned, that is much less the case today. This is testament to the much speedier and (generally speaking) much more professional complaints systems operated by prisons. However, the consequences for this office need little elucidation.

Two further features of the complaints statistics are worthy of mention. First, the proportion of investigations resulting in formal reports is now less than 10 per cent, an illustration of the extent to which we have developed simpler, less formal methods for solving problems. Much of what we are trying to achieve

can be done by negotiation and the results recorded in a letter. However, I would not wish the ratio of reports to investigations to fall any further.

The second aspect of the statistics is that the rate of 'upholds' has fallen to 24 per cent. As I have explained in past Annual Reports, the concepts of 'uphold' and 'not uphold' do not translate very well to the restorative approach we now adopt. Indeed, when I visited Ottawa as the guest of the Correctional Investigator (my equivalent postholder in the Canadian federal system), I was very interested to learn how his office assesses each case in terms of the *impact* of their involvement rather than whether they have *upheld* a particular grievance. This terminology may reflect rather better the brokerage that is central to large numbers of complaints investigations.

On my visit to Canada, I was also struck by the Correctional Investigator's ready access to computerised case files. Although it will be some time before its impact is felt in PPO, the introduction of a single information system for prisons and probation (C-NOMIS) should shorten and simplify investigation times. The laborious task of tracking down and analysing paper records (whether of property or any other matter) will then be a thing of the past.

Within PPO, I am delighted to record that we do now have modern case management IT for complaints work, replacing the legacy system with which we had laboured since the office first opened.

> "IN GENERAL, I BELIEVE THE PRISON SERVICE'S APPROACH TO DECISION-MAKING IS IMPROVING."

Although introduction of the new system was not without its headaches, it has greatly improved the appearance of our letters and reports, provided some better quality management information, and removed the greatest single threat to business continuity. Unfortunately, these benefits have yet to be rolled out to fatal incident investigations, although this should take place during 2007–08.

So much for the statistics, what of the complaints themselves? I personally review all decision letters and reports on a weekly basis, and continue to be struck by the range of issues that have been brought to our attention. These include everything from lost property to security categorisation, from prison discipline and incentives decisions to new subjects of complaint such as the Prison Service's uncertain approach to modern electronic goods.

In general, I believe the Prison Service's approach to decision-making is improving. There are far fewer one-line answers to complaints and most of the forms we review show a proper engagement with the issues. However, there can be little doubt that the decisions themselves are becoming more risk-averse. In popular terms, they are becoming tougher.

I witness this risk-aversion in categorisation and allocation decisions, in judgements about whether to grant early or temporary release, and in security decisions especially where drugs trafficking is suspected. It is now much less common for prisoners to be given the 'benefit of the doubt', and reflects a wider public sentiment that places public protection as the central purpose of the penal system. Indeed, while there may be many means of achieving that protection, it is hard to argue that the priority is an improper one.

Another trend in the Prison Service – that towards local discretion in decision-making – also presents challenges to PPO. Again, it is not hard to understand why this has occurred. It was once said that management in the Prison Service resembled the former East Germany – what was not banned was compulsory – and it is to be celebrated that this no longer applies. (Indeed, PPO investigators are also able to exercise significant delegated authority for managing their own work.) However, if the outcome is too great a discrepancy between different jails, prisoners themselves will not believe they are being treated fairly.

I am not alone in feeling that the high-security prisons should work to a common facilities list (that is, should have a common approach to what prisoners are allowed to retain in their possession). Where differences exist, they should have a rational basis. For example, differences in the size of cells, or in their soundproofing qualities, could reasonably justify a different approach to hi-fi equipment. But on the face of it, it is not easy to understand why something judged a threat to security in one jail is permitted in a prison fulfilling a like function down the road.

Immigration complaints

The office of what was then termed the Prisons Ombudsman received its first complaints from prisoners in October 1994. The remit was extended to complaints from those subject to probation supervision (and the office re-badged as Prisons and Probation Ombudsman) on 1 April 2001. On 1 October 2006, the complaints remit was further extended to those in immigration detention.

The move into immigration detention was a natural extension of our existing responsibility for investigating deaths in removal centres and the series of ad hoc inquiries I have held into immigration matters. Indeed, in my inquiry into allegations of racism and mistreatment of detainees at Oakington immigration reception centre (published in July 2005), I recommended that my office should become the independent tier of the detainee complaints system as a matter of priority. This followed similar recommendations from HM Chief Inspector of Prisons.

In practice, the number of immigration complaints we have received has been small. Most detainees are in detention for only short periods, their focus is very much upon their immigration status or what awaits them following removal, and there may be cultural and language barriers to using formal complaints systems. Nevertheless, my office's involvement is an important guarantee of the rights of vulnerable people. In respect of immigration detention, as of prisons and probation, I take very seriously my informal role as 'guardian' of the complaints process as a whole.

Deaths in custody

The year has witnessed a welcome fall in the number of deaths in custody referred to PPO. In total, we opened 185 investigations, a fall of 4 per cent. Apparently self-inflicted deaths fell from 83 to 74 (11 per cent) and there were no deaths at all in immigration detention.

Deaths from natural causes fell from 94 to 88 (6 per cent), although it is difficult to believe this marks a new trend. Although the number of prisoners over the age of 65 who have died has fallen during the past two years, the longer term consequences for mortality rates of a growing population of pensioner-prisoners seem unavoidable

The small overall fall in deaths in remit, combined with a full or nearly-full staff complement, has meant that we have been able to issue a record number of fatal incident reports and greatly improve timeliness. Nevertheless, I have not felt able to take on more than a small number of post-release discretionary investigations as we are simply not funded to do so. Given the resource constraints under which we labour, we may not be able to take on any during 2007–08.

> "MY OFFICE'S INVOLVEMENT IS AN IMPORTANT GUARANTEE OF THE RIGHTS OF VULNERABLE PEOPLE."

We also remain reliant on IT systems that are risible compared with those operated by our nearest sister organisation, the Independent Police Complaints Commission (IPCC). Nor do we have the staff to analyse and research the investigations we have conducted, or to communicate the learning embodied therein back to the services in remit and the world at large. It is also a weakness

(and a surprise) that our fatal incident investigation work has not been the subject of academic interest.

More positively, more than 140 anonymised fatal incident reports had been published on my website (*www.ppo.gov.uk*) by 31 March 2007. The website, which as I say below we have been waiting to refresh and redesign, now represents a unique repository of reports on deaths in state custody. It is an archive the like of which exists in no other part of the world.

A major purpose of my investigations is to assist Coroners conducting inquests. But different Coroners seem to have different expectations of what my office can and should contribute to an inquest. In some cases, my investigators have been called as witnesses for days on end, only to find that their evidence is not required or will take only a few minutes to deliver. This is neither an appropriate nor an acceptable use of public money. I have been working with colleagues in the Coroners' Society to try to achieve a more consistent and more sensible approach.

Coroners also have to be realistic about the timescale within which my investigations can be completed – especially given the requirement that I engage and involve the relatives of the deceased, and give both them and identified staff the chance to respond to a draft report.

Near-deaths

Since 1 April 2004, I have opened more than 600 investigations into deaths in prisons, probation hostels and immigration removal centres. This includes more than 250 deaths that were apparently self-inflicted. However, I am very aware of the number of deaths that are prevented each year by prison staff. The official resuscitation statistics show that for every one apparent suicide, two deaths are prevented. It is a dismal truth that prison staff and the Prison Service in general receive next to no public acknowledgement for the lives they save.

> "I AM VERY AWARE OF THE NUMBER OF DEATHS THAT ARE PREVENTED EACH YEAR BY PRISON STAFF."

It is now clear that the obligation upon the state to conduct independent investigations into life-threatening

situations in prison (further to Article 2 of the European Convention on Human Rights) can apply to near-deaths as well as to apparent suicides. The circumstances triggering an Article 2-compliant investigation have yet to be fully established by the courts, but following the Court of Appeal's decision in the case of a man who was found hanging in Pentonville just after Christmas 2001 (a man known as D as his identity is protected by court order), I have been conducting the first Article 2-compliant investigation into a near-death.[1]

> "IF PRISONERS START PURSUING COMPLAINTS THROUGH THE COURTS RATHER THAN VIA THE OMBUDSMAN … THE COSTS TO THE EXCHEQUER WOULD BE FAR HIGHER."

In November 2006, I was also asked to conduct an Article 2-compliant investigation into the case of a young woman (SP) who had repeatedly self-harmed in custody before her transfer to a special hospital. Because of continued legal action on the part of those representing SP, that investigation was in limbo at the end of the reporting year.

The requirements of Article 2-compliance (in particular the public element, almost certainly necessitating public hearings) are not usually regarded as a mainstream feature of an Ombudsman's trade. However, it is entirely consistent with the flexibility inherent in any Ombudsman process that we should be able to adapt our procedures to fit the circumstances. Wherever one looks, the methodology of PPO today bears little resemblance to that in place when the office was first established in 1994. The adoption of public hearings in respect of near-death investigations is simply a further step on that road.

That said, as the ambit of PPO becomes wider, the absence of statutory authority has become more and more glaring. The announcement in May 2007 that legislation is now imminent is therefore hugely to be welcomed.[2] Nevertheless, I believe that a shortfall in resources continues to represent a risk both to our reputation and to the services we provide.

Quite simply, a succession of functions has been placed upon the PPO team with little acknowledgement of the need to fund them appropriately and to provide sufficient back-office support. In round figures, our budget is less than one-fifth of that of the IPCC or of the Parliamentary Commissioner for Administration (the Parliamentary Ombudsman). I understand the pressure on all government budgets, and the need for parsimony in the use of public money generally, and we are not alone

[1] R(D) v Secretary of State for the Home Department [2006] EWCA Civ 143.
[2] House of Commons Hansard, 16 May 2007, col 664.

in operating under budget constraints. But our business is demand led and there are perverse financial consequences if we remain under-funded. If prisoners start pursuing complaints through the courts rather than via the Ombudsman, or if Article 2-compliant near-death investigations were to be presided over by judges or QCs, the costs to the Exchequer would be far higher.

Independence

There are five criteria defining an Article 2-compliant investigation. The last four of these are that the investigation must be effective, it must be reasonably prompt, there must be a sufficient element of public scrutiny, and the next of kin must be involved. However, the first criterion is that the investigation must be independent. And I must say something here about my own office's independence. For PPO, independence is not what Bagehot would have called the dignified part of our constitution. It is not an optional extra. Independence is crucial to our effectiveness. It is what gives credibility and authority to our investigations whether into complaints or fatal incidents.

In the absence of legislation, the bulwark of our independence since 1994 has been the clear blue water between our office and the management of the services in remit (first prisons, then probation, latterly immigration). However, the creation of the National Offender Management Service (NOMS) has changed the nature of the relationship. My budget for 2007–08 was actually discussed by the NOMS Board on which sit both the Director of Probation and the Director General of the Prison Service. This cannot be right.

I intend no criticism of the individuals concerned. Indeed, the Director General of the Prison Service has been a strong and kind supporter of the Ombudsman's office and (I believe) personally sympathetic to the case we made for increased resources. Moreover, at no time this year or since I became Ombudsman have I experienced any improper interference with any of my investigations, their findings or recommendations. However, I wonder how far outside observers would believe I still enjoy total independence of the services I oversee?

Concerns on this score have been buttressed by more day-to-day restrictions on my freedom of manoeuvre. Personnel, accommodation, IT, finance, publications and business planning were all subject to Home Office-wide policies and procedures. These rarely reflected my own office's needs and resulted in significant delays in a variety of areas, notably recruitment and IT (including a much delayed redesign of my website), and unnecessary demands upon staff time.

The transfer of responsibility to the new Ministry of Justice has been welcomed by most of my colleagues. Nevertheless, I now judge that something else may be needed to guarantee my office's independence (and, for that matter, our ability to do our job effectively and efficiently) in addition to legislation. We need to look for a different model – perhaps as a non-departmental public body (NDPB), perhaps outside of NOMS entirely. As I have said, our responsibilities are most akin to those of the Independent Police Complaints Commission. Yet our powers, resources and constitutional position are a poor relation of theirs. This, too, cannot be right.

Our staff and stakeholders

I must conclude this introduction to the Annual Report by paying a public tribute both to colleagues and to all those who have assisted us in our work. The PPO office is made up of a skilled, committed and diverse staff group, proud of the work for which they are responsible. On objective criteria (low rates of sickness and turnover; the results of our staff survey), ours is an office with high morale and a clear sense of purpose. I have been very fortunate in the people who have chosen to work as managers, investigators and support staff.

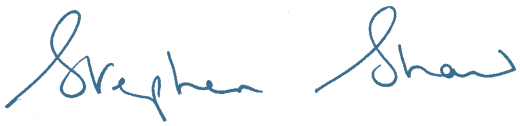
> "PPO IS MADE UP OF A SKILLED, COMMITTED AND DIVERSE STAFF GROUP, PROUD OF THE WORK FOR WHICH THEY ARE RESPONSIBLE."

I have emphasised in this essay the critical importance of our independence. But I have never mistaken independence for isolation, or believed that independence is a licence to ride roughshod over the views of others. Our efforts would be as nothing without the support and engagement of the Prison, Probation and Immigration Services – both nationally and at the local level. The Statement of Values that appears elsewhere in this Annual Report refers to us "helping" the services in remit to deliver justice and decency. And that spirit of co-operation does indeed characterise both complaints and fatal incident investigations, notwithstanding that we may not always agree on the conclusions to be drawn from a particular set of circumstances. I am most grateful to all those who have

contributed to the strengthening and development of my office over the past 12 months.

I was recently asked by a senior police officer how my office is perceived by prisoners and prison staff, and by those involved with probation and immigration detention. Of course, at one level there are as many answers as there are people to ask. But, judged overall, I am struck by the extent to which staff regard my office's work as necessary, legitimate and beneficial. Likewise, I am heartened by the trust that prisoners and other complainants place in our investigations, and moved by the willingness of bereaved relatives to assist and contribute following the tragedy of a death in custody.

In tough times, such expressions of confidence count for more than ever before.



Stephen Shaw CBE
Prisons and Probation Ombudsman

Investigating complaints

The rapid increase in the number of people in prison and the requirement to hold large numbers of prisoners in more confined spaces has, almost inevitably, resulted in prisoners' lives being more tightly regulated. Throughout the year, I have seen examples of prison officers working in crowded conditions yet handling dangerous and high-risk offenders in their charge with firmness and compassion. I have also come across instances when the restrictions imposed on prisoners have not been justified by the need for good order and discipline.

The year has also seen the Prison and Probation Services working together more closely than ever before on sentence planning and arrangements for release. The very real need to protect the public and prevent re-offending is reflected in expectations of the work prisoners will undertake during their sentence, decisions about release, and licence conditions. Such decisions call for careful judgements that are not always understood or appreciated by offenders. I have received a number of complaints about exclusion zones, and requirements for licencees to live, initially at least, away from their homes and families.

I have little doubt that the outcomes of my office's investigations are more risk-averse than was once the case. We have never readily substituted our opinions for those of frontline staff so long as the original decisions are even-handed, reasonable and proportionate. And as the public and political mood has hardened, so the definition of what is fair, reasonable and proportionate has also shifted. To take a daily example, how much risk is acceptable when determining whether a prisoner who has previously offended while on bail or subject to community supervision is being considered for early release on home detention curfew?

> "AS THE PUBLIC AND POLITICAL MOOD HAS HARDENED, SO THE DEFINITION OF WHAT IS FAIR, REASONABLE AND PROPORTIONATE HAS ALSO SHIFTED."

The shift in decision-making has been reflected in the issues drawn to my attention by complainants, and the variety of their complaints. I have received more complaints about the impact of regimes and restrictions of liberty, and I have chosen case studies to illustrate how the judgements of both the services in remit and of my office are made.

Control and punishment

MR A

complained that part of his pay for participating in a Therapeutic Community was being withheld whenever prisoners were subject to 'lockdown'. He said this was unreasonable, as it was not his fault he could not attend meetings when the prison kept him locked up.

My investigator contacted the prison to clarify its policy on payment of prisoners' wages. It replied that if prisoners were unable to work for operational reasons (such as lockdown, staff training or fire alarms), they were paid at a reduced rate. I thought this was unfair. In response, the prison argued that it was fair to reduce the pay of all prisoners when individuals or small groups disrupted the regime or threatened security.

I was concerned by the apparently punitive element to the policy, and did not find it reasonable that the actions of a small number of prisoners could result in a lockdown which would affect everyone's pay. I recommended that the prison amend its policy and reimburse Mr A for any pay lost as a result of operational lockdowns.

MR B

complained that his wing was locked down to allow for the cleaning of rubbish and excrement from the exercise yard. He argued it was unnecessary to lock up all prisoners on the wing for the whole afternoon. Mr B suggested the lockdown was intended to punish prisoners for the mess in the yard rather than to rectify the situation. He felt it was unfair to punish everyone for the behaviour of a minority, and drew attention to comments made by Her Majesty's Chief Inspector of Prisons regarding collective punishments.

I was disappointed with the unhelpful responses Mr B received to his complaints, including a statement that he had been "paid for the time off, don't worry". He was also told it was "not acceptable for prisoners to litter areas with excrement and rubbish and then enjoy the full range of facilities". Finally, when Mr B appealed, he was told he was complaining in an unhelpful manner and that the prison's stance would not change.

The Governor explained to my investigator that exercise had to be cancelled for health and safety reasons because of the excrement in the yard. However, the lockdown had also prevented prisoners from going to work. The Governor felt that it was a proportionate response designed to create a sense of wing responsibility. He added that such lockdowns were rare and seemed to be successful in minimising the problem for a short while. Attempts to identify the individuals throwing excrement into the yard had failed.

I recognised the difficulty facing the prison when it was unable to identify the perpetrators of such anti-social behaviour, and that the problem could not be ignored. However, I too believe it is wrong in principle to employ group punishments. I upheld Mr B's complaint.

MR C

was punished with seven days' cellular confinement and seven days' loss of canteen, association, tobacco, radio, publications and in-cell possessions after being found guilty of failing to comply with a prison regulation. It was alleged that Mr C had rung his emergency cell bell and then ignored the officer who attended, refusing to speak to him. The officer warned Mr C about misusing the emergency bell but he continued to activate it and ignored the officer's warnings on a number of occasions. Mr C complained about the finding of the adjudicator and the punishment handed down.

My investigator established that, despite pleading not guilty, Mr C was fully aware of the rules regarding the use of cell bells. Consequently, I considered the adjudicator's finding to be safe.

However, I was concerned about the severity of the punishment imposed. Mr C had no previous adjudications and his general behaviour was reasonable. Although his offence was serious, I did not consider that it warranted seven days' confinement in conditions of absolute deprivation. I considered that treating a prisoner in this way was disproportionate to the offence and bordered on the inhumane.

> "IT IS WRONG IN PRINCIPLE TO EMPLOY GROUP PUNISHMENTS."

MR D

was handcuffed to an officer while on an escorted visit to an outside hospital. The hospital consultant asked the escorting officer to remove the handcuffs for him to examine Mr D, but the officer refused to do so. The consultant felt he could not examine a patient under those conditions and the examination did not take place. Mr D complained that the lack of co-operation from the officer obstructed his treatment.

Prison Service guidance on hospital escorts specifies that a risk assessment should ascertain the level of escort and restraint required for the safe custody of each prisoner. It further says that restraints should be applied when out of prison up to the point of medical consultation or treatment. At this point, "the restraints will be taken off…unless the risk assessment shows the risk of escape is too high". The restraints are to be reapplied as soon as the examination is completed.

My investigator found that the assessment of Mr D's risk was based upon a number of factual inaccuracies that overstated the risk he posed. The risk assessment determined that restraints were not to be removed by the prison escort unless Mr D's life was in danger.

I was not convinced that the risk assessment completed by the prison accurately reflected the risk presented by Mr D. I upheld his complaint. However, I did not find fault with the escorting officer who was following the instructions contained in the (inaccurate) risk assessment.

A crowded system

As a result of prison overcrowding, there are significant numbers of prisoners who have been waiting many months for permanent transfers closer to home, or for accumulated visits (a procedure enabling temporary transfers to a prison nearer to relatives), or to access courses. My office has dealt with a number of their complaints but transfers are difficult to arrange when prisons are full almost to overflowing. Experience has shown that prisoners who are awaiting a single transfer are likely to have to wait much longer than those who require a move to a prison where several others need to go.

To a large extent, I have accepted that the constraints placed on the Prison Service by the shortage of spaces mean there is very little opportunity to resolve such complaints to a prisoner's satisfaction. Nevertheless, with no sign of the current population difficulties easing, more needs to be done to enable prisoners to maintain and strengthen their family ties.

> "AS A RESULT OF PRISON OVERCROWDING, THERE ARE SIGNIFICANT NUMBERS OF PRISONERS WHO HAVE BEEN WAITING MANY MONTHS FOR TRANSFERS CLOSER TO HOME."

MR E

was accepted for accumulated visits in January 2006. He complained that, some 10 months later, he had still not been able to take them. He was concerned that he would soon be in the 'parole window' and would be unable to move until all the reports were completed.

Unfortunately, although Mr E had been accepted for accumulated visits, his circumstances did not suggest there were any compelling reasons why his case should be given priority. Moreover, because of the distance between the

two prisons, he was reliant on the National Offender Management Service (NOMS) centrally arranging the transport. Although I sympathised strongly with Mr E, I was satisfied that the decisions taken in this case were reasonable and I did not uphold his complaint.

MR F

needed to participate in a drugs awareness course that was not available at his current prison. He complained that, although he had identified several prisons where the course was run, he was refused transfer and consequently could not carry out his sentence plan.

Unfortunately, the prisons identified by Mr F were all local prisons whose main role is to take prisoners from the courts before moving them on to longer-term establishments. My investigator found that, in current conditions, prisons are obliged to be more selective about the prisoners they can take. Nevertheless, staff at Mr F's prison were doing all they could to find him a place at a suitable prison closer to home. Furthermore, Mr F had sufficient time to complete the required course as he was not eligible for parole until 2010. In the circumstances, I was satisfied that the failure of Mr F to secure a transfer was not due to any inaction by prison staff but reflected the high prison population.

MR G

was a young offender who complained that he had not seen his mother in over two years and, despite several attempts, had been unable to go on accumulated visits. Mr G's mother lived a long way from the prison where he was located, and visiting involved an arduous journey by public transport. She also had several young children, including a new baby, making it impossible for her to visit Mr G. He had received no domestic visits at all in over a year.

The Prison Service had been making strenuous efforts to find a place for Mr G but to no avail. The NOMS Population Management Unit indicated it would consider arranging single transfers if there were compelling compassionate grounds. However, the prison considered that Mr G's position was not unique. It seemed to me that one of the effects of the high population was that the circumstances considered to constitute compassionate grounds had changed. Compassion itself was limited.

I was very concerned that a young offender had not seen his mother in over two years. In my report, I said there was a danger that Mr G might come to rely on the contacts made within prison for his emotional support and that, as external links weakened, the influence of his peers would strengthen.

I upheld Mr G's complaint and recommended that the Prison Service and NOMS consider, as a matter of urgency, a new strategy for ensuring that prisoners, particularly young offenders, are able to stay in touch with their family.

> "I WAS VERY CONCERNED THAT A YOUNG OFFENDER HAD NOT SEEN HIS MOTHER IN OVER TWO YEARS."

MR H

said his family lived in Scotland and had been unable to visit him for some time as he was in prison in England. Mr H applied to take accumulated visits – and complained about the time it took for his application to be approved.

My investigator found that cross-border transfers must be agreed by the Scottish Prison Service and the Prison Service for England and Wales, a process that requires liaison between the prison and the Cross Border Transfer Section of NOMS. The prison did not provide NOMS with the necessary paperwork until two months after Mr H made his application and I found this delay unacceptable. I was also critical of the time it took for the Cross Border Transfer Section to process Mr H's application and recommended that NOMS commission a review into the way it handles requests for cross-border transfers.

Keeping in touch

Contact with family is crucial to prisoners' well-being and their chances of going straight on release. When domestic visits are limited, the most common way of staying in touch is by phone. I have investigated a number of complaints about the cost of telephone calls for various groups of prisoners.

MR J

complained that telephone calls using the PIN phone system were several times more expensive than those from a public telephone. When the complaint was received, the minimum charge from a public telephone box was 30 pence for 15 minutes' call time. This has since changed to 40 pence for 20 minutes. In contrast, prisoners pay a minimum call charge of 10 pence for the first 55 seconds and 11 pence per minute thereafter. Consequently, prisoners have only 2 minutes 45 seconds for 30 pence and a 15-minute call costs £1.64.

The Prison Service told my investigator that prisoners benefited from a lower minimum call charge and that some

50 per cent of prisoners' calls last less than 2 minutes 45 seconds. They said that the link to the public payphone rate had been broken some years ago when BT changed its pricing structure for public telephones. The 10 pence minimum charge was advantageous for prisoners and had been retained.

> "IT IS RARE THAT ONE OF MY RECOMMENDATIONS IS NOT ACCEPTED AND A COMPROMISE CANNOT BE AGREED."

I did not believe that restoring the link to the public payphone rate would be in prisoners' interests, but I was far from convinced that the current pricing structure was optimal. The general public has benefited from much cheaper calls in the last 10 years as a result of increased competition. However, the cost to prisoners has remained static – making their calls relatively more expensive.

I appreciate that the PIN phone system required considerable investment by BT and was provided at no cost to the Prison Service. Previous trials in cutting the cost of calls by 2p a minute failed to generate a sufficient increase in the volume of calls to cover BT's loss of revenue. I recommended that, in future, when services are procured that will have an impact on costs to prisoners or their families, an impact assessment should be undertaken and considered during the tendering process. The Prison Service accepted this recommendation.

A further recommendation that the Prison Service should reopen negotiations with BT to reduce the cost of calls to prisoners was not accepted as it could require the Prison Service to compensate BT for the loss of revenue. It is rare that one of my recommendations is not accepted and a compromise cannot be agreed. However, on this occasion, despite lengthy negotiations with the Director General, no agreement has been reached.

Matters of faith

Issues of faith and conscience have been a feature of this year's work. The Prison Service does not recognise all faiths, Rastafarianism and Scientology being notable examples. I have investigated

a number of cases where prisoners have felt that their religious views have not been given due respect or recognition.

MR K

complained that the Prison Service did not recognise Rastafarianism as a religion. As a result he was unable to use the chapel for collective worship with fellow Rastafarians and their priest. The Prison Service recognises Rastafarianism as a culture rather than a religion but, as it was a Ministerial decision to do so, the complaint was outside my remit. Nevertheless, I agreed to investigate what support was being provided for Rastafarian prisoners.

After discussion with chaplaincy staff, I gained agreement that Mr K and other Rastafarians could have access to the chapel. It was also agreed that they would be put in touch with the Haile Selassie I Peace Foundation that has been working with prisoners and the chaplaincy at HMP Birmingham to support Rastafarian prisoners there. Given the limited scope of the investigation, I considered this was a reasonable compromise. I understand that the Prison Service intends to issue new guidance on Rastafarianism to all prisons this year. I am hopeful that the new guidance will enable prison chaplaincy teams to offer more effective support.

MR L

complained about an adjudication for disobeying a lawful order. Being a member of the Pentecostal faith, he refused to allow a female officer to search him as he said it would be a sin. Mr L argued that he had not refused to be searched and was willing to be searched by a male officer. He argued that it was unreasonable to insist he was searched by a woman, or to place him on report when he had genuine objection on faith grounds. Mr L said that Prison Service Order (PSO) 4550, which provides guidance on religious matters, supported his right to refuse the order because it said that "searches of male prisoners with a religious or cultural objection to being searched by a female member of staff must be carried out by a male member of staff".

I accepted the principle enshrined in PSO 4550 that prisoners could refuse a search from an officer of the opposite sex on grounds of religion. Consequently, I had to judge if Mr L's religious objections were well founded. The investigation uncovered a range of views within the Pentecostal church towards female searches of male prisoners, although some parts of the church held it would be 'preferable' if they could be done by a man. However, I considered that Mr L's personal convictions also had to be given proper weight. At his adjudication, Mr L

cited a previous occasion when a similar finding of guilt against him had been overturned, but the adjudicator did not explore this. For this reason, I considered the finding of guilt to be unsafe.

> "ONE OF THE CHALLENGES... IS MAINTAINING A FRESH AND FAIR APPROACH TO EACH GRIEVANCE."

This was not an investigation into the searching practices at the prison where Mr L was located. Nevertheless, I understood some concerns that the adjudicator raised about the breadth of PSO 4550 as currently drafted. While the Prison Service is currently bound by the provisions of the PSO, it is undesirable that there is very little to prevent prisoners routinely objecting to being searched by female staff. I therefore recommended an urgent review of the PSO to ensure that it provides sufficient safeguards to prisoners' religious principles while clearly defining the circumstances in which male prisoners may decline to be searched by female officers.

MR M

complained that films containing scenes of a sexual nature were available on the prison's video channel. He said he found the content offensive and degrading, and it was an affront to his religious beliefs.

My investigation established that prisoners recorded the material that Mr M found offensive from television channels and replayed it through the prison's video channel. All the material was checked by staff prior to transmission. Material with mild sexual content was permitted so long as it had previously been shown on terrestrial television. Before the material was shown, notices were displayed informing prisoners of the content. I agreed that the prison had taken reasonable steps to ensure prisoners were aware of what was being shown and it was up to individuals to choose what to watch.

The right to be heard

Indifference has been described as 'the essence of inhumanity'. One of the challenges that face those who manage

a complaints system is maintaining a fresh and fair approach to each grievance. The complaints I have featured in this section of my report illustrate common areas of complaint – control and restraint, drug testing and Rule 39 correspondence – and highlight failings that sometimes occur.

MR N

complained that he had been sworn at by a senior officer when he asked about being given a wing cleaner's job. The prison told him that a simple investigation would be undertaken, but Mr N alleged he had neither been interviewed nor informed of the outcome.

Over a six-month period, my investigator did everything possible to obtain a copy of the simple investigation paperwork. Eventually, the prison admitted that no investigation had taken place. I considered the prison's failure to investigate and subsequent apparent attempt to conceal this fact to be woeful. I upheld the complaint and recommended that the Governor apologise to Mr N for failing to respond appropriately to his complaint. I also said that, if complaints are made about the behaviour of staff in the future, the Governor must ensure they are appropriately and fairly investigated.

MR O

complained he had been assaulted by an officer at a young offender institution. He said that, while eating lunch in his cell, he was approached by an officer about an incident that had occurred earlier in the day. Mr O said he had been assaulted and asked for the police to be called. In contrast, the officer alleged that Mr O became abusive and was told he would be placed on report. The officer said that Mr O had then lunged at him and he had called for the assistance of other officers. Mr O was restrained and taken to the segregation unit.

Despite Mr O's request, the police were not called and his complaint was not answered until a month later, by which time the adjudication had taken place. Mr O's appeal against the adjudication was upheld by the Area Manager who recorded that the adjudicator had failed to investigate Mr O's defence or call a relevant witness. It was also noted that the hearing should have been adjourned pending the outcome of a simple investigation into the allegation of assault.

In fact, a simple investigation was conducted but not until the adjudication had been heard. However, no conclusions were reached by the investigating governor.

My own investigation found that no specific procedures exist for staff to respond to requests from prisoners for access to the police. Some prisons always allow prisoners to contact the police if they believe they have been victims of a criminal offence, but this is not the case throughout the prison estate. The Prison Service relies on an old Memorandum of Understanding for guidance on the

relationship between prisons and their local constabulary. This memorandum is vague and, as subsequent investigations also demonstrated, it leaves open the possibility that prisoners can be prevented from reporting serious complaints about prison staff to the police.

I was not satisfied that this serious complaint from a young offender had been dealt with properly. He did not receive a response to his complaint for over four weeks, nor was he allowed access to the police to report what he believed was a criminal offence. The lacklustre response to his complaint appeared to have been reflected in a similarly careless handling of the adjudication. I recommended that the Prison Service issue guidance to prisons on how staff should respond to prisoners who wish to report an incident to the police. I also recommended that the prison should apologise to Mr O for failing to respond appropriately to his complaint and his wish to contact the police.

MR P

tested positive after a voluntary drug test and lost his job in the workshop as a result. He challenged the reliability of the result and the way in which the tests were carried out. He was concerned that there was a positive result for at least 14 prisoners in his group. The chair of the local Independent Monitoring Board (IMB) also investigated Mr P's complaint.

My investigator established that the test kits used were on a trial period, although the local drugs co-ordinator was satisfied that they were being used correctly. My investigator spoke to the manufacturer who explained that each test should last for 10 minutes before a positive result could be properly established. It appeared that the tests in the prison could have been of a shorter duration.

> "I WAS PARTICULARLY PLEASED AT THE WAY IN WHICH MY OFFICE WAS ABLE TO WORK WITH THE DIRECTOR."

The IMB chair was also concerned about the way in which the kits were being used at the prison. The likelihood was that officers were not sufficiently acquainted with their use. The IMB chair agreed to raise our shared concerns with the prison's Director. As a result of this intervention, the Director decided Mr P



and the other prisoners who received a positive reading would have their history sheets amended to indicate that the positive result was 'unsafe'. Mr P was reinstated in the workshop.

I was particularly pleased at the way in which my office was able to work with the Director, the IMB and Mr P to achieve a satisfactory negotiated settlement to this complaint.

MR R

complained that a legally privileged letter from the Court of Appeal had been handed to him already opened, contrary to Rule 39 protocols. He also complained that another legally privileged letter had been processed as an ordinary letter.

I receive a large number of complaints about alleged interference with Rule 39 mail. (Rule 39 should ensure that legally privileged correspondence is protected.) In most cases, the explanation is human error and, while I appreciate the annoyance this causes to prisoners, I accept that in busy correspondence units mistakes will happen from time to time. However, I am concerned about the apparent shortcomings of some prisons' arrangements for handling correspondence between prisoners and their lawyers.

In Mr R's case, I was particularly concerned that those who responded to his complaint did not seem to be aware that the prison had specific handling procedures for letters from the Court of Appeal. Mr R was repeatedly advised that the letter had been opened in error by the correspondence unit when, in fact, there was no evidence it had passed through the correspondence office. Nevertheless, I was unable to identify who had opened the letter, and found nothing to suggest it had been anything other than human error. As Mr R had already received an apology, I felt there was nothing further that I could do for him. However, I drew the Governor's attention to the poor quality of responses to Mr R's complaint and the fact that his staff appeared to be unaware of the handling procedures for Court of Appeal letters.

I also concluded that the prison's system for distributing and recording letters opened in error was flawed. My investigator discussed the matter with the head of the correspondence unit who agreed to take steps to ensure that all legally privileged letters opened in error are identified and accorded Rule 39 protection. It was also agreed that a record should be kept of the reason for opening mail, and explanations for any errors should be given to prisoners on receipt of their letters.

Making progress

MR S

complained that he had been refused re-categorisation from category C to category D ('open conditions') because the prison said he was not doing the required offending behaviour work. Mr S

maintained he had done the work and provided my investigator with certificates demonstrating he had completed courses in adult literacy, drug awareness, justice awareness and alcohol and offending.

My investigation found that poor record keeping and inadequate communication between different departments in the prison resulted in misleading information being provided to the re-categorisation board. Although I was unable to say whether the board would have reached a different decision if it had been given accurate information, I found the lack of care unacceptable. I also found that the prison had failed to investigate Mr S's complaint fully, as the information establishing his claim was readily available at the establishment.

MR T

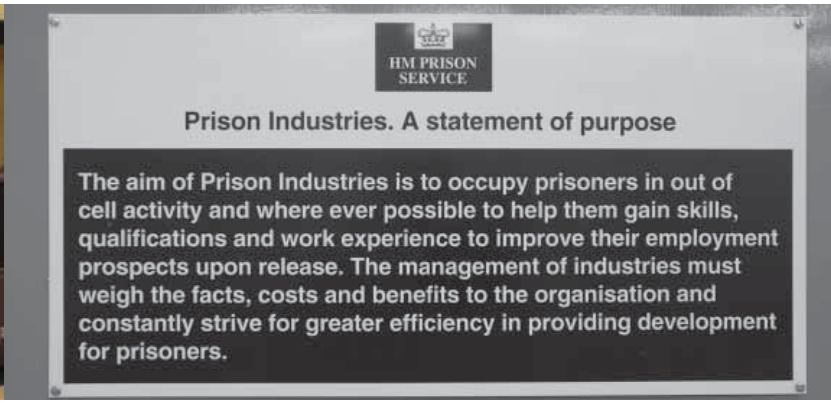
said he was a life sentenced prisoner in a high security establishment. He complained that he was unable to make progress through the system because his low IQ made him ineligible for offending behaviour programmes.

My investigator liaised with the Lifer Manager at the prison, who was sympathetic to Mr T's predicament. He arranged for a Lifer Review to take place and for assessments to be completed. A psychology report confirmed that Mr T was unsuitable for the available offending behaviour programmes but said that other work, particularly education, could be undertaken to reduce his risk. In his report, the Lifer Manager agreed with my investigator that meeting Mr T's educational needs could hold the key to addressing his offending behaviour. The Board accepted his recommendation to transfer Mr T to a prison with a lower security categorisation.

> "MEETING EDUCATIONAL NEEDS COULD HOLD THE KEY TO ADDRESSING OFFENDING BEHAVIOUR."

MR U

had been given a tariff of 30 months before he could be considered for release. He complained that the long waiting lists for offending behaviour courses meant he had no chance of being released on his tariff date. He said that IPP prisoners should be prioritised over automatic life sentenced prisoners, who usually have much longer tariffs.



Imprisonment for public protection (IPP) is an indeterminate sentence – similar to a life sentence – that requires people to be detained until there is evidence that the risk they pose has reduced sufficiently to enable them to be released.

My investigator found Prison Service instructions required lifers with short tariffs to be given priority for offending behaviour programmes. However, the prison said that the system of prioritisation had never been funded or formally introduced. My investigator consulted NOMS who said that the lifer population had grown by more than 25 per cent since IPP sentences were introduced in April 2005. The increase put pressure on prisons to deliver offending behaviour programmes aimed at high-risk prisoners. At the prison where Mr U was held, waiting lists of two to three years were not uncommon.

As Mr U's situation was similar to that of so many other prisoners, I did not judge I could sensibly uphold his complaint. However, I found it raised questions about whether the Prison Service had prepared adequately for the influx of short tariff lifers.

MR V

was refused early release on home detention curfew (HDC) as the prison considered he posed an unacceptably high risk to the victim of his offence and to members of the public. Mr V complained that his behaviour in prison had been exemplary, that he had shown remorse for his offending, and that prior to his conviction he had been a person of 'outstanding character'.

To uphold his complaint and ask the prison to reconsider the decision, my investigation would have had to find that the decision not to grant Mr V early release on HDC was either based on flawed or incomplete information, or did not accord with Prison Service guidance. In fact, my investigator found evidence to suggest that Mr V had not been a man of previous good character and found nothing to suggest the prison had acted unreasonably. I supported the prison's decision that to release him early could bring the HDC scheme into disrepute as he remained high risk.

On release

During 2006–07, I received 242 complaints about the National Probation Service (NPS) from prisoners and 70 from people in the community. Of those 312 complaints, all but six were from men.

In the five full years since the Ombudsman was given responsibility for investigating complaints from those dissatisfied with the actions – or inaction – of the NPS, I have referred more than once to the fact that many of those supervised by probation do not know how to complain or receive an inadequate response to their initial complaint. There are few signs of improvement. Only 35 (11 per cent)

of those who complained to me had completed the NPS procedures and were eligible for me to consider.

> "MANY OF THOSE SUPERVISED BY PROBATION DO NOT KNOW HOW TO COMPLAIN."

I have found that some probation areas are receptive to complaints, and deal with them promptly, thoroughly and fairly. Unfortunately, there are others where the procedures appear to be made unduly complicated, and complaints are dealt with as inquiries. Many people who approach me before completing the necessary procedures do so because the probation area has not provided information about how to make a complaint.

A number of the complaints I investigated in 2006–07 were about the actions and judgements of individuals, and the assessments of risk and dangerousness that probation officers (offender managers) make on a daily basis. The need to protect the public is central to the work of the NPS and it is not difficult to understand why here, too, decision-making has become more risk-averse. The consequences of getting it wrong are self-evident.

MR W

was released from prison on licence, without a fixed address. He said he was left to find his own accommodation, and was recalled to prison as a result of failing to do so. He complained that he had been treated unfairly by the NPS and had been given no resettlement assistance.

My investigator found that accommodation had been identified as a problem before Mr W's release. The offender manager had tried to identify suitable accommodation without success. Mr W was rejected by several Approved Premises (hostels) because of his history of violence and drugs, and the risk he continued to pose to the public. The offender manager also referred him to the local authority but he was not considered a priority.
Mr W found accommodation approved by the offender manager as a temporary measure. However, he then changed his address twice without informing the NPS as he was required to do, and there was information that he had breached a separate licence condition.

I was satisfied that the offender manager had gone to great lengths to identify suitable accommodation for Mr W, albeit unsuccessfully. I was also satisfied that he had not been treated unfairly, as his recall was a direct result of his failure to meet the conditions of his licence.

MR X

said he was a prisoner serving a life sentence, and complained about the lack of contact and assistance with sentence planning from his offender manager. He said his letters had gone unanswered and his attempts to initiate contact were ignored.

My investigator discovered that there had been a number of different offender managers allocated to Mr X's case since 2003, due to staff sickness and moves. Consequently, his letters had not always reached the person dealing with his case and he had not received a consistent quality of contact. However, the probation area accepted that Mr X had experienced variable levels of service, and acknowledged that correspondence from offenders should not go unanswered. The area undertook to review arrangements for recording and responding to external post. My investigator was also pleased to find that Mr X appeared satisfied with his current case manager. I agreed that his case had been handled poorly but I made no recommendation as the area had already taken steps to improve its systems.

MS Y

complained that, at her sentencing hearing, she had been misled by a court officer about the work she would be required to do on an order for unpaid work. She said that the author of her pre-sentence report had suggested Ms Y was unsuitable for unpaid work as she was housebound and claimed Invalidity Benefit. However, at the hearing, counsel for Ms Y said that she could get out and her illness would not prevent her from working. The court officer told the court that each case was placed individually and those claiming Invalidity Benefit would not necessarily be excluded. The officer said that an individual placement, such as working in a charity shop, could be found for Ms Y. She was placed first in a probation workshop and later on a painting project.

My investigator found evidence to confirm that the officer had explained clearly to Ms Y what the requirements of an order would be and gave her no specific promise about the nature of the work she would do. Ms Y agreed that the project supervisor allowed her to work at her own pace and took steps to ensure her health was not endangered. Although I did not uphold Ms Y's complaint, I was concerned about the lack of clear guidance available to probation staff about whether those claiming Invalidity Benefit are eligible for unpaid work, and I recommended that the Probation Board should issue new guidelines.

Immigration detainees

My terms of reference were extended from October 2006 to include complaints from detainees in immigration removal centres (IRCs) about their treatment in the IRCs or on escort. In the period to 31 March 2007, I received a total of 29 complaints from detainees, although not all of these were eligible for investigation. Complaints were received from almost every one of the removal centres and covered such matters as property, food, communications and staff behaviour.

Given the relatively small number of complaints received, it is difficult to draw any conclusions about this important area of work at this stage. Nevertheless, the case below encompasses a number of detainees' concerns.

In January 2007, 73 residents at an IRC signed a petition asking me to investigate a number of complaints. The petitioners complained about medical facilities, about the quality of the food, and about the amount of time they were locked in. Overall, they complained they were treated "like slaves and servants".

With the full co-operation of the IRC, my investigator visited the centre and met with both staff and detainees. She had lunch in the detainees' servery and found the centre to be clean and functional. Moreover, during a group meeting when detainees were encouraged to voice their specific complaints, it became clear that many of them had not been aware of exactly what the petition contained. The detainees denied that they were treated like slaves and servants, and wanted this allegation removed. Other complaints were dealt with in turn and concessions were made in several areas. The IRC agreed to inform all staff about translation services and how detainees could access them. A more varied menu was agreed and extra chefs were employed. There was agreement to recruit an imam and this has since been done. Access to telephones was addressed by the provision of mobile telephones and clear information about medical services was provided. As a result of the investigator's visit, and the follow-up undertaken by the IRC, I was satisfied that all the detainees' complaints were either resolved or were in the process of being resolved. I arranged for all those who had signed the petition to be made aware of my findings.

Investigating fatal incidents

This is the third year in which I have been responsible for investigating deaths of prisoners, residents of Approved Premises and immigration detainees. As I say in the introductory essay of this Annual Report, I am pleased to report that the number of investigations opened has fallen to 185, a reduction of 4 per cent.

As in previous years, a number of common threads emerge from my investigations. I provide examples below from cases where final reports have been issued and inquests have taken place.

It is especially welcome that there has been a further year-on-year reduction in the number of prisoners apparently taking their own lives in moments of despair and depression. I have no doubt that the introduction of the assessment, care in custody and teamwork (ACCT) process throughout the prison estate has reduced the risk to individuals and improved the multi-disciplinary approach to risk management.

ACCT is designed to be a care planning system in which staff from all disciplines work together to provide individual care to vulnerable prisoners. It allows any staff member to raise their concerns, take action, and document that action, for prisoners they identify as being at risk of suicide or self-harm. ACCT has now been rolled out to all prisons.

I welcome and applaud the objectives of ACCT, and already we have seen many examples of good practice. Nevertheless, I am disappointed that I have had to make recommendations about ACCT implementation in more than 30 per cent of my investigations into apparent suicides in prison. All but one of these prisoners had a history of harming themselves, eight were on an open ACCT when they died, and a further eight had been on an open ACCT until days before their deaths.

In my 2004–05 Annual Report, I wrote that some prisoners would have been more appropriately cared for under the mental health system than in a custodial environment. It remains a matter of concern that many individuals are sent into custody, or returned from psychiatric units early, because they are too challenging to manage. Prison officers are not mental health workers, yet all too often they are required to care for the most damaged individuals in our society.

That said, it is encouraging that the number of apparent suicides of segregated prisoners has fallen considerably since 2004–05. While small numbers are subject to substantial

random variation (an aspect of statistical theory that is insufficiently understood by most commentators), significant efforts have been made by the Prison Service – in particular, in the high security estate – to increase safety and care for those in segregation. This year, eight apparently self-inflicted deaths occurred in segregation units.

The use of restraints in hospital has featured in a number of my investigations into deaths from apparently natural causes. (I use the term 'restraints' to refer to handcuffs and escort chains. The latter is a long length of chain with a handcuff at either end. One handcuff is placed on the prisoner under escort and the other on an officer. The chain allows more freedom of movement for the prisoner and some degree of privacy for activities such as using the toilet.) There can be no dignity in dying while under restraint, but staff must properly balance this against the risk to the public.

> "IT REMAINS A MATTER OF CONCERN THAT MANY INDIVIDUALS ARE SENT INTO CUSTODY, OR RETURNED FROM PSYCHIATRIC UNITS EARLY, BECAUSE THEY ARE TOO CHALLENGING TO MANAGE."

Throughout the year, we have seen evidence of risk-aware thinking enabling even dangerous offenders to die with dignity. Terminally ill prisoners have been released early on compassionate or temporary licences to die outside prison. Families have been able to spend time with prisoners who have chosen to remain in custody to die, and living wills have been agreed to prevent unwanted treatment being given towards the end of prisoners' lives. All these actions have contributed to providing a culture of compassion and sensitivity.

In introducing the cases below, I should also say something about my team of Family Liaison Officers (FLOs). I am committed to placing the families and loved ones of those who have died at the centre of all my investigations into fatal incidents. To further improve our service to families, I have now appointed an FLO manager and increased the team to four. The FLOs have a crucial role to play. They liaise with families throughout the investigation process, providing an invaluable channel of communication and information.

Licence recall

The number of offenders on licence whose behaviour causes sufficient concern for them to be recalled to prison has more than trebled over the past five years. It can be several weeks before recalled offenders are given information about the reasons for recall, and in some cases the lack of information has led to a heightened risk of self-harm or suicide.

MR AA

was recalled to prison for breaching his licence conditions but was not immediately told why he had been recalled. Mr AA received a notification that he would have to serve four years in custody. But he was given no reasons and no information about any right of appeal. Mr AA died, apparently by his own hand, the day before a dossier containing a full explanation arrived at his prison.

I have also found that recalled prisoners sometimes by-pass procedures such as induction and full health-screening, and are less likely to be engaged in sentence planning. I am continuing to monitor the number of deaths of recalled prisoners with a view to providing a more detailed analysis.

Mental health

There are now 360 prison in-reach workers in 102 prisons providing mental health services for prisoners suffering severe mental illness. However, several of my investigations have indicated that these new resources are failing to keep pace with the high levels of need among the prison population. There have also been indications in some cases that the experience of imprisonment has materially increased an individual's vulnerability and distress, with tragic consequences. I regard my report on the self-inflicted death of Mr BB as one of the most significant I have issued.

> "THE NUMBER OF OFFENDERS ON LICENCE WHOSE BEHAVIOUR CAUSES SUFFICIENT CONCERN FOR THEM TO BE RECALLED TO PRISON HAS MORE THAN TREBLED OVER THE PAST FIVE YEARS."

MR BB

was a life sentenced prisoner who, at the time of his death, had been diagnosed as suffering from a severe and enduring mental illness. He was a prolific self-harmer whose behaviour led to black eyes, lacerations to his face and wrists, and the reopening of old self-inflicted wounds. Mr BB twice took an overdose of prescribed

medication and swallowed foreign objects that required removal at an outside hospital. Staff in the local prison where Mr BB was found hanging cared exceptionally well for him as far as they were able. However, his needs were too great for the local prison, or for any prison, as he really required treatment in a secure mental health facility.

In my report, I said that healthcare staff demonstrated great empathy with Mr BB. I found that the Head of Healthcare and Mental Health Lead were tireless in their efforts to have him transferred to a psychiatric hospital, but they were operating within a system that worked against them. It appeared that prisoner patients dropped to the bottom of a long waiting list. Although Mr BB's supervision was guaranteed and a degree of protection was offered, in all other respects the prison environment was entirely unsuitable for him.

> "I FOUND IT DIFFICULT TO IMAGINE THAT A SOLITARY CELL IN A SEGREGATION UNIT WAS AN APPROPRIATE LOCATION FOR A VULNERABLE AND MENTALLY UNSTABLE WOMAN."

I also found that the National Health Service failed to acknowledge its responsibility towards Mr BB. In my recommendations I urged the Department of Health to use the case as the basis for a fundamental mental health pathway review.

Some of the most distressing investigations I have undertaken concern prisoners with lengthy psychiatric histories who are not considered treatable when appearing before the courts.

MS CC

was a prolific self-harmer who, at the time of her death, was held in a prison where the very high level of prisoner self-harm placed prison officers and healthcare staff under severe and unremitting pressure.

Ms CC was found hanging in her cell in the prison's segregation unit. She had been sentenced to life imprisonment for setting fire to curtains in her sheltered flat, close to a psychiatric hospital where she had been admitted on a number of occasions. In her teenage years, she had been detained and treated in a secure psychiatric hospital for more than four years.

Shortly before she was sentenced, a forensic psychiatrist's report said that the damage to Ms CC's personality was severe enough to be diagnosed as psychopathic disorder. The psychiatrist said he found no evidence to suggest Ms CC was treatable. In his opinion, she did not suffer from a serious mental illness or disorder for which she could be detained in hospital. However, in sentencing her, the judge told Ms CC that her condition would require and receive constant supervision, assessment and monitoring.

I found it difficult to imagine that a solitary cell in a segregation unit was an appropriate location for a vulnerable and mentally unstable woman. The jury at her inquest agreed. They said that prison was unsuitable for someone with Ms CC's problems as the constant supervision and monitoring she required was lacking.

Assessment, care in custody and teamwork (ACCT)

One welcome aspect of the ACCT process is the holding of a review after the ACCT document is closed. Unfortunately, my reports have found the quality of post-closure reviews to be poor in a number of cases. Prison Service staff across the board have received foundation training in the use of ACCT. Nevertheless, the investigation of a number of deaths yet to come to inquest has suggested that implementation of ACCT may not always be consistent, and staff in reception and segregation units may not use it in the same way as staff on the wings. In addition, although ACCT is designed to be multi-disciplinary, in several cases the information in confidential clinical records was not mirrored in ACCT records and, consequently, could not be shared by the multi-disciplinary team. Locum healthcare staff have not always been familiar with ACCT arrangements and they have not always been invited to attend reviews as they should be. I have commented that the aims of ACCT cannot be wholly achieved without the full participation of all healthcare staff.

MR DD

was admitted to prison on remand. On arrival, he was withdrawn, tearful and distressed, and an ACCT document was opened immediately. He was placed in the healthcare department where he remained for the next two months. While there, he tried twice to harm himself and was supported by the mental health in-reach team. When his condition improved, Mr DD was moved to a wing where, as a precautionary measure, the ACCT document was kept open for two weeks. Observations continued for a further week and a final review was planned for after his trial. Mr DD's condition improved, he became friendly with other

prisoners, engaged in leisure activities and appeared settled.

Some seven months after he was remanded, Mr DD was convicted and sentenced to two years' imprisonment. Unfortunately, his key worker from the mental health in-reach team was not made aware of the changed circumstances and did nothing to arrange a final review. The media coverage of the trial was extensive. Mr DD was humiliated and began to refuse his meals. His cell mate told a wing officer who immediately reopened the ACCT document. The officer set up a detailed care plan including hourly observations whenever the cell was locked. The following day, Mr DD was left alone after he declined to go to exercise. He hanged himself.

My investigation found much good practice in Mr DD's care. ACCT documents were opened promptly, reviews were held as required, the same staff team provided consistent treatment, and Mr DD was consulted appropriately. However, my investigation also discovered that recommendations made at reviews were not always carried out, and there were discrepancies between the ACCT and Mr DD's clinical records. I judged that there should have been hourly observations whenever Mr DD was alone rather than just when his cell was locked.

Segregation units

Of the eight deaths occurring in segregation units, four prisoners were either monitored under ACCT arrangements at the time of their death or had been monitored until shortly before they died. In my reports, I have expressed concern that reviews were not reconvened when prisoners were moved to segregation units and safer cells were not always available.

Worryingly, I have also found examples of poor healthcare provision. In one case, healthcare staff did not read the prisoner's medical records before confirming him fit for segregation. In another case, the prisoner's access to specialist counselling support was terminated as the counsellor's work contract was limited to the wings and did not cover the segregation unit. Although the death of Mr EE occurred before the implementation of ACCT arrangements, it highlights a number of issues of continuing significance.

MR EE

was a young man in his twenties. He had a long history of harming himself and threatening to take his life. After being remanded into custody, he spent most of his time in the healthcare unit where a F2052SH suicide and self-harm monitoring form was opened. After a few months, he was well enough to be transferred to a wing, although the F2052SH remained open. Two weeks later, it was alleged that Mr EE had hit an

officer and he was transferred to the segregation unit. He hanged himself there three days later.

My investigation concluded that the decision to segregate Mr EE was reasonable, but I uncovered a number of deficiencies in his treatment. The open F2052SH document was not reviewed, and no specialist mental health assessment took place as required by PSO 2700. The segregation unit had one safer cell that was occupied by a prisoner said to need it more than Mr EE, but there was no assessment of that prisoner on record. Although regular monitoring was noted, it showed only if Mr EE was awake or sleeping, with no indication of whether officers attempted to engage him or try to discover how he was feeling. The chaplain visited Mr EE shortly before he died. Mr EE spoke of his suicidal ideas but the chaplain did not pass on the information. Finally, nothing was provided to help Mr EE fill his time. He had no television, radio or reading material.

> "THE USE OF RESTRAINTS FOR PRISONERS TEMPORARILY LOCATED OUTSIDE PRISON CALLS FOR CAREFUL JUDGEMENT."

In Mr EE's case, as in others, I found that officers caring for segregated prisoners can be ill equipped to recognise and support those who are a risk to themselves. Officers in segregation units have told my investigators that suicide and self-harm training is designed for wing officers who have more time to get to know prisoners and establish relationships, and who consequently can identify warning signs. Appropriate training for officers in segregation units could help reduce risk.

Use of restraints

The use of restraints for prisoners temporarily located outside prison calls for careful judgement on the part of the manager making the decision. The manager must assess the likelihood, risk and implications of escape for both the public and hospital staff. They must also ensure the prisoner receives appropriate medical treatment and is afforded decency and compassion. A number of my investigations have considered how those judgements have been exercised, and whether prisoners have been managed sensitively while on bedwatch in hospital up to the moment of death.


I have found that establishments where procedures work well are those where decisions about the use of restraints on bedwatches are regularly reviewed and reassessed by operational managers. Best practice requires each new risk assessment and decision to be recorded in order that the reasoning behind them is apparent. In addition, bedwatch staff should be encouraged to tell the duty governor or security manager of any changes in the prisoner's condition, relevant comments from medical staff and the extent of the prisoner's compliance with the hospital regime.

MR FF

was over 60. At the time of his death he had served four years of a 10-year sentence for serious offences against children. He had a history of emphysema and chronic obstructive airways disease. He also had reduced mobility due to chronic breathing difficulties and was assessed as needing a wheelchair. Mr FF had been to hospital on several occasions and was on continuous oxygen. The long-term prognosis was very poor. When Mr FF's condition deteriorated further, he was escorted to hospital by two officers, handcuffed to one by an escort chain. He was admitted as an in-patient and the operational manager decided the two-officer escort should continue and the escort chain would not be removed.

Over the next four days, Mr FF's condition progressively worsened although he remained on the escort chain until the consultant cardiologist faxed a letter to the prison doctor. The latter asked for the escort chain to be removed as Mr FF's condition was critical and his chances of survival were very low. The restraint was removed and the escort reduced to one officer.

The prison's policy is for restraints to be removed if a senior healthcare professional makes such a request when the patient's condition is life-threatening. There is no discretion for the duty governor to authorise removal of the restraint without a direct request from medical staff. My investigator was told that Mr FF's mobility was reassessed during the duty governor's daily visits.

I appreciate that security considerations are crucial when a prisoner is subject to bedwatch outside the prison, but I was not satisfied with the arrangements in Mr FF's case. He was elderly with poor mobility and in considerable pain. I considered that, in the four days preceding the consultant's intervention, Mr FF's condition was such that restraints were not necessary and the presence of staff in the room constituted an adequate security arrangement.

I recommended that the prison should consider giving the duty governor more discretion to authorise the removal of restraints in similar circumstances. Although the prison accepted my

recommendation, the result of its consideration was to leave the existing procedure in place.

Approved Premises

During 2006–07, 12 residents of Approved Premises died, five fewer than in 2005–06. All were men. Six deaths were due to natural causes, four to substance misuse and two residents apparently took their own lives.

Time and again my investigators have seen commitment from dedicated staff teams supporting other residents and each other after a death, and I have commended good practice in many of my reports. As an example, when one man's frailty increased, the rule about the number of visitors in his bedroom was relaxed so that he could enjoy the company of his friends.

However, licence conditions can mean that Approved Premises residents are placed away from their home area, which has an impact on local health and social care agencies. My investigators have found Approved Premises managers making extensive efforts to obtain the necessary care for residents.

Probation areas and NOMS have welcomed most of the recommendations in my reports. A probation circular based upon previous years' recommendations has been issued for implementation nationally.

This year, I highlighted the benefit of staff carrying mobile telephones or alarm fobs to help them summon assistance quickly. I also recommended more regular monitoring of residents' medication and improvements to the systems for recording next of kin details so that families can be contacted quickly. I have every confidence that NOMS will also consider whether these local recommendations have national implications.

> "MY INVESTIGATORS HAVE SEEN COMMITMENT FROM DEDICATED STAFF TEAMS SUPPORTING OTHER RESIDENTS AND EACH OTHER AFTER A DEATH."

MR GG

was released from a local prison with a condition of residence at an Approved Premises. He told

the staff he had a number of chronic health conditions, and was prescribed medication. Although the staff were responsible for administering his tablets, when Mr GG's condition worsened and his medication was changed, he did not tell them and patient confidentiality meant they were not informed. Mr GG was admitted to hospital and returned the following day saying he had been discharged. In fact, he had discharged himself and died just over a week later. I recommended that the Approved Premises should introduce a formal system for following up significant medical events.

The number of apparent suicides in Approved Premises is small, but no less significant. Both of the self-inflicted deaths in 2006–07 occurred in a probation area where a system of assessment, care and teamwork (ACT) for monitoring residents at risk of suicide or self-harm is in use, modelled on the Prison Service's ACCT process.

MR HH

was remanded in custody for almost a year, and then bailed to live at an Approved Premises. Two days after he arrived, he spoke to the staff about feeling suicidal and the area's Risk of Self Harm or Suicide form was opened. Mr HH was sentenced soon afterwards, with a condition that he should continue living at the Approved Premises. He appeared to settle in and the form was reviewed and closed. However, the same day his offender manager visited, and Mr HH spoke about feeling depressed. The offender manager had not been at the review, so only learnt afterwards that the form had been closed and took immediate steps to reopen it. Close monitoring and support resumed immediately, but sadly it was insufficient to keep Mr HH safe and he took a fatal overdose some weeks afterwards. I recommended that supervising officers should be fully involved in the implementation of suicide and self-harm monitoring.

Family liaison

I have already indicated my pride in the sensitive and supportive service that my Family Liaison Officers (FLOs) continue to offer bereaved families. They provide the family with a link to my investigator while remaining separate from the investigation itself. The FLOs identify the family's concerns and attempt to ensure that the investigation provides answers. If the family chooses, the FLO may remain in regular contact throughout my office's involvement. Although FLOs cannot offer advice about legal matters or provide a bereavement counselling service, they advise about other agencies or services providing appropriate specialised support.

MS JJ

After liaising with an FLO for some time, Ms JJ advised that she had suffered mental health problems

and was worried that her bereavement would escalate them. The FLO became concerned about sending a draft report containing distressing information for her to read alone. The FLO arranged to hand-deliver the report and to go through it with the family. With Ms JJ's consent, the FLO also arranged for her support worker to attend at the appropriate time, and to remain with her after hearing the findings of the investigation and once the FLO had left. At the FLO's request, and with Ms JJ's agreement, extra support was provided in the weeks after the disclosure, enabling her to be involved in the process while limiting the damaging effect this could have had on her health.

Feedback from families and others about the service we provide is hugely important to us. In the coming year, we shall be exploring ways of obtaining their views more systematically. However, in the interim, I do not think it is misleading or self-satisfied to share the following comments from a bereaved family and the manager of an Approved Premises:

"I would like to thank you for the compassion and understanding with which you have treated us. The way in which you have kept us informed of progress on the report, and the advice you have offered has been much appreciated."

"Many thanks for the way in which you undertook your investigation. There were understandable anxieties about being subjected to external scrutiny of such a sad matter, but all of us felt that your thoroughness was balanced with sensitivity and support."

> "FEEDBACK FROM FAMILIES ABOUT THE SERVICE WE PROVIDE IS HUGELY IMPORTANT TO US."

Other investigations

Discretionary investigations

I have a discretionary power to investigate deaths of ex-prisoners where the circumstances suggest a link to their treatment or care while in custody. In practice, I have to exercise that discretion conservatively as the death rate on release from custody is considerable. Resource constraints mean that only the most complicated cases can now be investigated. However, I am conscious that a valid interpretation of the investigative obligation under Article 2 of the European Convention on Human Rights is that some post-release deaths may require an independent investigation of the kind my office carries out.

Many of the post-release deaths are related to renewed drug-taking. I welcome the actions the Prison Service has taken, in part in response to my reports, to alert prisoners to the dangers of intravenous drug use once their tolerance levels have fallen in prison.

One discretionary investigation had wider implications concerning the response of the criminal justice system as a whole to offenders with addictions.

MR KK

was found dead in a multi-storey car park the day after his release from prison. I made a number of recommendations to the Prison Service (all of which were accepted).

However, the investigation was most significant for what emerged about Mr KK and the use of anti-social behaviour orders (ASBOs). Mr KK had been made subject to an ASBO following convictions for a series of minor offences – all apparently related to his abuse of alcohol. The terms of the ASBO were that for two years Mr KK should not use threatening or abusive behaviour in a public place, or be found drunk or consume alcohol within a designated area, or enter any licensed premises in that area (including the alcohol aisles of supermarkets).

He subsequently breached the ASBO on no fewer than seven occasions – each of which led to short periods of imprisonment. During the course of the two-year ASBO, Mr KK served a total of 12 months in custody in six separate instalments. Yet during that time, nothing was done about the alcohol problems that had repeatedly led to those breaches and to his spells in custody. Mr KK had had no contact with probation. He underwent no relevant courses in prison. And on the final occasion, he left the prison homeless. Insofar as he had come to attention at all, Mr KK

was regarded as a good (that is, compliant) prisoner and little was done to help him prepare for the challenges he would again face on release from custody.

Mr KK was punished again and again for minor anti-social behaviour, the roots of which lay in his addiction. While I understand the public nuisance issues that gave rise to his ASBO, Mr KK's story is an essay in the futility of breach proceedings against those whose behaviour is addictive in nature and an illustration of the ineffectiveness of so many short prison sentences. I concluded that ASBOs should not be imposed upon chronic alcoholics and recommended accordingly.[3]

Special investigations

It is widely agreed that there is as much or more to be learned from an attempted suicide in which a life is saved as there is from a death in custody. It is also agreed that the circumstances surrounding such a near-death can give rise to the investigative obligations under Article 2 of the European Convention on Human Rights. Exactly what those circumstances are is a matter upon which the courts have yet to decide. But whatever the criteria may eventually turn out to be, my view is that it is most appropriate for the investigations to be conducted by the PPO office. Two separate investigative systems would be unwieldy and expensive; much better to draw upon my office's existing expertise and consistently to share the insights gained from investigating deaths and near-deaths.

During the past year, I have been conducting an Article 2-compliant investigation into the case of a man known as D. This followed a judgment of the Court of Appeal in February 2006 requiring the Home Secretary to commission such an investigation and offering guidance on the manner in which it should be conducted.[4] The most significant aspect of that guidance is that part of the investigation must be conducted in public, and I shall be holding public hearings once all the documentary evidence has been collected and assessed.

As the investigation is not yet complete, it would be improper here to share more than the bare details. D was a young man who attempted to kill himself in prison during 2001. He was discovered and cut down in time to save his life, but suffered brain injuries and is detained under the Mental Health Act. An internal investigation was conducted by the Prison Service but this did not engage

[3] A training film, *The Overdose Notes*, based on the case of Mr KK, was subsequently commissioned by Wiltshire Criminal Justice Board with funding from the Office for Criminal Justice Reform and the Government Office for the South West. It won three awards (including the first prizes for Best Script and Best Drama) at the prestigious awards ceremony organised annually by the International Visual Communications Association (IVCA) in March 2007.

[4] See footnote 1 on page 10.

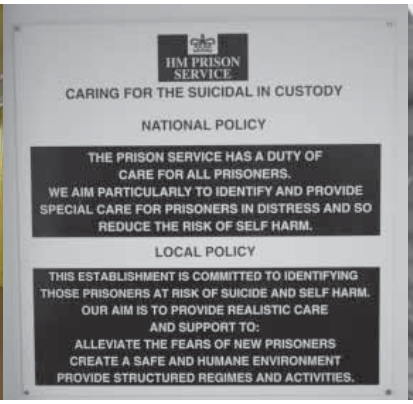
with D or his representatives and many of the papers have since been lost.

My terms of reference in D mirror those used when I investigate a death in custody, but I have also been asked to consider the implications for future investigations into near-deaths.

At the end of the reporting period, I was about to start work upon a second Article 2-compliant investigation. This concerns the treatment of a young woman (known as SP) at two prisons in 2003–05. SP frequently self-harmed, and I will be examining what might have helped to prevent her repeated self-harming, or would contribute now to the safe care of prisoners exhibiting similar behaviour. Necessarily, this investigation will also engage with health service and child welfare and protection issues.

> "THERE IS AS MUCH OR MORE TO BE LEARNED FROM AN ATTEMPTED SUICIDE IN WHICH A LIFE IS SAVED AS THERE IS FROM A DEATH IN CUSTODY."

I should also mention here that I have conducted two deaths in custody investigations on Jersey at the request of the island's Minister for Home Affairs. My formal powers do not extend to Jersey, but I was invited to conduct both investigations entirely in line with the policies and protocols I have developed in relation to the Prison Service in England and Wales. A particularly noteworthy feature was the huge assistance I received from the Jersey Police based upon, but going much further than, the Memorandum of Understanding agreed between my office and the Association of Chief Police Officers (ACPO) which mandates the sharing of information. Reports into both Jersey deaths will be published once the inquests have taken place.



The wider picture

It is right that the bulk of this Annual Report focuses on my investigations and what they have taught us and the relevant services. But like most busy offices, our core work is supplemented by a raft of other activities that are rarely formally recorded or recognised. This year, for the first time, I want to give a flavour of some of the work that supplements our core investigation function.

Partners

Liaison with the outside world is a particularly rewarding part of our working lives. The PPO office was a trailblazer for specialist Ombudsmen for prisons when it was set up in 1994, and it is pleasing that we can share our experiences with others across the world. Regrettably, we have had to scale back this aspect of our work because of pressures elsewhere, but we have still had time to field enquiries from around the globe. We have also hosted delegations from China, Malaysia, Japan, Georgia, Serbia, South Korea, New Zealand, Bermuda and, closer to home, from Scotland.

In addition, we have undertaken training for Healthcare Inspectorate Wales, and maintained our contribution to the annual Public Administration International course which is always rich in learning from similar bodies in countries near and far.

We particularly value our continued and close contact with the office of the Prisoner Ombudsman for Northern Ireland. We also have fraternal ties with the Scottish Prisons Complaints Commissioner.

As well as the routine though essential liaison we conduct with representatives in the Prison, Probation and Immigration Services, colleagues from my office have also met with representatives of the Local Government Ombudsman, the Healthcare Commission and the Parliamentary Ombudsman, on a variety of issues. These latter contacts will be of added importance as PPO too takes on the authority of a statutory Ombudsman's office. It is critical from the point of view of the potential complainant that there should be no gaps and no overlaps between the responsibilities of the postholders and their offices.

Recruitment, training and development

We have invested significantly in our future. I have elsewhere referred to the growth in our remit over the years. With that has come a seemingly endless round of recruitment so that my office now stands at nearly 90 strong.

It is always pleasing to welcome new colleagues but I have been particularly proud to have strengthened our team of Family Liaison Officers in the past year. After an open recruitment campaign, the new team has made great strides in redefining their role and strengthening the commitment to involve families in our death in custody investigations.

Open recruitment can be time consuming and expensive, but I am committed to it when it is clear we need the skills and experience which are not currently developed among mainstream civil servants. This is no reflection on the admirable qualities of those who have joined from within the mainstream, but I am strongly of the view that our work stands outside the civil service norm. In the past year, my office has spent considerable time chafing against rules and procedures that quite simply are unsuited to our work.

Given a dynamic and growing office, we have sought to instil greater structure in our support and development of staff. A staff survey and skills audit have provided the baseline for investing in our development. There has been a step-change in our training provision including regular lunchtime seminars hosting guest speakers, a bespoke 'Investigation skills' course for all investigators, and regular meetings of all staff, again with guest speakers.

Policies and procedures

We have introduced new office policies designed to promote greater awareness among colleagues of our impact on others, and to provide a consistent approach. Our formal complaints procedure – for complaints about our behaviour – is publicised on our website. We have also published a policy that sets out how we respond to the very small minority of unreasonable or abusive complainants who undermine our ability to provide a good service; that policy also makes plain our commitment to treat others with respect.

A code of conduct for behaviour when conducting investigations is also due to be introduced. All this is in addition to refining and reviewing policies relating to how we carry out and report on investigations.

This office also has a keen sense of our place in the wider community. Each year we vote for and support a charity with fund-raising events. We have now instituted a greening committee from which no carelessly discarded bottle-top is safe, and which battles against the paper mountain that even a paperless office seems to build.

Communications

The office continues to try and bring our IT and communications up to date. Despite the frustrations I have alluded to in my introduction to this Annual Report, we have sought to re-vamp the website and introduce an electronic casework system for death in custody investigations. I trust I will be able to report some success a year from now.

I attach particular importance to updating the website. Our death in custody investigations are of international significance, and I want the learning embedded within those reports to be available as widely as possible. In that regard, I should also mention the strong support that PPO has given to the Forum for Preventing Deaths in Custody, a broad coalition of service providers and investigative organisations (see *www.preventingcustodydeaths.org.uk*).

Alongside electronic communications, we continue to print and distribute large quantities of our quarterly newsletter, *On the Case*. This provides an opportunity to share the findings from our investigations in a readily accessible form.

This year, we have also issued new material to publicise our work in immigration removal centres. We are already planning to revise all promoted literature to coincide with implementation of our new legislation.

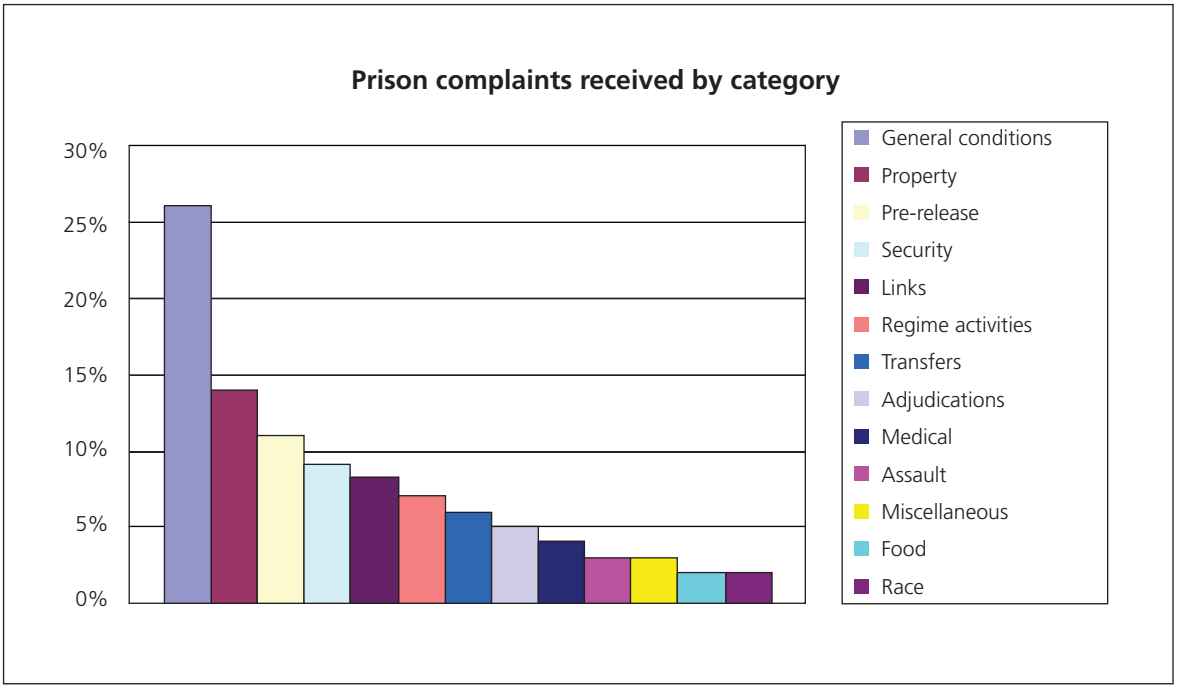
The year in numbers

In this section of the Annual Report, I set out statistical information about complaints and fatal incident investigations, together with information about the costs of my office.

Complaints workload

I received a total of 4,666 complaints during 2006–07, 164 more than in the previous year. Of these, 4,321 were about the Prison Service, 316 were about the National Probation Service (NPS) and 29 were from detainees in immigration removal centres (IRCs).

The following chart shows the most common categories of prison complaints. Those concerned with general prison conditions and loss or damage to property constituted two in every five complaints received.

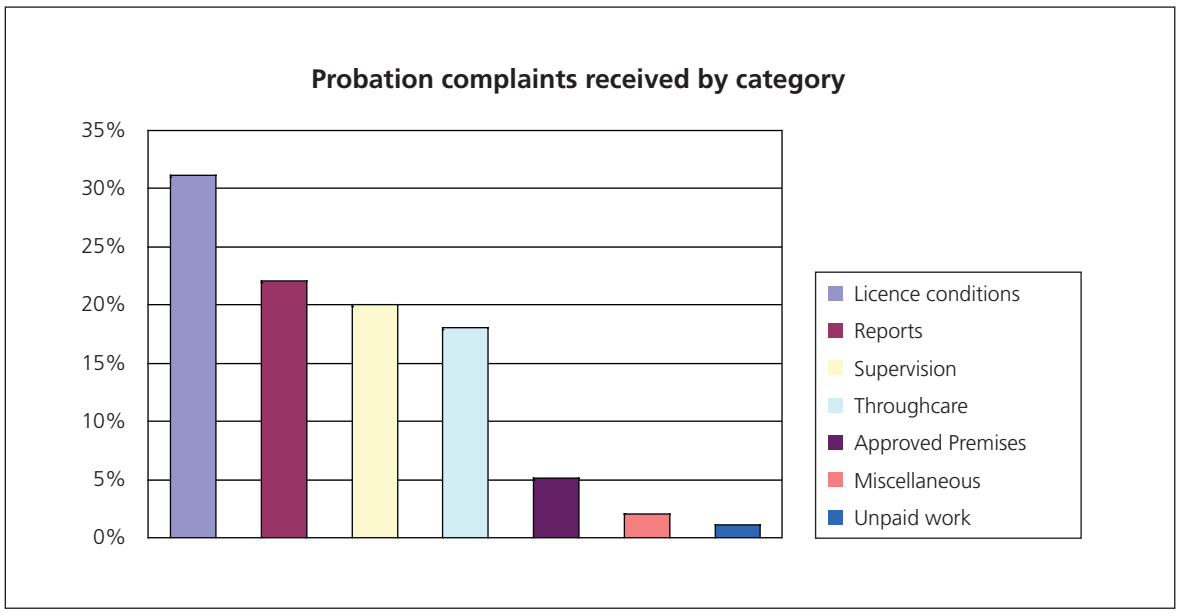


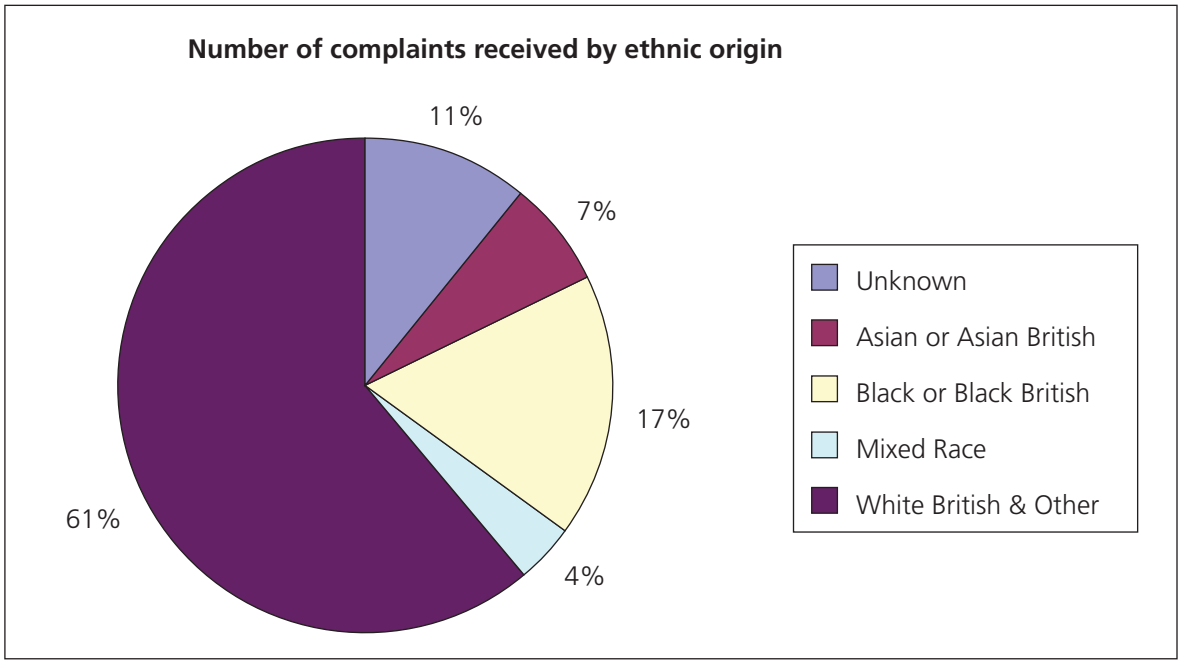
My office completed investigations into a total of 1,560 complaints about the Prison Service, 22 about the NPS and eight about IRCs. Some 1,549 (97 per cent) of the complainants were male. This is a slightly higher proportion than the proportion of males in the prison population and those subject to probation supervision or in immigration detention.

The chart below shows that complaints about licence conditions and the content of reports represented well over half of all probation complaints received.

The introduction of our new computerised case management system has enabled the office to collect information about complainants more accurately than in previous years. We shall use this information in 2007–08 to target our services more sensitively.

The diagram opposite shows the ethnic origin of complainants to the PPO office. I have been pleased to note that we are attracting complainants broadly in line with their representation within the criminal justice system.





Complaints performance

An increasing workload over many years, unmatched by resources, has affected our ability to meet targets across the board. Since my appointment as Ombudsman, I have been proud of the assessment team's record in determining the eligibility of cases within 10 days. Indeed, their performance in many previous years his exceeded targets. Regrettably, in 2006–07 we met our target to assess eligibility within 10 days in only 54 per cent of cases. Although this represents an improvement upon 2005–06, it lags well below what I think is acceptable. Although the shortfall in resources affects this part of my office's work no less than it does the investigations themselves, I have made it clear to colleagues that this level of performance must be substantially improved upon during the coming year.

The timeliness of investigations must also improve.

Fatal incidents

It is pleasing to report that the number of deaths I investigate has fallen for the third year in succession. The total fell last year from 193 to 185, a reduction of 4 per cent. Of those who died, 162 were prisoners, 10 had been recently released from prison (and their deaths thus came within my discretionary remit), and 13 were resident in Probation Service Approved Premises. No one died in immigration detention.

It is particularly encouraging that the total number of apparently self-inflicted deaths fell to 74 from 83 in 2005–06, a reduction of 11 per cent.

The table on page 56 provides details of the 185 deaths on which investigations were opened.

Location and apparent cause of death

	Public adult prison	Private adult prison	Female prison	Young offender institution	Approved Premises	Discretionary	
Self-inflicted	59	3	5	3	1	3	74
Natural causes	72	8	1	1	6		88
Homicide	1					1	2
Substance misuse	4				5	5	14
Unclassified	5				1	1	7
Total	**141**	**11**	**6**	**4**	**13**	**10**	**185**

Value for money

The office cost £6,280,476 this year. Of the total, around £4.3 million represented the office's cost budgets and nearly £2 million was the notional share of Home Office central costs. The table below provides the full details.

	£
Staffing costs (salaries)	3,740,413
Non-pay running costs[5]	615,794
Share of departmental overhead[6]	1,924,269
Capital[7]	–
Total	**6,280,476**

[5] Includes elements for depreciation and cost of capital which were not charged during 2006–07 but will be applied retrospectively.

[6] Based on the 2005–06 figure inflated by 2 per cent, as the official Home Office figure was unavailable at the time of publication.

[7] Although there was no capital expenditure in 2006–07, work began on a project to provide the fatal incidents investigation team with its own bespoke caseworking software. The total cost of the project is estimated at just under £400,000 and an appropriate capital allocation has been provided in 2007–08 instead.

Mission statement and Statement of values

Mission statement

Within one united office, to deliver two services that contribute to just and humane penal and immigration detention systems:

- To provide prisoners, those under community supervision, and those in immigration detention with an accessible, independent and effective means to resolve their complaints.
- To provide bereaved relatives, the Prison Service, National Probation Service, Immigration Service, and the public at large, with timely, high-quality investigations of deaths in prison custody and other deaths in remit.

Statement of values

- To be accessible to all who are entitled to make use of the Prisons and Probation Ombudsman and actively to seek removal of any impediment to it.
- To be independent and to demonstrate the highest standards of impartiality, objectivity, thoroughness, fairness and accuracy in the investigation, consideration and resolution of complaints, and in the investigation of deaths in custody and other deaths in remit.
- To be sensitive to the needs of bereaved relatives, providing explanations and insights, and ensuring that information from investigations is shared.
- To be fair in the treatment of all complainants, relatives and witnesses, without regard to criminal history, race, ethnicity, gender, disability, sexual orientation, age, religion, or any other irrelevant consideration.
- To be effective by ensuring that both complaints and fatal incident investigations are conducted thoroughly and as quickly as possible, and that recommendations are well founded, capable of being implemented and are followed through.
- To be constructive in helping the Prison Service, the National Probation Service, and the Immigration Service to deliver justice and decency by improving their handling of complaints and eliminating the underlying causes of them, and to assist the three services to reduce the incidence of avoidable deaths.
- To be empowering by creating and maintaining a working environment in which colleagues are respected, engage in continuous learning, obtain job satisfaction and have equal opportunities for personal and career development.
- To be accountable to stakeholders for the fulfilment of our mission statement, our values and aims and objectives.
- To be efficient in the management of resources and deliver value for money.

Terms of reference

Terms of reference applying in 2006–07

The terms of reference reproduced here are those to which I worked during the reporting year. References to the Home Secretary etc. should be read in that light.

Complaints

1. The Prisons and Probation Ombudsman, who is appointed by the Home Secretary, is independent of the Prison Service and the National Probation Service for England and Wales (the NPS) and reports to the Home Secretary.

2. The Ombudsman will investigate complaints submitted by the following categories of person:[8]

- individual prisoners who have failed to obtain satisfaction from the Prison Service complaints system and who are eligible in other respects; and

- individuals who are, or have been, under the supervision of the NPS or housed in NPS accommodation or who have had pre-sentence reports prepared on them by the NPS and who have failed to obtain satisfaction from the NPS complaints systems and who are eligible in other respects.

3. The Ombudsman will normally act on the basis only of eligible complaints from those individuals described in paragraph 2 and not on those from other individuals or organisations.

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

5. The Ombudsman will be able to investigate:

- decisions relating to individual prisoners taken by Prison Service staff, people acting as agents of the Prison Service, other people working in prisons and members of the Independent Monitoring Board, with the exception of decisions involving the clinical judgement of doctors and those excluded by paragraph 6. The Ombudsman's Terms of Reference thus include contracted out prisons, contracted out services and the actions of people working in prisons but not employed by the Prison Service; and

- decisions relating to individuals described in paragraph 2 taken by NPS staff or by people acting as agents of area boards in the performance of their statutory functions including contractors and not excluded by paragraph 6.

6. The terms of reference do not cover:

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

- the merits of decisions taken by Ministers, save in cases which have been approved by Ministers for consideration;[9]

[8] Complaints from those in immigration detention came within remit from 1 October 2006. This was formalised in a letter I received from the Minister of State for Immigration and Asylum on 28 November 2006, although my terms of reference have yet to be amended and updated. Work towards a comprehensive revision of my terms of reference was postponed following the announcement of the Government's intention to introduce legislation for the PPO office.

[9] A personal Ministerial decision is one where the Minister makes a decision either in writing or orally following the receipt of official advice or signs off a letter drafted for their signature.

- the personal exercise by Ministers of their function in the setting and review of tariff and the release of mandatory life sentenced prisoners;[10] or
- actions and decisions outside the responsibility of the Prison Service and the NPS such as issues about conviction, sentence or immigration status; cases currently the subject of civil litigation or criminal proceedings; and the decisions and recommendations of outside bodies including the judiciary, the police, the Crown Prosecution Service, the Parole Board and its Secretariat.

Submitting complaints and time limits

7. Before putting a grievance to the Ombudsman, a complainant must first seek redress through appropriate use of the Prison Service and NPS complaints procedures. 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.

8. The Ombudsman will consider complaints for possible investigation if the complainant is dissatisfied with the reply from the Prison Service or the NPS area board or receives no final reply within six weeks (in the case of the Prison Service) or 45 working days (in the case of the NPS).

9. Complainants submitting their case to the Ombudsman must do so within one calendar month of receiving a substantive reply from the Prison Service or, in the case of the NPS, the area board. However, 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 either of the services.

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

Determining eligibility of a complaint

11. The Ombudsman will examine complaints to consider whether they are eligible. To assist in this process, where there is some doubt or dispute as to the eligibility of a complaint, the Ombudsman will inform the Prison Service or the NPS area board of the nature of the complaint and, where necessary, the Prison Service or area board will then provide the Ombudsman with

[10] These functions no longer exist.

such documents or other information as the Ombudsman considers are relevant to considering eligibility.

12. The Ombudsman may decide not to accept a complaint or to continue any investigation where it is considered that no worthwhile outcome can be achieved or the complaint raises no substantial issue. The Ombudsman is also free not to accept for investigation more than one complaint from a complainant at any one time unless the matters raised are serious or urgent.

Access to documents for the investigation

13. The Director General of the Prison Service and the National Director of the NPS will ensure that the Ombudsman has unfettered access to the relevant service's documents. This will include classified material and information entrusted to that service by other organisations, provided this is solely for the purpose of investigations within the Ombudsman's terms of reference, and is subject to the safeguards referred to in paragraph 16 below for the withholding of information from the complainant and public in some circumstances.

Local settlement

14. It will be open to the Ombudsman in the course of investigation of a complaint to seek to resolve the matter by local settlement.

Visits and interviews

15. In conducting an investigation the Ombudsman and staff will be entitled to visit Prison Service or NPS establishments, after making arrangements in advance, for the purpose of interviewing the complainant, employees and other individuals, and for pursuing other relevant inquiries in connection with investigations within the Ombudsman's Terms of Reference and subject to the safeguards in paragraph 16 below.

Disclosure of sensitive information

16. 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. Such circumstances will arise when disclosure is:

- against the interests of national security;
- likely to prejudice security measures designed to prevent the escape of particular prisoners or classes of prisoners;
- likely to put at risk a third party source of information;

- likely to be detrimental on medical or psychiatric grounds to the mental or physical health of a prisoner or anyone described in paragraph 2 of these terms of reference;
- likely to prejudice the administration of justice, including legal proceedings; or
- of papers capable of attracting legal professional privilege.

17. Prison Service and NPS staff providing information should identify any information which they consider needs to be withheld on any of the above-named grounds with a further check undertaken by the relevant service on receipt of the draft report from the Ombudsman.

Draft investigation reports

18. Before issuing a final report on an investigation, the Ombudsman will send a draft to the Director General of the Prison Service or to the Director General of the NPS depending on which service the complaint has been made against, to allow that service to draw attention to points of factual inaccuracy, 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.

Recommendations by the Ombudsman

19. Following an investigation all recommendations will be made either to the Home Secretary, the Director General of the Prison Service, to the Director General of the NPS or to the Chair of the area board as appropriate to their roles, duties and powers.

Final reports and responses to complaints

20. The Ombudsman will reply to all those whose complaints have been investigated, sending copies to the relevant service and making any recommendations at the same time. The Ombudsman will also inform complainants of the response to any recommendations made.

21. The Ombudsman has a target date to give a substantive reply to the complainant within 12 weeks from accepting the complaint as eligible. Progress reports will be given if this is not possible.

Prison Service and National Probation Service response to recommendations

22. The Prison Service and NPS have a target of four weeks to reply to recommendations from the Ombudsman. The Ombudsman should be informed of the reasons for delay when it occurs.

Annual report

23. The Ombudsman will submit an annual report to the Home Secretary, which the Home Secretary will lay before Parliament. The report will include:

- a summary of the number of complaints received and answered, the principal subjects and the office's success in meeting time targets;
- examples of replies given in anonymous form and examples of recommendations made and of responses;
- any issues of more general significance arising from individual complaints on which the Ombudsman has approached the Prison Service or the NPS; and
- a summary of the costs of the office.

Fatal incidents

1. The Ombudsman will investigate the circumstances of the deaths of the following categories of person:

- Prisoners (including persons held in young offender institutions). This includes persons temporarily absent from the establishment but still in custody (for example, under escort, at court or in hospital). It excludes persons released from custody, whether temporarily or permanently. However, the Ombudsman will have discretion to investigate, to the extent appropriate, cases that raise issues about the care provided by the prison.[11]
- Residents of National Probation Service Approved Premises (including voluntary residents).
- Residents of immigration detention accommodation and persons under Immigration Service managed escort.

2. The Ombudsman will act on notification of a death from the relevant service. The Ombudsman will decide on the extent of investigation required depending on the circumstances of the death. For the purposes of the investigation, the Ombudsman's remit will include all relevant matters for which the Prison Service, the National Probation Service (including area boards) and the Immigration Service are responsible, or would be responsible if not contracted for elsewhere by the Home Secretary or area boards. It will therefore include services commissioned by the Home Secretary from outside the public sector.

3. The aims of the Ombudsman's investigation will be to:

- Establish the circumstances and events surrounding the death, especially as regards management of the individual by the relevant service or services, but including relevant outside factors.

[11] Further to a second letter from the Minister for Immigration and Asylum, also dated 28 November 2006, this discretionary power also applies following a person's release from immigration detention.

- 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 in achieving fulfilment of the investigative obligation arising under Article 2 of the European Convention on Human Rights, 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.

4. Within that framework, the Ombudsman will set terms of reference for each investigation, which may vary according to the circumstances of the case, and may include other deaths of the categories of person specified in paragraph 1 where a common factor is suggested.

Clinical issues

5. The Ombudsman will be responsible for investigating clinical issues relevant to the death where the healthcare services were commissioned by the Prison Service (until March 2006), by a contractually managed prison or by the Immigration and Nationality Directorate.[12] The Ombudsman will obtain clinical advice as necessary, and will make efforts to involve the local Primary Care Trust (in Wales, the Local Health Board) in the investigation. Where the healthcare services were commissioned by the NHS, the NHS will have the lead responsibility for investigating clinical issues under their existing procedures. The Ombudsman will ensure as far as possible that the Ombudsman's investigation dovetails with that of the NHS.

Other investigations

6. Investigation by the police will take precedence over the Ombudsman's investigation. If at any time subsequently the Ombudsman forms the view that a criminal investigation should be undertaken, the Ombudsman will alert the police. If at any time the Ombudsman forms the view that a disciplinary investigation should be undertaken by the relevant service, the Ombudsman will alert the relevant service. If at any time findings emerge from the Ombudsman's investigation which the Ombudsman considers require immediate action by the relevant service, the Ombudsman will alert the relevant service to those findings.

[12] As the reference to March 2006 suggests, the first part of this sentence is now otiose.

7. The Ombudsman and the Inspectorates of Prisons and Probation will work together to ensure that relevant knowledge and expertise is shared, especially in relation to conditions for prisoners and detainees generally and judgements about professional probation issues.

Disclosure of information

8. Information obtained will be disclosed to the extent necessary to fulfil the aims of the investigation and report, including any follow-up of recommendations, unless the Ombudsman considers that it would be unlawful, or that on balance it would be against the public interest to disclose particular information (for example, in exceptional circumstances of the kind listed in the relevant paragraph of the terms of reference for complaints). For that purpose, the Ombudsman will be able to share information with specialist advisers and with other investigating bodies, such as the NHS and social services. Before the inquest, the Ombudsman will seek the Coroner's advice regarding disclosure. The Ombudsman will liaise with the police regarding any ongoing criminal investigation.

Reports of investigations

9. The Ombudsman will produce a written report of each investigation which, following consultation with the Coroner where appropriate, the Ombudsman will send to the relevant service, the Coroner, the family of the deceased and any other persons identified by the Coroner as properly interested persons. The report may include recommendations to the relevant service and the responses to those recommendations.

10. The Ombudsman will send a draft of the report in advance to the relevant service, to allow the service to respond to recommendations and draw attention to any factual inaccuracies or omissions or material that they consider should not be disclosed, and to allow any identifiable staff subject to criticism an opportunity to make representations. The Ombudsman will have discretion to send a draft of the report, in whole or part, in advance to any of the other parties referred to in paragraph 9.

Review of reports

11. The Ombudsman will be able to review the report of an investigation, make further enquiries and issue a further report and recommendations if the Ombudsman considers it necessary to do so in the light of subsequent information or representations, in particular following the inquest. The Ombudsman will send a proposed published report to the parties referred to in paragraph 9, the relevant inspectorate and the Home Secretary (or appropriate

representative). If the proposed published report is to be issued before the inquest, the Ombudsman will seek the consent of the Coroner to do so. The Ombudsman will liaise with the police regarding any ongoing criminal investigation.

Publication of reports

12. Taking into account any views of the recipients of the proposed published report regarding publication, and the legal position on data protection and privacy laws, the Ombudsman will publish the report on the Ombudsman's website.

Follow-up of recommendations

13. The relevant service will provide the Ombudsman with a response indicating the steps to be taken by the service 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 service as to its suitability, append it to the report at any stage.

Annual, other and special reports

14. The Ombudsman may present selected summaries from the year's reports in the Ombudsman's Annual Report to the Home Secretary, which the Home Secretary will lay before Parliament. The Ombudsman may also publish material from published reports in other reports.

15. If the Ombudsman considers that the public interest so requires, the Ombudsman may make a special report to the Home Secretary, which the Home Secretary will lay before Parliament.

Members of the PPO office 2006–2007

Listed opposite are the names of the office's permanent staff during the reporting year. We are also indebted to those who have worked for us in a temporary capacity.

Ombudsman
Stephen Shaw CBE
Senior Personal Secretary
Jennifer Buck
Deputy Ombudsmen
Emma Bradley
Rhian Evans
Personal Secretary
Janet Jenkins
Assistant Ombudsmen
Louise Baker
David Barnes
Lucy Eames
Angela Hickey *(died in service, September 2006)*
Ali McMurray
Marian Morris
Olivia Morrison-Lyons
Colleen Munro
Jane Webb
Nick Woodhead
Head of Central Services
Caroline Smith
Investigators
Christina Arsalides
Terence Ashley
Don Barrell
Stephen Beal *(to August 2006)*
Tamara Bild
David Cameron
Karen Chin
Althea Clarke-Ramsey
Lorenzo Delgaudio
Rob Del-Greco
Carol Dowling
Kate Eves
Lisa Flanagan
Angie Folkes
Ann Gilbert
Kevin Gilzean
Helena Hanson
Michael Hegarty
Denise Hotham
Ruth Houston
Sarah Hughes
Karen Jewiss
Mark Judd
Razna Khatun
Andy King
Madeleine Kuevi
Lisa Lambert
Anne Lund
Steve Lusted
Eileen Mannion
Kirsty Masterton
Steven McKenzie
Beverly McKenzie-Gayle
Wayne Morley *(to January 2007)*
Anita Mulinder
Peter Nottage
Ifeanyichuku Ochei
Amanda O'Dwyer
James Rogerson
Tracey Scheepers
Anna Siraut
Kevin Stroud
Rick Sturgeon
Anne Tanner
Dorne Thompson
Steve Toyne
Ian Truffet
John Unwin
Thea Walton
Louisa Watkins
Bryan Woodward
Senior Family Liaison Officer
Demelza Penberth
Family Liaison Officers
Abbe Dixon
Jennifer Howse
Lucy Phelan *(to April 2006)*
Laura Stevenson
Information Manager
John Maggi
Assistant Information Manager
Jay Mehta
Office Manager
Geoff Hubbard
Office Support Team
Durdana Ahmed
Sophie Benger
Sandra Bent *(to December 2006)*
Elizabeth Buatsi
Louise Jacobs
Margaret Richards
Samantha Torrington
Assessment Team
Lisa Johnson (Assessment Manager)
Sydal Alam *(to March 2007)*
Kaya Banerjee
Ranjna Malik
Emma Marshall
Gladys Onyebuchukwu
Claire Quigley *(to June 2006)*
Tony Soroye
Tracy Wright

This report was prepared by Marian Morris, Helena Hanson and James Rogerson.

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