PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

ANNUAL REPORT

2009 – 2010

Prisons and Probation Ombudsman for England and Wales

Annual Report 2009–2010

Presented to Parliament

by the Lord Chancellor and Secretary of State for Justice

by Command of Her Majesty

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This Report was compiled by Marian Morris, who also took the photographs.

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STATEMENTS OF PURPOSE AND VALUES

Statement of purpose

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

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

Statement of values

1. Accessible

We will provide a service that meets the needs of the people who use our services and their expectations. We will promote awareness and understanding of the services we provide, using plain language and in a range of formats.

2. Professional

We will be sensitive to the needs of bereaved relatives and share the information that we gather in our investigations. We will be open, honest and fair in the way we treat all complainants, relatives and witnesses. We will treat the organisations that we work alongside professionally and cooperatively.

3. Impartial

We will act independently and ensure that we investigate all our cases objectively. We will be transparent and consistent in our decision-making and will set out clearly the reasons for our decisions, which will be sound and justified.

4. Efficient

We will use our time, money and resources effectively and efficiently. We will listen to customer feedback and look to continuously improve our processes and the service we provide.

5. Influential

We will seek to improve the performance of services within remit by advising our stakeholders on scope for improvements that have been identified in the course of our investigations.

6. Accountable

We will take responsibility for our actions and be open to learning from constructive criticism.

This is my eleventh and final Annual Report as Prisons and Probation Ombudsman. I have been hugely proud of the opportunity to have led this organisation since 1999 and of our achievements in that time.

DECENCY AND JUSTICE IN LEAN TIMES

Ombudsmen's offices exist for two reasons: they protect the citizen against powerful public or private institutions; and, by identifying and resolving problems, they help those institutions to deliver better services in the future.

This Annual Report sets out how the PPO office carried out both halves of this role over 2009–2010. It includes a selection of complaints and fatal incident investigations that I hope give a flavour of the issues we have considered. It also talks about the many recommendations we have made, and the constructive relationship we have enjoyed with the three operational services whose activities we oversee.

The Report also includes more detail of what are sometimes rather inelegantly described as business outcomes. This is as it should be. The PPO office is now a sizeable operation – employing well over 100 people and with a budget of several million pounds.

Given the pressures on the national finances, it is right that there should be proper accountability. Neither in the PPO office nor elsewhere in public service is there an excuse for wastefulness or duplication, or for practices that are disproportionate or not fit for purpose.

I will say a little more about these matters later in this introduction. But I make no apology for beginning with the casework itself. It is the opportunity to promote decency and justice within the penal, probation and immigration detention systems that represents the public value of the PPO office's work. And it is what motivates the talented team of colleagues that I have had the pleasure of working with these many years.

It is now nearly two decades since the landmark Woolf Report,[1] which followed the Strangeways prison riot that led to the establishment in 1994 of what was then simply the office of the Prisons Ombudsman. In paras 14.345–14.347, Woolf argued as follows:

> **"The case for some form of independent person or body to consider grievances is incontrovertible … A system without an independent element is not a system which accords with proper standards of justice … The influence of an independent element would permeate down to the lowest level of the grievance system. It would give the whole system a validity which it does not otherwise have. It would act as a spur to the Prison Service to maintain proper standards."**

To those words could now be added something about the PPO's roles in respect of immigration detention and probation, and the Article 2-compliant responsibility in respect of deaths in custody.[2] I am confident both that the office is enhancing the quality of justice and that this is assisting the services in remit in improving the care they offer, just as Lord Woolf intended. Indeed, who can doubt the extent to which all three services have transformed their performance in recent

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1 Woolf H (1991) *Prison Disturbances, April 1990*, Cm 1456.

2 In an important judgment this year, the Court of Appeal confirmed that Article 2 compliance is achieved in combination between the Coroner's inquest and the Ombudsman's report (*The Queen (on the application of P) v HM Coroner for the District of Avon* [2009] EWCA Civ 1367).

years? Although it does not pay to crow about such matters, and any avoidable death is one too many, the reduction in the rate of self-inflicted deaths in prisons (a fall of over one-third in the three-year moving average since 2004, when the PPO's independent investigations began) is exceptionally encouraging.

Although the central message of this introduction – and of the Annual Report as a whole – is an upbeat one: that the PPO office is a modern, efficient, forward-looking organisation, proud of its achievements and ambitious to build upon them – it cannot be pretended that 2009–2010 was without its strains. In particular, the volume of eligible complaints received grew by 27 per cent. This followed a 10 per cent rise in 2008–2009. The demand-led nature of the business represents a risk that is very hard to manage, although I am very gratified by the performance figures that I reproduce in this Annual Report. We issued 564 more complaints reports in 2009–2010 compared with 2008–2009, and 46 more fatal incident reports. These improvements were achieved in part through the use of additional resources that are unlikely to be available in the future. Performance on this scale also increases expectations for the future beyond what may be realistic.

Of those complaints received, 4,050 concerned prisons, 488 concerned probation, and 103 were complaints relating to immigration detention. 48 per cent of those complaints met the eligibility criteria under our Terms of Reference, and 2,083 investigations were carried out. In broad terms, we upheld the complaint or reached an accommodation that was generally favourable to the complainant in 30 per cent of cases.

In respect of fatal incidents, the total number of deaths investigated was 193, compared with 181 in 2008–2009. The number of apparently self-inflicted deaths in prison was 63, compared with 65 in 2008–2009. There were no deaths in immigration detention – continuing a trend that goes back several years.

Although our performance against time targets in respect of both complaints and fatal incidents is not as good as it should be, there have been significant developments this year. The performance of the Assessment Team has been splendid, with more than 80 per cent of cases assessed for eligibility within the target of 10 days. 47 per cent of complaints investigated were in time and while only 17 per cent of fatal incident investigations were in target, most missed by a relatively short time or for reasons entirely out of our control. The average age of overdue reports has fallen sharply and this is a much better indicator of performance. Very old cases are wholly unacceptable; missing a very tight target may be a sin but it is a venial one.

Ensuring that the lessons are learned from our investigations and reports is a core element of our work. We took a number of initiatives during the year to enhance the way we and our stakeholders distil and then disseminate knowledge. With support from the Department of Health, the office now has a small research arm, and a number of reports have now been issued. I am especially pleased by the partnership that the PPO office has forged with the NHS. The National Patient Safety Agency is now receiving the office's fatal incident reports and clinical reviews and this has greatly increased the reach and influence of our work. However, regular meetings and/or Memorandums of Understanding

are now in place with all major stakeholders – and the supportive feedback received from the three services in remit is especially gratifying. Feedback from a stakeholder survey and from a survey of those bereaved people with whom we have engaged during fatal incident investigations has also been very valuable. (We also conducted a comprehensive survey of complainants.)

I do not normally like to quote from private letters – especially from the bereaved – as this may appear either maudlin or exploitative. However, I think it is pardonable to note one letter I received from the widow of a man who died in prison:

"It was a great comfort knowing that the death of my husband was to be investigated by an independent body. It is very difficult for a relative to obtain information as to what exactly happened in the prison … and without the intervention of the Ombudsman I sincerely doubt I would ever have known the details. I could not have asked for two better people as my contacts. They were both professional and sympathetic in all our dealings. They have kept me informed throughout."

Further significant progress was made during the year in ensuring that the PPO office is a lean, effective organisation. A performance scorecard has been developed, and we achieved virtually everything we set out to do in the business plan. This included the performance improvements to which I have referred above, new manuals and guidance for staff, a new support and care service for the Fatal Incident Investigations team, and an annual staff survey. The office also has new internal and external communication tools, including three DVDs (which can be accessed via the PPO website).

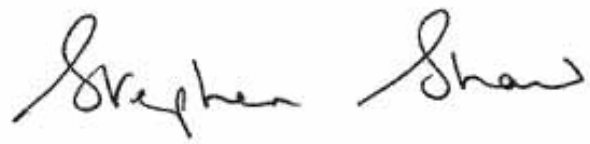
We continued the bespoke investigative skills training for all investigators, and this has paid rich dividends. Indeed, there are many staff in all roles who are of the highest calibre. The management team that my successor will inherit is also a very strong one, and I am particularly pleased that the two operational Deputy Ombudsman posts are now appropriately graded at Senior Civil Service level.

Although I remain of the view that the absence of statutory authority for the Ombudsman is unacceptable and probably untenable for much longer, I was delighted during the year to agree a framework document with the then Secretary of State for Justice formalising the status of the PPO. This specifies the PPO's operational independence from the Ministry of Justice (MoJ) and total independence from NOMS, the UK Border Agency and the Youth Justice Board. Indeed, the document expressly recognises that the "principle of operational independence is fundamental to the work of the Ombudsman". It also repeats the Government's commitment to putting the Ombudsman on a statutory basis "at the first suitable legislative opportunity", and recognises the PPO's aspiration "to have greater administrative independence from the MoJ" while acknowledging that this has not been agreed by the Government or the Ministry itself. (We spent some time looking at the models of a Non-Departmental Public Body and a Non-Ministerial Department, either of which I believe would offer conspicuous independence, greater day-to-day freedoms, and a greater degree of accountability.)

Supplementary to the framework document are a series of protocols on such matters as HR, IT, communications and finance. All those that have been agreed are published on the PPO website at www.ppo.gov.uk.

I was also pleased to agree new Terms of Reference; these are reproduced at the end of this Report. They bring together our responsibilities for both complaints and fatal incidents in one cohesive set of rules, and have been modernised to take account of changes in the prisons and probation landscape and in the responsibilities of Ministers. For the most part, the new Terms of Reference do not alter previous practices. However, in an important improvement to 'customer service', complainants now have three months, not one, within which they must refer matters to the PPO after exhausting the internal processes. In addition, the Terms of Reference provide power of access to prisons and other premises without giving prior notice. This latter power is likely to be deployed only very rarely. However, it represents a clear acknowledgement of the authority of the Ombudsman to conduct investigations without hindrance.

I must conclude these valedictory remarks by publicly commending what my colleagues have achieved in trying circumstances – especially in 2009–2010 but also throughout my time as Ombudsman. I believe that the office has been severely under-funded by comparison with sister organisations with which the PPO office could sensibly be benchmarked, yet it is likely to face further resource constraints in future years. And I am not naïve about the impact that financial pressures on the services in remit may have upon the PPO's workload. However, I hope the reader will share my view that, despite these evident difficulties, I leave the PPO office in a stronger position than it has been in for many years.



Stephen Shaw CBE

Prisons and Probation Ombudsman for England and Wales 1999–2010

In the face of substantial challenges, 2009–2010 has been a year of very considerable achievements for the Fatal Incident Investigations (FII) team. Performance in terms of timeliness has improved markedly. The quality of investigations and reports has been sustained and developed. And much progress has been made in feeding back the lessons of those investigations to the services we oversee.

INVESTIGATING FATAL INCIDENTS

Issuing reports

All our stakeholders tell us that what matters most to them is the timeliness of fatal incident investigations and reports. Without timely reports, bereaved families do not know what has happened to their relatives or friends, the National Offender Management Service (NOMS) may not learn the lessons from deaths, and Coroners' inquests may be delayed. Consequently, the team's priority throughout the year has been to reduce its backlog.

It is a source of great pride, therefore, that the FII team's delivery of draft reports was 8 per cent higher in 2009–2010 than in the previous year. In numbers, this means that 205 draft reports have been issued, of which 17 per cent were within target.[3] We are conscious that 44 remain overdue but the target for the coming year will be to complete the oldest outstanding reports and to overcome any external obstacles. The delivery of final reports has also increased and 214 have been issued, 27 per cent more than in the last reporting year.

A programme of team training in investigative skills, time management, writing skills and assertiveness has contributed to improved practice and increased performance. And we have reviewed our processes, our investigation manual, and the staffing structure to make best use of our time. Addressing these priorities has meant that fewer discretionary investigations were undertaken. However, for the first time since 2004 when the Ombudsman's office began investigating deaths, there has been a stable leadership team and – at least for part of the year – a full complement of investigative and administrative staff.

Although, as has been acknowledged in previous years, the responsibility for a small number of overdue reports is entirely our own, there are significant contributory factors that are outside our control. Previous Annual Reports have referred to delays caused by clinical reviews and this year has been no exception. Under our Terms of Reference we are required to rely on Primary Care Trusts or Healthcare Inspectorate Wales to provide suitably qualified and independent reviewers to conduct these reviews. Unfortunately, this does not always happen and far too many of our draft reports are being held up by late clinical reviews. Moreover, there are issues about the quality and relevance of at least some of the clinical reviews we receive. The analysis can be thin, and the recommendations vague or ill-directed.

The National Patient Safety Agency (NPSA) now receives FII reports and will be using our recommendations in its Patient Safety in Prisons project to improve patient safety in prisons. Guidance for clinical reviewers, *Undertaking a Clinical Review following a Death in Custody*, was revised during the year and reissued jointly with the NPSA and the Department of Health. We will monitor the quality of the reviews in the coming months and consider the implications of the findings.

[3] There is a 20-week target for issuing draft reports of deaths due to natural causes and a 26-week target for other deaths, including those that are apparently self-inflicted.

New cases

As in previous years, most of the deaths investigated this year were those of prisoners. Only 11 of the deaths were of Approved Premises residents and none was in the immigration detention estate. For this reason, much of what follows refers to prison deaths.

Although the number of apparent self-inflicted deaths was fewer than in 2008–2009, at 63, deaths due to natural causes seem to be on a rising trend increasing to 116 from 107 in the previous year. NOMS and Offender Health have made a huge investment in reducing prison suicides. HM Chief Inspector of Prisons also, looks closely at suicide and self-harm monitoring. The same focus is not always given to prisoners who die from natural causes and we will be considering how to raise the profile in the coming year. As well as rising numbers, we have found that the average age of those who die from natural causes is low. The average age of men whose deaths in prison from natural causes have been investigated by the PPO since 2004 is 56 years, and it is even younger (47 years) for women. The most common cause of natural deaths is heart disease, followed by cancer.

A rising and ageing prison population does not necessarily mean that the number of deaths from natural causes should also continue to increase. Offenders are a 'hard to reach' group so far as healthcare in the community is concerned. Reception into custody is an opportunity to evaluate someone's health and provide any necessary treatment. It is therefore pleasing that, in many of our investigations, we have found that prisoners received a level of care at least on a par with that which they would have received if at liberty.

Many of our investigations this year have focused on the consideration shown to prisoners during their last days. We have found that restraints were used on more than half the prisoners during their final stay in hospital. In many cases their use was appropriate but there were times when the restraint remained in place until only a few hours before death. While public protection is paramount, prisoners – no less than anyone else – should be allowed to die with dignity and a number of our recommendations focused on these matters. For example, releasing terminally ill prisoners on compassionate grounds should be the norm unless security factors militate against it.

Sharing the lessons

A core purpose of our investigations is to improve the general care and treatment of prisoners, Approved Premises

residents and detainees. The vast majority of recommendations in our reports have been accepted, and action plans developed, and there have been welcome developments in the way our reports are used by all the services in remit. Several regional offender health teams now have well-established routines whereby a recommendation to one establishment is introduced across their region. Similarly, NOMS has introduced a range of communication vehicles to disseminate FII recommendations to every gaol.

Our recommendations have contributed to important improvements in practice. For example, NOMS has provided updated guidance about staff entering cells at night.

Recommendations to the young persons' estate formed the basis for a conference for Governors, thus promoting the safety of young people. Recommendations made after the death of a hostel resident are now incorporated into the revised national standards for every Approved Premises. We also contributed to the evaluation of a pilot programme whereby hostel residents were permitted to retain their own medication (an evaluation that demonstrated that the policy, which we had proposed, was successful). Responsibility for holding medication now rests with the resident unless risk factors suggest otherwise.

Several research reports have been shared with FII stakeholders during the year to spread the lessons from our investigations. We have greatly benefited from the Department of Health's funding for a dedicated researcher. His first report analysed all the FII cases finalised in the 12 months leading up to August 2009. As far as self-inflicted deaths are concerned, it confirmed the following:

- Most were of men and occurred in local prisons.
- Hanging was the most common method used.
- One-quarter happened within three months of coming into custody.
- Nearly half the deaths were of prisoners on remand.
- More than half had harmed themselves previously.
- More than half were charged with or convicted of violent or sexual offences.

Working with stakeholders

During the reporting year we have continued to improve our liaison with those with whom we work. The main forum for meeting the services in remit has been the Fatal Incidents Stakeholder meeting. Until this year, responsibility for the meeting was shared with NOMS, but we have now taken over full responsibility, enabling us to report on our performance in addition to keeping abreast of developments within each of the services we oversee. The meetings are themed. Minutes of these stakeholder meetings will be published on the Ombudsman's website, to share the knowledge as widely as possible.

The Ombudsman's Terms of Reference say that another of the purposes of our death in custody investigations is to "assist the Coroner" and it is a matter of some regret that, for the second year in succession, Coroners have expressed less satisfaction with the work of the PPO than any other group of stakeholders. In an effort to improve joint understanding, we signed a Memorandum of Understanding

with the Coroners' Society in June 2009, and will review it in the coming year. We contributed to a coronial training event in January 2010, and will continue to look for other ways to develop our shared responsibility for investigating deaths.

Improving our service

Continuous improvement has become a cliché of modern public service, but the PPO office takes very seriously its commitment to improving the quality of work we offer to all stakeholders and in particular to bereaved families.

To ensure that we incorporate the views of stakeholders into our practice, we have undertaken two surveys, including a very sensitive survey of the views of families of prisoners whose deaths we have investigated. The results of these surveys have provided detailed information about how our work is viewed. They have confirmed that PPO colleagues are seen to work professionally and communicate effectively. And we now have validation of current practice such as making the first contact by telephone with those who are bereaved.

Families also told us that the four weeks that they are currently given to comment on draft reports is not long enough. They said that they need more time to reflect upon the large amount of information contained in our reports, much of it distressing. In light of this feedback, in the coming year we will extend the feedback time.

As some of the families who responded to our survey could not recall receiving the PPO information leaflet that is sent out, we now include with it a copy of our specially produced DVD. The DVD (which is also available online via the PPO website) gives an insight into the work of the FII team and its impact on one family and one prison. It also provides information for families and staff who are going to be interviewed for an investigation.

Staff welfare

Working continuously on the subject of death and bereavement is potentially stressful for FII staff. We have invested in the wellbeing of our team by commissioning a specialist staff support service. Each member of the team is now offered an annual check-up that considers their resilience and develops strategies to enhance it. Additional short-term support can also be provided. To protect staff further, in the coming year we will consider how to address any shared issues identified at these check-ups.

However, the main source of stress is an unremitting workload not matched by a sufficient staff resource. Sadly, on most days of the year we learn of a new death, and a new investigation is required. Allocating new cases seems relentless at times and takes its toll on everyone as team members are constantly required to reprioritise their commitments.

We ended the year with 10 per cent of our posts vacant either due to long-term absence or turnover. Combined with high referrals in the last quarter of the year, the vacancies will inevitably make it more difficult to maintain our increased delivery. Nevertheless, with the experience gained from our work in the past six years, we believe that we have the skills and the confidence to go forward and progress.

Suicide following unlawful killing

Although suicide following homicide is a relatively rare occurrence, a study published in the *Journal of Forensic Psychiatry and Psychology* in April 2009 recorded 203 such incidents over the nine years between 1996 and 2005.[4] The same study suggested that the risk increased the closer the relationship between perpetrator and victim. The Prison Service Order (PSO) 2700 on suicide prevention and self-harm management also rightly suggests that prisoners accused of killing a partner or family member pose a greater risk of subsequently taking their own lives. This has been reflected in a number of the Ombudsman's investigations where the alleged homicide of a family member or partner has been followed, sometimes very swiftly indeed, by the self-inflicted death of the person accused of the offence.

The three investigations below were completed on prisoners who apparently took their own lives within days of arrival at their respective local prisons.

Mr A handed himself into the police confessing that he had murdered his young son. After being held in police custody for three days, Mr A was transferred to a local prison where he spent the last days of his life. Although prison staff were aware that he had been charged with the murder of his son, was in custody for the first time, and was the subject of abuse from other prisoners, there were no specific concerns in respect of suicide or self-harm.

[4] Flynn S, Swinson N, White D *et al.* (2009) Homicide followed by suicide: a cross-sectional study. *Journal of Forensic Psychiatry and Psychology* 20(2): 306–321.

During the standard reception procedures Mr A was adamant that he did not have any suicidal or self-harm intentions, and staff decided that it was not necessary to open an Assessment, Care in Custody and Teamwork (ACCT) form.

PSO 0500 alerts reception staff to the increased risk of suicide or self-harm by those in prison for the first time and those charged with violent offences against family members.

The investigation discovered that it was routine at the prison that was holding Mr A for staff completing the first reception healthscreen to refer prisoners charged with murder or manslaughter to the Inreach team. However, Mr A had arrived at the prison on a public holiday and, as his first days in prison coincided with an

extended Bank Holiday, he had not been seen by a member of the Inreach team at the time of his death three days later. Mr A may have felt especially isolated and vulnerable as he was in a single cell, and the prisoner Listeners (those trained by the Samaritans to provide emotional support to fellow prisoners in crisis) had refused to see him. The Ombudsman was pleased to note that those Listeners were no longer used in that capacity after Mr A's death.

Ms B was found hanging in her cell approximately 41 hours after arriving in prison. It was her first experience of custody. She had been charged with the murder of her son. While in police custody, Ms B had said that she had been prescribed diazepam by her doctor following the death of her son. Later she told police that she was depressed, and nodded her head when asked if she had ever harmed herself. The police placed her under constant supervision and, two days later, after reviewing information about Ms B's state of mind, escort staff at court opened a Suicide and Self-Harm Warning form. She had marks on her forearm caused by harming herself and the information was well documented by police and escort staff. However, when she arrived in prison, concerns about her wellbeing were overlooked by those who assessed her in reception.

The investigation found that staff failed to read Ms B's history, failed to recognise the additional risk arising from the charges she faced, and failed to notice anything untoward. Much of the information gathered at reception was not recorded or passed on to those who subsequently assessed Ms B in the first-night centre.

It seemed that staff in both reception and the first-night centre focused on what Ms B herself told them about her risk, rather than considering those risks identified by other agencies with the most up-to-date knowledge. Not for the first time, the Ombudsman's report emphasised that, while what prisoners say is important, they cannot be relied upon to declare when they intend to harm themselves. Calm assurances from the prisoner that they are not contemplating suicide may be misleading, indeed deliberately so. Staff should be guided in their decision-making not simply by what the prisoner says but by the documented information supplied by police, escort staff or medical professionals.

After being charged with the murder of his partner, Mr C was received at a large local prison. He was found hanging in his cell 18 days later. During his time in police custody and as soon as he arrived in prison, Mr C was identified as being at risk of suicide or self-harm. He had previously attempted suicide; indeed, he had tried to kill himself on the day of his arrest. Mr C also had a number of other risk factors, including a history of drinking to excess and depression, for which he had been admitted to a psychiatric hospital.

A number of measures were taken to support Mr C during his time in prison. The day after his arrival he was seen by two mental health nurses and, as a consequence, was referred to the Mental

Health Inreach team. He was also seen by a consultant psychiatrist. Mr C regularly spoke to Listeners at the prison but, disappointingly, the investigation found no evidence of any contact between Mr C and a personal officer during his time in custody. It seemed that the person who was most aware of the psychological anguish experienced by Mr C was his cellmate. It was noted that the two men spoke on the day before Mr C's death about why they were in prison. Mr C told his cellmate that he felt he did not deserve to live after what he had done, and wept as he spoke. Mr C's cellmate tried to console him, but in interview with the investigator he described Mr C as being grief-stricken.

It was once a NOMS requirement that all those charged with murder were first assessed in the prison's healthcare department. A policy of that kind may no longer be appropriate, but the Ombudsman believes that a very prompt mental health assessment should be carried out on all those facing murder charges.

Entering cells at night

Many of those prisoners who take their own lives do so at night when prisons typically have only one officer (or operational support grade (OSG)) to supervise each wing. On such occasions, staff have just moments to assess risk and decide whether to enter the cell alone.

Mr D had been on an open ACCT document until shortly before he died. Because an ACCT form had very recently been closed, the night patrol had agreed with the day staff to observe Mr D periodically and decided to make 30-minute checks. The night patrol made several such checks, but when he looked in Mr D's cell shortly after midnight he saw him hanging from the window bars. He immediately used his radio to call for assistance but judged that it would not be possible to assist Mr D alone.

In interview for the Ombudsman's investigation, the night patrol said that he thought it would take two people to offer any effective help: one to hold Mr D's weight while the second cut the ligature. Consequently, he did not enter the cell. As it was, other staff arrived after a few minutes and went in. Mr D was cut down and resuscitation attempts were made while awaiting the arrival of the ambulance team. The paramedics managed to resuscitate Mr D and he left the prison alive, albeit with a weak pulse. Sadly he did not recover further and his life support machine was switched off later that morning.

In these circumstances, it might have been better had the night patrol entered the cell and taken Mr D's weight while waiting for assistance. While it is not possible to know if this would have saved Mr D's life, what is certain is that the prison's local policy indicated that staff should go into a cell alone only if they were "100 per cent certain" that a life could be saved. It is difficult to see how such a judgement can be made from outside a cell door.

Mr E was on an open ACCT document and so was subject to hourly monitoring by staff during the night. During the evening he told the OSG that he was fine. However, when the OSG returned an hour later he saw Mr E with a

ligature around his neck. The OSG radioed for immediate assistance and for permission to enter the cell. He then opened the secure pouch that night staff carry for use in an emergency, took out the cell key and went into the cell.

When interviewed for the investigation, the OSG said that he had lifted Mr E but found that this took all of his strength and he was unable to cut the ligature as well. He continued to hold Mr E's weight until other staff arrived a few minutes later. Together, staff were able to cut the ligature and commence resuscitation, but they were not able to revive Mr E. In this case the Ombudsman commended the actions of the OSG, who had made determined efforts to help Mr E without delay.

In response to the findings of several similar investigations (and one where a cell was not entered when two members of staff were present), the Chief Operating Officer of NOMS issued a letter to all governors and directors in January 2010. The letter asked each prison to review its instructions to provide staff with clearer guidance on entering a cell in an emergency and about the assessment of risk necessary when deciding what to do.

Emergency response

Heart-related illness is the single largest cause of natural death in prisons. Of those deaths investigated by the PPO office during the reporting year, the average age of prisoners dying from heart-related conditions was 53.

The NHS advises that prompt treatment increases survival prospects following a heart attack. Unfortunately, the Ombudsman has had cause to comment on cases where prisoners' symptoms have not been acted upon quickly and potential opportunities to save lives have been missed. There have been a number of recommendations about training in cardiopulmonary resuscitation, and about emergency response equipment and procedures.

Mr F suffered from high blood pressure that had been closely monitored during the three years he had been in prison. One morning in the early hours, Mr F called an OSG saying that he was experiencing pain in his chest and left arm. The OSG contacted the night orderly officer who was in charge of the prison at night, and he arrived some 15 minutes later. When Mr F told him about the

pain he was experiencing the night orderly officer contacted an out-of-hours doctor's service and Mr F was left alone in his cell. Due to problems in the control room, the doctor was unable to speak with staff. About 50 minutes after leaving the cell, staff returned to check on Mr F. They found him collapsed, apparently not breathing. More than an hour after Mr F had first complained of pain, an ambulance was called.

Although the prison did not have 24-hour healthcare, the investigation found that emergency equipment such as oxygen and an automated external defibrillator was kept in the healthcare centre. Consequently, the staff attending Mr F had no access to emergency equipment when they commenced cardiopulmonary resuscitation. When paramedics arrived, they were unable to do anything for Mr F. The clinical reviewer judged that Mr F might have been saved by a swifter response. The investigation found that prison staff had failed to respond adequately and there had been a serious lapse in care.

Mr G was 41 years old and experienced chest pains and numbness in his left arm. Prison staff called an ambulance and he was transferred to hospital. It was found that Mr G had suffered a heart attack and, after recovering, he was returned to prison and referred for an outpatient appointment. Some two weeks later, a prisoner found Mr G collapsed on the floor of his cell and called for assistance.

The subsequent investigation highlighted a number of failings in the prison's response. The officer who first entered his cell was unable to call for emergency assistance as his radio failed. The member of staff designated as first emergency response did not immediately hear the emergency radio call. None of the discipline staff who responded to the alarm was trained in cardiopulmonary resuscitation. Two of the masks in the emergency medical kitbag were defective, and the wrong leads were attached to the defibrillator, making it unusable. Overall, the investigation found that the prison was not well equipped to deal with such an emergency.

Use of restraints

The apparent over-use of physical restraints on terminally ill and dying prisoners in hospital has been a recurrent theme in fatal incident investigation reports. Both public protection and the reputation of NOMS rely on the Prison Service's admirable achievements in reducing the number of prisoners who have escaped or absconded in recent years. Nevertheless, there have been a number of occasions where investigations have found that earlier removal of restraints would have been more consistent with NOMS' own 'decency' agenda.

The level of restraint required for escorting prisoners to hospital for outpatient or inpatient treatment is determined by a risk assessment. Guidance produced by NOMS indicates a presumption that, unless the risk assessment states otherwise, prisoners should not be restrained during treatment or medical examination. Assessments consider a number of factors, in particular whether the prisoner has the resources to escape and the risk posed were they

to do so. Such decisions necessarily balance security and decency. However, the judgement of the PPO office is that excessive weight is sometimes placed upon the former at the expense of the latter.

The review of fatal incident reports published this year found that restraints were used on 29 of 52 prisoners who were in their final inpatient stays. On most occasions, the levels of restraint used were assessed as both appropriate and proportionate to risk, but in 20 per cent of cases they were not. In 19 cases restraints were removed more than 24 hours before death but there were five cases where the restraints were removed less than five hours before the prisoner's death. This was dignified neither for the prisoner nor for the member of staff to whom the prisoner was physically attached.

Several investigations have criticised the lack of flexibility in local policy on escorting prisoners to hospital, as the following example illustrates.

Mr H was an 81-year-old prisoner who had several longstanding health problems, including kidney disease and heart disease. Prison staff were particularly concerned when he became unable to attend to his personal hygiene or to dress himself without assistance. After a spell as an inpatient in hospital, Mr H was transferred to the inpatient wing of another prison, where staff made special arrangements to organise visits and make certain that he received appropriate 24-hour care. Although Mr H's condition temporarily improved, when he became unable to walk he was again admitted to hospital, where he died.

The risk assessment completed on the day of Mr H's admission to hospital concluded that he was unlikely to try to escape, and was of low to medium risk to the public or hospital staff. He was noted to be mobile but physically frail. On the basis of this risk assessment, it was decided that Mr H should be accompanied by two officers at hospital, restrained by means of an escort chain (a long chain with a handcuff at each end to enable the prisoner to be cuffed to a prison officer). Although a revised risk assessment was completed the following day when it became clear that Mr H was unlikely to be discharged, it contained no additional information and it was decided that the escort chain should remain in place. The same evening, Mr H's condition deteriorated when he suffered a suspected heart attack. The escort chain was then removed and Mr H died some four hours later.

Given Mr H's age, medical condition, degree of infirmity, level of discomfort

and the consequent improbability of him attempting to escape, the investigation concluded that it would have been reasonable to have escorted him without the use of restraints. The presence of two prison officers would have been an adequate security arrangement. The recommendation was that the prison should be less risk averse in determining the level of restraint required for seriously ill, older prisoners with very limited mobility.

Some time ago, NOMS accepted an earlier PPO recommendation that explicit instructions be drawn up regarding security and care for gravely ill or dying prisoners in outside clinical environments. However, this is yet to be widely translated into more sensitive decisions in individual cases.[5]

Food refusal

Deaths in England and Wales of prisoners who decide to stop taking food are fortunately rare, although the possible long-term effects of nutritional deprivation should not be underestimated. In the first five years that the Ombudsman's office was responsible for investigating deaths in custody, only one death directly attributed to food refusal was reported upon. More recently, there have been two more deaths from such causes.

When considering the earlier death, the Ombudsman had noted the "professionalism and sensitivity demonstrated by staff and management" at the prison concerned. Nevertheless, it was recommended that NOMS and Department of Health should prepare a briefing about the pathway of care for a prisoner who is determined to die through food refusal. Guidelines about the clinical management of such cases were published earlier this year by the Department of Health.

Mr J began refusing food shortly after moving prisons. The prison immediately opened an ACCT form, setting out the support and monitoring they could provide for him.

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[5] The use of handcuffs for prisoners on escort to hospital has also been the subject of case law, in which the Prison Service was found to be in breach of Article 3 of the European Convention on Human Rights (inhuman and degrading treatment) when restraints were applied to a prisoner undergoing a course of chemotherapy. In the opinion of the judge, there was insufficient evidence to support the decision that such restraints were justified (judgment by Mr Justice Mitting on 23 November 2007 in the case of *(1) Graham (2) Allen v Secretary of State for Justice*).
The judgment made a distinction between the risk of escape posed by a prisoner when fit and those risks posed by the same prisoner when suffering a serious medical condition. It deemed that the restraining by handcuffs of a prisoner receiving chemotherapy (and, by implication, other life-saving treatment) was degrading. With regard to risk assessments, the judgment required each decision to be properly considered taking account of all relevant information, and to be proportionate to the risks involved. The judge also instructed that a fresh risk assessment should be conducted each time to establish the level of restraint to be used on the journey to and from the hospital and whether this should be varied during the prisoner's stay in hospital. Following the judgment, NOMS undertook to review existing procedures in relation to risk assessments and hospital escorts. Substantive guidance has yet to be published.

Mr J was assessed on a daily basis and staff frequently attempted to persuade him to reconsider his decision. Despite their best efforts, Mr J continued to fast and drew up an advance directive with his solicitor, refusing further medical treatment. All staff and carers who had contact with Mr J were made aware of the terms of the directive and what it allowed them to do for him.

Mr J's condition gradually worsened, and he was admitted to hospital where he reaffirmed to hospital staff that he did not want to be resuscitated. Two days after he was admitted, some four months after he first refused food, Mr J died in his sleep.

No recommendations were made as a result of this investigation as Mr J had been cared for both professionally and compassionately. However, the Ombudsman endorsed a recommendation from the clinical reviewer that more prison staff should be trained to provide end-of-life care.

Palliative care

Even when they are near the end of their lives, some prisoners may still represent such a risk to the public that they cannot be released early. By definition, this is particularly likely to involve prisoners in the high security estate.

The quality of palliative care services in prisons has improved significantly since 2004. Specialist services such as Macmillan nurses, hospice care and palliative care consultants are now regularly visiting terminally ill prisoners in many establishments. These specialists provide expertise and training, alongside the in-house healthcare services, to improve end-of-life care. The use of controlled pain relief medication, resources and support offers prisoners access to services that are otherwise only available in the community. This is a substantial achievement on the part of NOMS and the NHS that is little known or appreciated outside the criminal justice system.

Our analysis of final reports issued between June 2008 and December 2009 included 39 deaths where the prisoners were receiving palliative care. The clinical reviewers judged that the care was equivalent to that which could have been expected in the community in all but two cases.

The Ombudsman has addressed other issues linked to respect and dignity in end-of-life care. The majority of prisoners with terminal illnesses die in outside hospitals. Release on compassionate grounds and liaison between the prison and the prisoner's family may be of particular significance.

Mr K had been transferred to a prison without 24-hour healthcare services that was almost 200 miles from his home. When he became ill, Mr K had various tests and treatment at an outside hospital before being diagnosed with terminal lung cancer. Following the diagnosis, Mr K remained on normal location and was helped in his daily routine by his friends and prison staff. As his illness progressed, Mr K was transferred to a wing with a cell that had been fitted out with special equipment to support him. A trained family liaison officer was allocated as Mr K's personal officer and this ensured that his partner was kept informed of his medical condition on a daily basis. When his condition deteriorated and Mr K was transferred to

hospital, the prison decided that he did not need to be restrained.

In his investigation report, the Ombudsman applauded the way in which the prison had cared for Mr K. The use of specially trained staff demonstrated the support that can be offered to prisoners and their families. The prison's decision not to restrain Mr K when he was admitted to hospital was also highly creditable.

Mr L had served several years of a life sentence when he was transferred to a category C prison to prepare for a Parole Board hearing. A year later he was admitted to hospital, where the results of medical investigations indicated that he was terminally ill and had a short life expectancy. An application for compassionate release on medical grounds was started by the lifer manager, who had been told by the hospital doctor that Mr L had only weeks to live. However, another member of staff felt that the seriousness of Mr L's condition was not clear and the application was not pursued. Mr L was transferred to a prison resourced to care for prisoners with terminal illnesses. There the application was completed. It was received by the Public Protection Casework Section of NOMS the day before Mr L died.

Mr L's case, like others investigated by the PPO office, illustrates how difficult it can be to assess the life expectancy of someone who is terminally ill. Cancer develops unpredictably, and medical professionals are often unable or unwilling to predict exactly how fast it will spread. The PSO that sets out the criteria for release on compassionate grounds requires that death is likely to occur very shortly and offers a guide period of three months. However, such guidance could encourage prison staff to think only in terms of definite time periods rather than looking at each case on its merits. In the investigation report on Mr L, the Ombudsman recommended that the guidance in the PSO on

compassionate release on medical grounds should be revised. Either the guide period of three months should be removed or the guidance should make clear that a definitive life expectancy is not required before an application for compassionate release may be made.

Approved Premises

In 2009–2010, there were 11 deaths of Approved Premises residents, a similar number to the 10 deaths reported in 2008–2009. Three were self-inflicted and four were deaths from natural causes. Although it is a matter of quiet satisfaction that the numbers remain so low, this has the consequence that it is difficult to identify overall themes. However, the following two examples illustrate some of the issues that can arise from a death in Approved Premises.

Mr M had a long history of mental health problems and self-harm. After being charged with a serious violent offence, he was remanded in custody, but complained of having delusions and hallucinations. He was assessed by the prison psychiatrist and transferred to a secure mental hospital for further treatment. Some months later, he was discharged after being diagnosed with anxious and depressive personality traits, but not a treatable mental illness. Mr M was convicted of his offence and sentenced to imprisonment. During his sentence he continued to complain of hallucinations and made several attempts to harm himself. He was prescribed antipsychotic medication, which seemed to help. On his release from prison, Mr M resided at an Approved Premises as a condition of his licence.

Although he appeared initially to settle well, when he met with his community psychiatric nurse, Mr M said that he was once again suffering from hallucinations. The next day, he left the Approved Premises without collecting his medication. He made his way to a hotel where he had made a previous attempt on his life. On this occasion, he jumped from a hotel window.

The investigation concluded that Mr M had received appropriate care from the Approved Premises. However, despite the concerns that were apparent while Mr M was in prison, information was not passed to healthcare professionals in the community who were therefore unaware of his history of mental health difficulties. The Ombudsman recommended that the prison establish an information-sharing agreement with relevant healthcare providers to ensure continuity of treatment when prisoners are released.

Mr N was subject to level three Multi-Agency Public Protection Arrangements (MAPPA) because of the seriousness of his offences. He applied to move location because of difficulties he was facing in his local community, and accommodation was found in an Approved Premises in another probation area. Before the move, Mr N had seen a doctor as he had lost weight and felt unwell. A new doctor in the new location referred him to hospital and he was found to be suffering with cancer of the bowel. Over the next

few months, Mr N spent several periods in hospital, and staff at the Approved Premises ensured that he was given the most suitable room on his return there. Sadly, he developed pneumonia and died in hospital.

The investigation found that staff at the Approved Premises had cared for Mr N well, and they were commended for this. In particular, they had made every effort to ensure that his religious needs were met (this had been a particular cause for concern for him). However, when Mr N was taken to hospital for the final time, staff had difficulty tracing his next of kin, and it was recommended that these details should be updated more regularly. The investigation also found that, despite staff efforts, the facilities that could be provided within an Approved Premises were not sufficient for the needs of a terminally ill person such as Mr N. It was recommended that when a resident subject to MAPPA restrictions becomes terminally ill, a multi-disciplinary approach involving social services and healthcare agencies should be taken, to ensure both public protection and an appropriate standard of care.

Family liaison

The Ombudsman's team of four family liaison officers (FLOs) and one assistant FLO performs a crucial role for bereaved families. The team maintains contact to provide information and explain procedures at key stages during the investigation of deaths in custody. In this reporting year the team was involved in 206 new investigations. All families were offered a visit from an FLO and an investigator to discuss the investigation process and any issues or concerns the family might have. In the first feedback survey of bereaved families that was undertaken this reporting year, those families who took up the offer of a visit rated it as 'most helpful'. They found the FLOs courteous and professional. The families also said that the summaries of visits that were prepared by FLOs accurately reflected their concerns.

FLOs are responsible for ensuring that families receive a copy of the Ombudsman's report at the draft stage if they wish to see it. If required, they will also go through the report to assist the family in understanding the issues. The results of the survey indicated that not all families were aware of this aspect of the FLO service, and in the coming year we shall seek to publicise it more widely.

At the time of the survey, inquests had been held in less than half of the cases investigated. The majority of families were not in contact with the PPO office during this period. Families surveyed suggested that they would have appreciated more contact with an FLO during this interim period. FLOs are also tasked with contacting families after inquests have taken place, to explain the process of publishing reports anonymously on the PPO website. Two-thirds of the families surveyed were satisfied with this part of the procedure.

The results of the survey were encouraging, indicating that FLOs provide comfort and reassurance at times of considerable stress for bereaved families. Suggestions for improvement will form the basis of an action plan to develop and improve the service further. The survey will be repeated during the coming year.

NOMS aims to provide a fair service to all prisoners. Indeed, the Director General of NOMS has stated his personal commitment to eliminating discrimination.

INVESTIGATING COMPLAINTS

A fair service

"Right relationships and fair service delivery are crucial to our business. They are the key to safety in prisons."

Nevertheless, in this reporting year the Ombudsman received a number of complaints from prisoners who did not believe that the Director General's words (above) had been translated into action. The following are examples of complaints from prisoners who believed that they had been dealt with unfairly.

Mr P complained that the prison discriminated against him on the grounds of his sexual orientation. Mr P said he was an openly gay man who was significantly older than other gay men on his unit. He said he had been unfairly accused of 'grooming younger men' and given written warnings under the Incentives and Earned Privilege Scheme (IEPS) before being downgraded from enhanced to standard level.

There was no evidence of the prison engaging in institutional discrimination against gay men in general. There was a gay support group and prisoners were permitted to purchase gay magazines. Mr P should have been able to make friends with other gay men as he chose. However, the investigation found that there had been a number of security reports about incidents of Mr P's inappropriate sexual behaviour or comments. It was evident that the reports originated from both staff and prisoners and were reliable. Records indicated staff's concerns over many months about Mr P's behaviour towards younger men. He had been warned for sending sexually explicit letters and making sexual gestures.

Staff have a duty to protect vulnerable prisoners from bullying, and inappropriate and unwelcome comments or advances of a sexual nature fall into this category, whatever the age of the prisoner being bullied. The IEPS warnings and downgrade were thus judged to be appropriate, as Mr P's behaviour did not meet that expected of an enhanced prisoner. Mr P had been dealt with robustly but not unfairly, and his complaint was not upheld.

Mr Q's solicitors complained on his behalf that an assault on Mr Q had been neither reported to the police nor addressed through the prison's disciplinary procedures. Mr Q said he had sustained a broken jaw, and identified his assailant. However, the prison had taken no action.

The investigation found that the prison had completed the necessary forms to record the incident. However, the completion of documentation is not the same thing as an investigation, and there was no evidence of any investigation, either simple or formal, as required by PSOs. Although Mr Q had identified his assailant, prison staff did nothing to inquire fully into the events and did not charge the alleged perpetrator.

It was apparent that prison staff believed only a minor assault had taken place and the seriousness of the assault did not become clear until Mr Q was taken to hospital the following day. Nevertheless, when the extent of Mr Q's injury was known, the prison failed to take any action. The incident was not reported to police until six days later, after Mr Q himself had insisted that the police should be involved. The prison then did Mr Q a considerable disservice by describing what had

happened as minor, and failing to describe his injury. Presumably as a consequence, the police decided to take no action.

The investigation found substantial failings on the part of the prison concerned. Mr Q's complaint was upheld and the prison was asked to apologise to him for its failures. However, as the relevant PSO was about to be updated, there were no other useful recommendations to be made.

Mr R complained that inaccurate entries in his security record had been instrumental in the prison's refusal to allow him to attend his father's funeral. Mr R was concerned that the entries could affect his future progress and asked for them to be removed.

The investigation established that the entries were initially recorded on the front-page summary of Mr R's intelligence record more than 15 years ago when he was first sentenced to life imprisonment. The information said that Mr R would try to escape given any opportunity and that he was likely to feign illness to get to an outside hospital. However, the investigation found no evidence in security information or elsewhere to justify the comments. It was discovered that, although the practice had now ceased, some prisons had previously classified all potential category A prisoners as likely to escape if given the opportunity, due to their level of risk. In Mr R's case, the information had been passed from establishment to establishment without verification or further investigation.

The PPO investigation found that the decision to refuse Mr R permission to attend his father's funeral was reasonable and justified. However, his complaint highlighted the potential for serious errors when information likely to have a significant impact on the lives of prisoners is not properly processed and kept up to date. The prison agreed to remove the inaccurate comments from Mr R's record with immediate effect.

Mr S complained that he had been unfairly treated when the prison placed him on the basic regime of the IEPS. Mr S said he had been charged with possession of an unauthorised article but was placed on the basic regime the following day before there had been a hearing to consider his guilt. He said he remained on the basic regime for 24 days with no privileges and had been punished without being found guilty.

The investigation considered the prison's local IEPS policy. This said that decisions about the appropriate privilege level should be open, fair and consistent. Prisoners should be notified of decisions to change their IEPS level and be given the opportunity to make prior representations. The policy also said that prisoners on the basic level should be afforded structured reviews after the first seven days.

The investigation found that the prison had not followed its own guidelines. It was of concern that Mr S had been on the basic IEPS level for 24 days before he was given the opportunity to make representations. The investigation could find no record of the decision to demote him and there were no structured reviews during the time he was on the basic level. The prison's record-keeping was exceedingly poor and no one was able to say who took the decision or why. However, all the indications were that it was used as a *de facto* punishment for the adjudication charge in contravention of local and national policy.

Mr S's complaint was upheld in the strongest terms and the Ombudsman recommended that staff be reminded that changes to prisoners' IEPS levels should be in accordance with policy, in line with PSO 4000. In recognition of the extraordinarily poor handling of the case, which left Mr S with substantially reduced privileges, the Ombudsman recommended that he should exceptionally be offered financial compensation.

Maintaining outside contact

It is rare indeed to meet a prisoner for whom contact with the outside world is not important. The continuing support of friends and family has a significant part to play in resettlement, and prisons are required to do what they can to foster such contact. Most prisoners eagerly await letters from home and visits from loved ones. But in busy prison post-rooms, where hundreds of letters are processed daily, mistakes can occur. Likewise, visits do not always run smoothly. The following cases are a small selection of the many complaints received about correspondence and visits.

Mr T complained that he had been placed on closed visits because of suspected drug use. He said this was despite the fact that he had not been found in possession of drugs and had produced a negative sample when tested. Mr T also said he had been kept on closed visits for more than eight months until he was transferred to another establishment.

The investigation considered NOMS guidance on preventing the smuggling of drugs through visits. The guidance makes it clear that closed visits should be applied proportionately, and only where prisoners are proved to have been involved in drugs smuggling through visits or are viewed as posing a reasonable risk of such involvement.

In Mr T's case the investigation established that the decision was based on an officer's observation that he might have been using cannabis in his cell, and a report that he had asked to be segregated having been threatened by other prisoners over a drug debt. However, the prison had subsequently confirmed that there had been no evidence to indicate that Mr T had been at risk from other prisoners.

There was little doubt that in imposing closed visits the prison acted with the good order and discipline of the establishment in mind. But the information giving rise to the decision fell well short of what was necessary to form a reasonable suspicion that Mr T was abusing the visits system. The investigation found that the decision to impose closed visits was disproportionate to any risk he might have posed. The prison agreed to issue a formal apology to Mr T and to review its local policy.

Mr U complained that he had not received photographs of his granddaughter that his son had sent enclosed in a Father's Day card. Mr U believed that the prison had confiscated the photographs without good reason.

As Mr U was not subject to monitoring by the prison's Public Protection Unit, there was no reason to withhold anything enclosed with his correspondence and he should have been given any photographs sent to him. Indeed, it was noted during the investigation that Mr U had received similar photographs that had been sent subsequently by his son. The prison had checked, but was unable to find any trace of the pictures that Mr U said had gone astray, and there was no evidence that the prison was at fault – notwithstanding Mr U's fears that they might have been given to another prisoner in error. The complaint could not be upheld, therefore. However, the Ombudsman criticised the prison's continued use of the term 'censors' to describe those working in the communications department. The censoring of prisoners' mail ended many years ago, and the word should be confined to history.

Mr V's partner was banned from visiting him for six months following an incident in the visits room when she was said to have insulted an officer. Mr V complained that the ban was unfair as his partner had reacted to inappropriate behaviour from the member of staff. Mr V also said that visitors who had brought in drugs or mobile phones were not banned for such a lengthy time. He added that his partner was willing to apologise for her behaviour. When he appealed using the prison's internal complaints procedure, the ban was reduced to three months but Mr V felt that was still too harsh.

The PPO investigation found that Mr V and his partner had engaged in inappropriately intimate contact in the visits room. They had been asked on more than one occasion to tone down their behaviour. Witnesses said they had both become abusive and used foul language to an officer in the presence of another prisoner's children.

It is particularly important for prisoners to maintain contact with their families, and the ban had prevented Mr V from seeing his partner for some time. Nevertheless, another prisoner had objected strongly to the language used in front of his children and the incident had had the potential to become a serious threat to the security of the visits room. In any case, prison staff have the right to conduct their duties without being subject to abuse from prisoners or their visitors. The investigation considered whether closed visits would have been more appropriate than a ban, but this would not have prevented the possibility of further abuse directed at staff

by Mr V's partner. It was judged that the length of the ban was not disproportionate once it had been reduced on appeal, and Mr V's complaint was not upheld.

Ms W complained that the prison had intercepted a letter she had sent to her husband and copied it to a Social Services department. She said the prison had responded by saying she was not subject to mail or telephone monitoring and there was no reason for the prison to copy her mail. However, she knew that they had done so.

The investigation revealed that Ms W's letter had been intercepted in a routine mail-monitoring exercise. The letter asked Ms W's husband to speak to their son and persuade him to withdraw allegations about his mother's cruelty to him. Given the nature of the letter's contents, it was passed to the prison's Public Protection Unit and in turn to the Police Liaison Officer for advice. The Police Liaison Officer properly requested a copy of the letter for police to investigate the possibility of an offence of perverting the course of justice. However, the police took no action other than to disclose the contents to Social Services in the light of concerns for the safety of Ms W's son.

In view of the child protection concerns, it was considered that the prison's action was entirely reasonable. However, the PPO investigation found no record of the decision to pass the letter to the police, and the prison's initial response to Ms W's complaint was vague and misleading. Should similar cases arise in future, the prison has undertaken to record all decisions and discussions to provide a proper audit trail.

Good order and discipline

Maintaining good order and discipline is crucial to the wellbeing and safety of prisoners and staff alike. If not dealt with promptly but fairly, breaches of the Prison Rules can lead to a culture of mistrust and fear.

Nowadays, those disciplinary offences that can lead to a punishment of added days are heard by independent adjudicators (district judges), and many other misdemeanours are managed through the IEPS. As a consequence, the

Ombudsman receives proportionately fewer complaints about adjudications than in the office's early years. However, as the volume of complaints is much higher than in those early years, the actual number of adjudications that the Ombudsman is asked to review is much greater than in the 1990s. In carrying out that responsibility, the Ombudsman's role is, in general, to consider if the hearings have been properly conducted and if the adjudicator's conclusions were reasonable based on the evidence that was heard.

Mr X was charged with using threatening, abusive or insulting words or behaviour. He was found guilty and punished with five days' loss of earnings at 50 per cent and five days' loss of television. Mr X appealed on the basis that he had been unable to question the reporting officer about a second officer's contradictory evidence.

At the hearing, the reporting officer's evidence was read out and Mr X asked for a second officer to be called as a witness. The adjudicator heard Mr X's submissions and questioned the reporting officer. He then agreed to adjourn the hearing for the second officer to give evidence and to hear what the reporting officer had to say in response. When the hearing was resumed, the second officer gave evidence and Mr X was given the opportunity to question him. Having done so, Mr X expressed his concern that, as the reporting officer was not present, he could not be questioned about his responses to his colleague's evidence. He said the evidence given had raised issues that he wished to put to the reporting officer, and he asked for a further adjournment.

However, the adjudicator refused and concluded that the burden of proof had been met. He said he was satisfied beyond reasonable doubt that the charge was proved. When the NOMS' Briefing and Casework Unit (BCU) considered Mr X's appeal, they afforded the adjudicator the opportunity to rebut Mr X's arguments but Mr X was not asked for his comments.

The investigation carefully reviewed all the adjudication paperwork, Mr X's grounds for appeal and the BCU's comments. It was of concern that it was not made clear at the first hearing that the reporting officer would not be present when the hearing was reconvened, and consequently Mr X could not question him. Although it was impossible to say what such questioning might have elicited, it was unfair to refuse Mr X's request and this undermined the safety of the finding of guilt. The adjudicator's discretion to call or refuse witnesses is set out in PSO 2000, but the Ombudsman considered that the failure to allow Mr X to question the reporting officer was a flaw and his complaint was upheld. It was recommended that the conviction be quashed and Mr X's lost earnings restored to him.

There were also concerns that the BCU had invited the adjudicator to comment on the appeal while Mr X had no opportunity to respond to what was said. This did not offer a wholly impartial appeal process and may have been unfair to Mr X. It was further recommended that the BCU should seek legal advice and review the implications of its current practice. It has subsequently been decided that the requirement for governors to send their comments will be omitted from the new PSI when it is issued.

Mr X's complaint also raised a concern that the Ombudsman has expressed on

many occasions about the accuracy of the records maintained during adjudication hearings. There can be little doubt that adjudicators do all they can to keep a balanced and accurate record of the proceedings. Nevertheless, a handwritten note penned while actually conducting the hearing has evident weaknesses. In the Ombudsman's view, it would be good practice for a clerk to minute the hearing or (as in the Northern Ireland Prison Service) for the hearing to be recorded on tape or electronically. Although NOMS has understandably pointed to the costs involved, such an approach would ensure an independent and comprehensive record of the entire proceedings. This is an issue to which it seems certain that the Ombudsman will return in future years.

The Howard League complained on behalf of Mr Y, a young offender, that he had been convicted of possessing an unauthorised item (cannabis) at a flawed adjudication. They provided evidence to show that Mr Y had a low IQ, was vulnerable and had limited understanding of Young Offender Institution (YOI) procedures.

At the preliminary adjudication hearing, Mr Y did not request any assistance or name any witnesses. He had submitted a written statement pleading guilty to the charge, the details of which were that an "unauthorised substance, possibly cannabis, was found hidden wrapped in tissue paper inside a deodorant stick [in his cell]". When Mr Y was asked if the substance found was cannabis he said that he did not think it was. In his statement he admitted having the item in his room but said he had been given it that day to look after for someone else. He would not reveal who had given it to him.

The Howard League suggested that Mr Y had been pressurised into pleading guilty by staff. It said that it was only when he obtained legal advice after the hearing that Mr Y realised he had a defence to the charge. It also suggested that the wording in the charge (the words "possibly cannabis") did not meet the mandatory requirements of the PSO dealing with drug offences, nor had it been sufficiently demonstrated that Mr Y had the knowledge and control of the substance necessary to prove the charge.

The Ombudsman's investigation confirmed that the relevant PSO says that charges in cases involving possession of unauthorised items should be specific. It requires the charge to be formulated clearly (for example, 'had in his possession a controlled drug') and not left open to doubt, as was the case with Mr Y. The Ombudsman concluded that the text used in the charge did not meet the requirements of the PSO, and was surprised that this point had not been considered by the BCU during the appeal.

As noted, during the preliminaries Mr Y apparently declined any assistance and, as the adjudicator did not know of Mr Y's low IQ, there was no reason for him to question Mr Y's decision. In effect, the PSO places the onus for requesting assistance in defending a charge on the defendant. However, this presupposes that the prisoner is aware that they might benefit from assistance. This may be an appropriate assumption in the case of adults (although in some circumstances even that may be questioned), but young people are much less likely to be assertive in such

matters. The Ombudsman concluded that there would be merit in adjudicators taking a more proactive approach than that currently set out in the PSO. It was suggested that young people in YOIs facing disciplinary charges should automatically be provided with information about the advocacy service available to them.

At the draft report stage, a number of comments were received from NOMS and the Youth Justice Board. All accepted that the wording of the charge was flawed, but there was disagreement over other aspects of the Ombudsman's report. The NOMS Safer Custody and Offender Policy Group agreed that reference to the advocacy service should be included in the PSO when a new specification for adjudications was developed. In the meantime, an item about the advocacy service was to be included in the next issue of the newsletter circulated to all adjudicators. The Youth Justice Board also supported the proposal that young people should be advised of the advocacy service in advance of adjudications. However, it expressed concerns that any system prompting young people to request an advocate could be seen as 'leading the service' rather than allowing it to be shaped by the needs of young people themselves. The Youth Justice Board suggested that further evaluation of the role of the advocacy service was required.

In sum, the Ombudsman was satisfied that the doubts about the wording of the charge were sufficient to make the finding of guilt unsafe and to recommend it be quashed. The discussion that arose from the recommendation about the provision of greater assistance to young people at adjudications is welcome, and a review of how the advocacy service operates would be valuable.

Control and restraint

Few issues in prison are more controversial than the use of force. None is more controversial than the use of force against children and young people in custody.

Mr Z, a young offender, complained about an incident during which a 'nose distraction technique' had been used. This had led to his nose being broken. Mr Z said he had been misbehaving with others during

an education session and three officers had asked him to return to his cell. The officers accompanied him, one on either side and one behind. Mr Z alleged that one of the members of staff prodded him in the back several times. He said that, when he turned to protest, one officer held his nose and face, pushing his head to the floor, while the others held his arms and legs. Mr Z described this as an extremely painful experience.

The investigation ascertained that the technique is indeed an extremely painful procedure. It should be used only if a young offender continues to kick out with arms and legs after being brought to the ground by normal control and restraint (C&R) procedures. Mr Z had no history of violence towards officers and, although there had been a number of incidents resulting in force during the same month, Mr Z was the only person to have been injured.

In their accounts of the incident, the officers described Mr Z as surly and argumentative, although he said he had been compliant and non-threatening throughout. All those involved agreed that Mr Z was reluctant to leave the education room but did so after persuasion. The investigation found CCTV footage confirming that Mr Z had turned around several times during the escort, but there was no evidence to show that an officer had been provocative by prodding him.

The management and control of challenging or violent behaviour by teenage boys is both sensitive and difficult in the community, let alone in a closed institution. The use of C&R is sometimes necessary in YOIs, and in the circumstances of this case the Ombudsman could not be certain that the use of force was not justified. For that reason, Mr Z's complaint could not be upheld in full. But to say the least, any situation in which a boy has his nose broken as a result of being restrained by three adult prison staff must be a cause for great concern – all the more so when, as in Mr Z's case, there was no violent struggle prior to the injury and no previous history of violence by Mr Z towards staff.

Mr Z's case illustrates that C&R techniques developed specifically for adult prisoners may have severe consequences when used on a young offender. The report of a review of restraint across the young people's secure estate that was commissioned in 2008 recommended significant changes to restraint and behaviour management in YOIs.[6] The Ombudsman was concerned at the slow progress in implementing the report's proposals and recommended that they should be taken forward as a matter of urgency. Given the importance of the investigation report, the Ombudsman also asked NOMS to ensure that it was shared with the Youth Justice Board.

Prison life

Loss of liberty is a severe punishment that carries with it other privations. When access to things that are taken for granted in the community is curtailed, minor slights or perceived injustices can assume a significance that may appear disproportionate to the harm suffered.

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[6] Smallridge P and Williamson A (2008) *Independent Review of Restraint in Juvenile Secure Settings*. Ministry of Justice.

However, in the Ombudsman's office no complaint is treated as trivial. Priority is given to complaints about ill-treatment or discrimination along with those where release or progress might be delayed. But investigators recognise that each complaint is significant and matters to the individual concerned.

Mr AA, an elderly prisoner, complained that he had been required to pay television rental fees when other pensioner prisoners had their fees refunded. Mr AA said he understood that Prison Service guidelines indicated that no pensioner should have to pay for television rental.

Mr AA was partially mistaken. The guidelines state that all prisoners are required to pay a weekly television rental fee of £1, regardless of age. However, the investigation found that the prison in question had in fact refunded other prisoners' rental fees in error. As a result of the investigation, the prison issued an apology to Mr AA for the misunderstanding. It also reviewed its policy and issued a notice to prisoners, making it clear that in future anyone, whatever their age, who had an in-cell television would be required to pay the weekly rental fee.

Mr BB complained that, on his unit, there was a general policy of full body searches for prisoners on voluntary drug testing (VDT) compacts, but that this did not apply on other units. He said that this was inconsistent and in contravention of a PSO stating that, in respect of VDT, strip searches should be used only when there was specific information about an individual.

Mr BB raised an important point about inconsistency within his prison, and a wider and perhaps even more important question about whether the national guidance relating to strip searching was sufficiently clear. The investigation established that Mr BB was right in saying that there was inconsistency in the approach taken by different staff in different units of the prison. Indeed, it was a matter of concern that the practice of strip searching VDT prisoners on some wings continued despite a former Governor's instruction that it should cease.

Mr BB's complaint was upheld and the Ombudsman recommended that the Governor remind staff of the correct policy and ensure that it was applied consistently across the prison. In addition, a national recommendation was made to the Director General of NOMS to issue revised guidance regarding the searching of prisoners subject to VDT compacts.

Mr CC complained that security information about him relating to extremist activities had been inappropriately disclosed around the prison. He said this had resulted in verbal and written threats that led him to fear for his safety.

The prison readily accepted that security information about Mr CC and a number of other prisoners had been inappropriately printed by a staff member with the intention of assisting other staff responsible for allocating accommodation. The investigation found that the prison had taken action to prevent similar breaches occurring by recording such information in a format that could not be printed. The

prison had also offered Mr CC protection immediately after the inappropriate disclosure came to light.

It was clear that the prison was at fault in allowing the sensitive information to be printed, and the error was compounded when the information was left openly on view to other prisoners. There could have been serious implications for the safety of Mr CC and the other prisoners involved (although in practice it had not escalated beyond Mr CC's distress over the threats made to him). However, the prison had acted quickly to mitigate the adverse effects by offering to relocate Mr CC and had taken steps to ensure that such sensitive information could no longer be printed. The prison's actions demonstrated a robust handling of the situation and, although Mr CC's complaint was upheld, no further action was recommended.

Mr DD complained that when he transferred from one prison to another his stereo system was damaged in transit. He asked for reimbursement of the cost of the equipment.

Mr DD's property cards confirmed that a stereo system had been received from his previous prison in a badly damaged condition. However, although Mr DD said he had bought the stereo, the investigation found that some years earlier the prison had loaned him a system of the same make and serial number at no cost, on condition that it was not removed from the prison. Mr DD had signed a loan agreement to the effect that any loss or damage would be his responsibility.

The investigation found no evidence that Mr DD had purchased another stereo. It

seemed clear that Mr DD had taken the system with him from prison to prison in breach of his agreement. As Mr DD sought compensation for an item that did not belong to him, the Ombudsman was not persuaded that he was due any payment. His complaint was not upheld.

Mr EE complained that the in-cell electricity at the prison was switched off during working hours. Mr EE said this was spiteful and unfair, denying prisoners their earned privileges such as in-cell television and deterring them from undertaking in-cell education. He was also concerned that the electricity was not turned back on before the afternoon lock-up.

The policy of switching off in-cell electricity had been implemented about a year before Mr EE complained and a notice had been issued to prisoners. This said that sockets for using televisions, kettles and music systems would be turned off to coincide with times that prisoners attended work or education classes. The electricity was not turned off on Friday afternoons or at weekends when work and education were not available. The intention was to deter prisoners from remaining in their cells and to encourage them to participate in the prison regime. In fact, Mr EE was himself in full-time education and was rarely affected by the policy.

Self-evidently, prisoners are dependent on the supply of electricity to benefit from privileges that they have earned such as in-cell television. Nevertheless, the decision to encourage prisoners to participate in regime activities while saving electricity could not be deemed unreasonable. The electricity was controlled by timers and turned off only at times when the majority of prisoners were out of their cells. In these circumstances, the Ombudsman did not uphold Mr EE's complaint.

Prisoners' property

It is discouraging to note that comments by the Ombudsman about the handling of prisoners' property have changed little over the years. It is perhaps inevitable that, given the number of property transactions taking place, mistakes will be made. However, year after year the Ombudsman has indicated that loss and damage might have been avoided if recording was more accurate.

There can be no doubt that recording movements and changes to property can be time consuming, particularly when staff are involved in cell clearances. But as the cases below illustrate, inadequate record-keeping and failure to follow the correct procedures can be costly for the prisoner and the prison.

Mr FF said that when he first arrived in prison, he had handed in a mobile phone to be stored as a valuable item. He complained that his phone did not transfer with him when he moved to another establishment. Mr FF said that, when he enquired about his phone, he had first been told it had been sent on but was later told it had been destroyed.

PSO 0500 requires reception staff to record all prisoners' property on property cards and the prison did not dispute that Mr FF had handed his mobile phone in for safe keeping. However, conflicting and unclear entries in

the valuables property book completed for Mr FF on reception made it impossible to ascertain if the phone had been destroyed or sent out.

It was established that a parcel had been sent from the first prison to the second. But while there was proof that the parcel had been received, there were no records to indicate what it had contained and it had been addressed to reception rather than to an individual. The prison said it had received no valuables for Mr FF.

Mr FF's phone was held as a valuable item in the first prison and as such NOMS was responsible for its safe keeping. However, as a result of the poor record-keeping, it was impossible to prove what had happened to the phone. The prison agreed that the record-keeping fell short of what was expected and accepted responsibility for the loss. It made an offer of compensation, which Mr FF accepted.

Mr GG complained that items of his clothing had gone missing from the prison laundry on a day when he had been moved from his cell to the segregation unit. Mr GG acknowledged that he had signed a property disclaimer and had used the laundry at his own risk. However, he said he was not in a position to collect his clothes due to a cell move that he had not anticipated.

The investigation ascertained that the laundry was the only place in which prisoners could wash their clothes, and there were no written procedures to govern its use. In addition, there was no audit trail to indicate who handed in laundry, and it was left unsecured awaiting collection. As a consequence, although prisoners retained responsibility for their in-possession clothing, it was unreasonable to hold them responsible

after items had been handed in to the laundry. It was accepted that there was no evidence to confirm that Mr GG's items were received by the laundry orderly but this was due to the system in operation rather than any omission on the part of Mr GG.

There was no dispute that Mr GG had been in possession of the lost items as they were recorded on his property card. However, the prison was unable to establish who had collected his laundry. The prison accepted that Mr GG could not be held responsible for the loss and agreed to compensate him.

Adverse transfers

Wherever possible, the Prison Service is committed to locating prisoners within reasonable distance of their homes and families. Nevertheless, there are a number of reasons why prisoners may be adversely transferred: for example, if their security category changes or if they need to access courses that only run at particular prisons. Given that the prison estate operates at close to capacity, prisoners are less likely to be moved to a prison of their choice. The following examples illustrate some of the complaints about transfer that the Ombudsman investigated this year.

Mr HH complained that he was transferred to a prison several hundred miles from his home to attend a court hearing. When the court case was over, he was transferred to a second prison, also far from home, on the understanding that he would soon be moved back nearer to where he came from. Mr HH said that the subsequent move did not take place and he was suffering as his family had been unable to visit.

The investigation confirmed that Mr HH was initially transferred to attend court but staff in the transferring prison failed to make arrangements for his return. Consequently, he was transferred to a second prison still some distance from his immediate family. It was evident that Mr HH had lost his place at the first prison for reasons that were beyond his control, and the failure to return him was counter to assurances he had been given. Although it was recognised that there are population pressures across the prison estate, Mr HH had fallen prey to circumstances that with a little forethought could have been avoided. His complaint was upheld and the Governor undertook to liaise with other gaols to enable Mr HH to return either to his original establishment or to another close to his home.

Mr JJ complained about the prison's refusal to transfer him to another establishment shortly after his arrival. He said he was in fear of an officer he had complained about during a sentence some six years earlier and did not feel safe.

The prison operated an informal policy that required prisoners to be resident for six weeks before applying for transfer. This was designed to give prisoners the opportunity to settle into their surroundings, and was said to have had a significant effect upon the number of early requests for transfer being dealt with by the induction wing. The policy could be varied in exceptional circumstances.

The investigation found that the officer about whom Mr JJ had complained did not work on the wing where Mr JJ was housed. There was no suggestion that Mr JJ had been threatened or intimidated during his current sentence. As Mr JJ confirmed that he had not experienced problems since his return to the prison, it was not considered unreasonable for the Governor to say that there were no exceptional circumstances requiring his early transfer, and the complaint was not upheld. However, it was of concern that the six-week policy was not formalised. It would be fairer for prisoners to be told about it during their induction. Although the Ombudsman made no formal recommendation, it was suggested that the prison should include an entry in the prisoners' induction pack.

Offender management

The NOMS model of offender management is committed to an "end to end seamless approach" to the management of offenders. Offender managers in the community work closely with offender supervisors in prison to assess risk and plan how it might be reduced prior to release under supervision. However, for those prisoners who complain about delays to essential sentence-planning paperwork and lack of contact with offender managers, the reality appears to fall short of the ideal.

Mr KK complained about the alleged mismanagement of sentence-planning targets that required him to participate in a sex offenders treatment programme (SOTP). His reluctance to take the course affected the level of assessed risk within his Offender Assessment System (OASys) reviews. Mr KK suggested that the course was inappropriate as both prison and probation had misinterpreted the nature of his

offences. He said they had been financially motivated rather than sexually motivated.

There was no doubt that Mr KK had been convicted of offences under the Sexual Offences Act 2003. This made him eligible for the SOTP and the course had been included as a target in his sentence plan. However, as the offences were 'non-contact' he had been given conflicting information at different establishments about his suitability. The investigation found that it was Mr KK's readiness to change that was at issue. Although he was not yet ready to undertake the programme, it did not follow that it should be removed from his sentence plan, and his complaint was not upheld.

However, during the investigation it became clear that Mr KK's risk factors had not been reassessed as his OASys review was overdue. When probation staff were made aware of this, they agreed to conduct the review as a matter of urgency.

Mr LL complained that his release on temporary licence (ROTL) had been delayed by a late response from his offender manager in the community with whom he had had only minimal contact. Mr LL said he had sent numerous letters to his offender manager but received only one response.

The investigation showed that Mr LL had applied for home leave some two months in advance of the date required. The prison faxed the relevant paperwork to the probation office within days, but six weeks later had received no response. When the offender manager said he had not received the paperwork, it was re-sent. A week later, the offender manager told the prison that the two possible addresses submitted by Mr LL were unsuitable.

Mr LL then offered a third address that had previously been found suitable for ROTL and a revised application was sent to the probation office on the same day. However, prison staff were unable to contact the offender manager to ask him to expedite the application and, as a consequence, Mr LL was obliged to defer his proposed ROTL dates. On three consecutive days prior to the revised ROTL date, the prison attempted to contact the offender manager, but he did not return the calls. When the prison finally managed to contact the offender manager the day before Mr LL's ROTL, he said he had not received the revised application. Because approval for the address had not been received, Mr LL again deferred his ROTL dates.

The evidence in this case indicated that the offender manager acted promptly to deal with the ROTL application once he was aware of it. However, there was a delay of some seven weeks after the prison forwarded the request. The probation area could offer no explanation for the delay and the assumption was that the request was mislaid within the probation office after it was received by fax. As there had been an administrative delay within the probation area, this aspect of Mr LL's complaint was upheld and the probation area agreed to apologise to Mr LL.

So far as the lack of contact was concerned, the probation area agreed that not responding to Mr LL's letters meant that they had failed to keep him informed of progress. However, although the NOMS National Standards for the Management of Offenders require continuity of offender management to be

maintained, the minimum requirement for frequency of contact with prisoners is annually. In addition, the NOMS Offender Management Model states that during the middle stages of a custodial sentence the role of offender supervisors (probation staff seconded to prisons) becomes central, while the involvement of offender managers in the community may be reduced to a minimum. Although there was no evidence that Mr LL suffered any detriment through the lack of contact, the probation area apologised for failing to keep him informed about the management of his case.

Mr MM complained that he had not received a discharge grant after the prison had said it would be paid to him. He had written to NOMS and had received a response confirming that he was entitled to the grant. However, Mr MM then heard from the prison that no grant could be paid as he had been in custody awaiting trial, and was released directly from court following a bail application.

The investigation discovered that Mr MM had in fact been a convicted prisoner who had been serving an indeterminate sentence of imprisonment for public protection (IPP). However, when he appealed against his sentence, it was quashed by the Court of Appeal, which ordered him to be remanded in custody to await a retrial. Mr MM was on remand for less than a month before being granted bail and released from court.

Prison instructions governing discharge grants make it clear that prisoners discharged at court or from prison after a period of custody on remand are not eligible for discharge grants. However, the instructions also say that any prisoner discharged from court after a sentence has been quashed or reduced on appeal is eligible for a discharge grant provided that they have served at least half of any sentence longer than 14 days. Discharge grants provide financial assistance to ex-prisoners in the period between their release and receipt of benefits, with the intention of reducing the risk of re-offending. If Mr MM had been released with immediate effect after the quashing of his conviction, he would have been entitled to such a grant. The Prison Service agreed that, although Mr MM had not been granted bail until some time later, the spirit of the instructions should apply and agreed to pay Mr MM his discharge grant.

Immigration removal

The Ombudsman's complaints remit was extended in 2006 to those held in immigration detention or subject to managed escort. Between 35 and 40 per cent of detainees are now time-served former prisoners, and there is much common ground between complaints arising in prison and those in immigration removal centres (IRCs). Issues about property predominate. However, other matters specifically relating to the nature of immigration detention also feature, as the following two cases illustrate.

Mr NN complained that he was not given a single room when he was transferred from one IRC to another, despite evidence on his medical file indicating that he should be accommodated alone. Mr NN said he told staff that he had a medical condition necessitating a single room but he could not provide proof and his request had been ignored. When staff attempted to place him on a residential unit, he had refused and had to be forcibly moved and segregated.

The investigation found that, at his previous IRC, Mr NN had been assessed by a doctor who found evidence to indicate that Mr NN could pose a threat to others

with whom he was accommodated. The doctor recommended that he should be placed in a single room. However Mr NN's medical file did not accompany him to the new centre and did not arrive there until some two months later. Consequently, at the time of Mr NN's arrival staff would not have been aware of the doctor's recommendation.

Mr NN's complaint highlighted the absolute necessity to ensure that detainees' full detention records accompany them when they transfer from centre to centre. Missing paperwork means that a full risk assessment cannot be undertaken, and the Ombudsman was particularly concerned that in Mr NN's case the recommendation for a single room was for the safety of others. Had he been placed in a shared room, another detainee could have been endangered.

It was not apparent why Mr NN's medical file had not been transferred more speedily. The Ombudsman recommended that the UK Border Agency's Director of Detention Services remind all centre managers of the importance of collating and sending detainees' full detention records with them when they transfer to another centre or to a prison. It was also recommended that, should a detainee arrive at a centre without the full record, the previous centre should be contacted immediately to obtain the missing paperwork.

Mr PP complained about an IRC's refusal to refund him £10 he paid for a copy of his medical records. Mr PP said that, when he asked for a copy of his medical records, he was required to sign a form printed in English. Because his command of English was poor, he did not appreciate that his signature gave the IRC authority to take £10 from his account to pay for the record. He said he would not have signed the form if he had understood this, as the payment had used up all the money he had in his account.

During the Ombudsman's investigation, the Office of the Information Commissioner confirmed that medical records are covered by the Data Protection Act 1998 and that it was appropriate for the IRC to charge £10 for a copy. The medical records clerk at the IRC said she had spent some time explaining to Mr PP that he would have to pay £10 and she believed he had understood. The Ombudsman had no doubt that the clerk had done her best to ensure that Mr PP understood the procedure, but considered it would have been better to have used an interpreter to explain the process to him.

Given the population held in IRCs, it was disappointing that important information relating to payments for the disclosure of documents was available only in English. The situation could have been avoided if an explanation for the charges had been available in other languages.

On the balance of probability, the Ombudsman concluded that Mr PP did not understand what he signed when he gave authorisation for the £10 deduction. Mr PP's complaint was therefore upheld and it was recommended that the IRC should refund the £10. A further recommendation was that the Director should arrange for information sheets to be printed in a range of languages. Both recommendations were readily accepted and implemented.

In 2009–2010, the Ombudsman received 4,641 complaints. This represents an overall increase of eight per cent on the previous year (although complaints about probation increased by 26 per cent).

THE YEAR IN FIGURES

Complaints

In 2008–2009, as in previous years, the majority of complaints received were not eligible for investigation – usually because the complainant had not followed the necessary procedures. However, during the first half of 2009–2010, there was a striking rise in the number of complaints eligible for the Ombudsman to investigate – to the extent that over half the complaints received were eligible. Although the eligibility rate fell slightly in the second half of the year, across the reporting year 48 per cent of all complaints received were eligible for investigation. This represents an increase of five percentage points from 2008–2009. The following tables provide details of the complaints received and the eligibility of complaints across the services in remit.

Complaints received			
	2009–2010	Percentage of total	Increase from 2008–2009
Prisons	4050	87%	6%
Probation	488	11%	26%
Immigration	103	2%	3%
Total complaints 2009–2010	**4641**	**100%**	**8%**

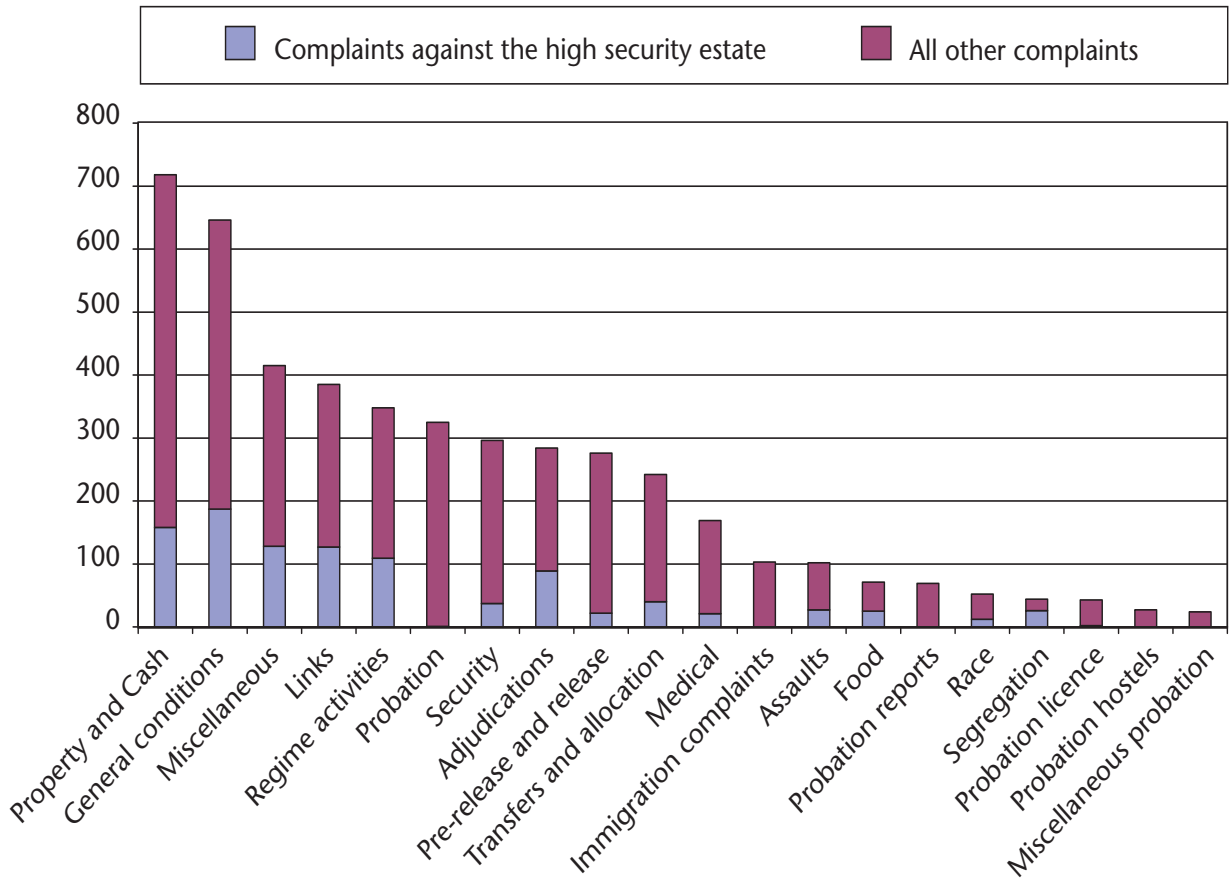
Eligible complaints		
	2008–2009	2009–2010
Prisons	46%	52%
Probation	14%	16%
Immigration	56%	67%
Overall eligibility 2009–2010	**43%**	**48%**

The increased number of complaints, together with higher eligibility rates, led to a considerable increase in the number of cases that met the criteria for investigation: 2,324 cases were eligible, an increase of 27 per cent from the previous year. This increase had a significant impact upon the workload of the office. As a result of measures taken to deal with a backlog of cases, output increased by 37 per cent and 2,083 investigations were completed. However, as most complaints in the backlog were outside the Ombudsman's target time of 12 weeks from when the complaint is assessed as eligible for investigation, the overall timeliness of investigations declined. 47 per cent of all complaints were completed within the 12 week target and the average time taken for a complaint to be completed was 17 weeks.

As in previous years, complaints were predominantly from men. Women remain under represented although the proportion of complaints from women rose from two per cent to three per cent. The percentage of complaints from young offenders under 21 fell. Prisoners in this age group account for 12 per cent of the prison population, but during the reporting year only one per cent of complaints came from them.

Prisoners from the high security estate continue to generate a high proportion of the PPOs workload and 22 per cent of complaints came from high security prisons. The following chart illustrates the types of complaint received from all services in remit and highlights those received from high security prisons.

Total complaints received by category, 2009–2010



Of the 2,083 complaint investigations completed, the Ombudsman found in favour of the complainant in 633 cases (30 per cent) and investigators achieved mediated settlements in 157 of these.

Fatal incidents

There was an increase in the number of deaths referred to the Ombudsman during the reporting year. Investigations were opened into 193 deaths, compared with 181 in 2008–2009. However, it is encouraging to report that the number of self-inflicted deaths fell from 65 in the last reporting year to 63. This represents the lowest proportion of self-inflicted deaths since the Ombudsman began investigating deaths in custody in 2004.

Investigations included three discretionary cases: the death of a man from natural causes following compassionate release; the death of a woman apparently from a drug overdose the day after her release from prison; and the death of a man from an apparent drug overdose within a day of his release from prison.

The following table illustrates the distribution of the 193 deaths into which investigations were opened.

	Male prison	Female prison	YOI	Approved Premises	IRC	Discretionary	Total
Self-Inflicted	54	1	5	3	0	0	**63**
Natural Causes	107	4	0	4	0	1	**116**
Homicide or Attack	0	0	0	0	0	0	**0**
Illicit Drug Overdose	2	0	0	3	0	1	**6**
Accidental	0	0	0	0	0	0	**0**
Unclassified	6	0	0	1	0	1	**8**
Total	**169**	**5**	**5**	**11**	**0**	**3**	**193**

Despite the increased workload, fatal incident investigators completed a number of investigations outstanding from 2008–2009. A total of 205 draft reports and 214 final reports were issued during the reporting year, representing a substantial increase on the previous year.

There were also 135 reports published anonymously on the PPO website (www.ppo.gov.uk), where there is now an archive of over 600 reports available to researchers and other interested parties.

Stakeholder feedback

As mentioned elsewhere in this Report, during the reporting year the Ombudsman continued the programme of surveying stakeholders to discover their thoughts on PPO's work and how it might be improved. This year groups surveyed included those eligible to complain and bereaved families, in addition to prison governors and other staff from the three services in remit, and those who work in the wider public, private and third sectors.

Although the surveys differed in their methodologies, the resulting response rates were similar – between 40 to 50 per cent. The Ombudsman received 462 completed questionnaires from complainants, 741 from general stakeholders and 56 from bereaved families.

The office was rated highly for professionalism, with two-thirds of general stakeholders rating PPO as 'very professional'. Investigators were rated as courteous and professional; interviews were conducted sensitively; and complainants thought investigators had treated them with respect. Family liaison officers demonstrated sensitivity and made no unreasonable demands. The aspect which received the least-positive ratings from all stakeholders was the extent to which they are kept informed of progress of the investigation.

Disappointingly, ratings for effectiveness and efficiency remained lower, with only just over one-third of respondents rating PPO as 'very effective', and less than one-third rating the office as 'very efficient'. This is taken as a reflection of dissatisfaction with the time it takes for investigations to be completed, because a number of respondents commented on the lack of timeliness. It is apparent that we need to do more to improve our performance in this area.

PPO reports continue to be well thought of. Over 90 per cent of respondents said that recommendations are realistic, are based on evidence and lead to changes in practice. However, only 40 per cent rated the PPO as 'very influential'. Not surprisingly, those complainants whose complaint was upheld were significantly more satisfied than those whose complaint was rejected: 46 per cent of those who had findings in their favour were 'very satisfied', while only 12 per cent of those whose complaint was not upheld expressed themselves satisfied with the outcome.

The detailed results of the surveys are available on the PPO website (www.ppo.gov.uk). Action plans have been developed to address many of the issues raised, and the results will act as a benchmark for evaluating the success of these initiatives.

The costs of the office

In the reporting year the office's budget was a little over £6 million. The table below provides the full details.

	£
Staffing costs (salaries)	4,441,173
Non-pay running costs	1,593,831
Capital	Nil
Total	**6,035,004**

Development activities

In 2009–2010, the Ombudsman published a corporate three-year plan, so that annual objectives could be seen in the context of a longer term picture. The published intentions were to build upon progress made in the previous year when the foundations were laid for a more professional organisation. The table below provides details of what has been achieved.

AIM: Reinforcing our independence	
ACTIONS	In November 2009, we published a framework document defining the Ombudsman's relationship with the Secretary of State for Justice.
	Protocols with the Ministry of Justice about the services to the Ombudsman's office on accommodation and health and safety matters were agreed and published.
AIM: Effective organisation and delivery	
ACTIONS	The Ombudsman conducted and implemented a review of job roles across PPO to ensure that the office is organised in the best possible way.
	A temporary complaints investigation team was set up to clear the backlog of complaints investigations.
AIM: Supporting and getting the most from staff	
ACTIONS	A new human resources strategy was produced.
	The investigative skills training courses for investigators, developed in 2008–2009 were fully implemented.
	A new external care support service for the fatal incidents investigation team was put in place.
	Work started on a comprehensive office manual, which will be issued in 2010–2011.
	A new internal communications plan was developed and implemented.
AIM: Managing performance	
ACTIONS	A performance management framework was developed to help the office to manage and improve its performance. The framework provides a rounded view of performance, focusing not only on strategic objectives but also on office capability (such as human resources, IT, accommodation, research and communications).
	A staff survey was carried out and the results were used to improve the management of the office.
AIM: Developing a more effective knowledge base	
ACTIONS	Work began on the development of a comprehensive knowledge base for fatal incidents work; this will continue into 2010–2011.
	Fatal incidents that had occurred over a 12-month period were fully analysed and the results published in the first of a series of research bulletins to be issued.
	A system of annual surveys of complainants, bereaved families and general stakeholders was introduced. Issues arising from the first survey have been taken into account in the development plans for 2010–2011.
AIM: Improving communications	
ACTIONS	An external communications plan was issued.
	DVDs commissioned in the last reporting year were produced and publicised. They provide general information about the office together with specific information about each of the Ombudsman's functions

TERMS OF REFERENCE

1. The Prisons and Probation Ombudsman is wholly independent of the National Offender Management Service (including HM Prison Service and Probation Services in England and Wales), the UK Border Agency and the Youth Justice Board.[7] The Ombudsman is appointed following an open competition by the Secretary of State for Justice.

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

Reporting Arrangements

3. The Ombudsman will publish an annual report, which the Secretary of State will lay before Parliament. The report will include:
   - anonymised examples of complaints investigated;
   - recommendations made and responses received;
   - selected anonymised summaries of fatal incidents investigations;
   - a summary of the number and type of investigations mounted and the office's success in meeting its performance targets;
   - a summary of the costs of the office.

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

Disclosure

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

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

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

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

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

classified material and information entrusted to that authority by other organisations, provided this is solely for the purpose of investigations within the Ombudsman's Terms of Reference.

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

Complaints

Persons able to complain

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

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

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

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

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

Matters subject to investigation

12. The Ombudsman will be able to investigate:

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

    ii) decisions and actions (including failures or refusals to act) relating to the management, supervision, care and treatment of offenders under probation supervision by NOMS or by people acting as agents or contractors of NOMS in

the performance of their statutory functions including contractors and those not excluded by paragraph 14;

iii) decisions and actions (including failures or refusals to act) in relation to the management, supervision, care and treatment of immigration detainees and those held in short term holding facilities by UKBA staff, people acting as agents or contractors of UKBA, other people working in immigration removal centres and members of the Independent Monitoring Boards, with the exception of those excluded by paragraph 14. The Ombudsman's Terms of Reference thus include contracted out establishments, contracted out services including escorts, and the actions of contractors working in immigration detention accommodation but not employed by UKBA.

Further provisions on matters subject to investigation

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

14. The Ombudsman may not investigate complaints about:

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

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

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

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

v) the clinical judgement of medical professionals.

Eligibility of Complaints

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

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

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

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

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

Time Limits

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

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

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

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

Outcome of the Ombudsman's investigation

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

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

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

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

considers appropriate given their role, duties and powers.

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

Fatal Incidents

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

    i. prisoners and trainees (including those in Young Offender Institutions and Secure Training Centres). This includes people temporarily absent from the establishment but still in custody (for example, under escort, at court or in hospital). It generally excludes people who have been permanently released from custody;

    ii. residents of Approved Premises (including voluntary residents);

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

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

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

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

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

    - establish the circumstances and events surrounding the death, especially regarding the management of the individual by the relevant authority or authorities within remit, but including relevant outside factors;
    - examine whether any change in operational methods, policy, practice or management arrangements would help prevent a recurrence;
    - in conjunction with the NHS where appropriate, examine relevant health issues and assess clinical care;
    - provide explanations and insight for the bereaved relatives;
    - assist the Coroner's inquest fulfil the investigative obligation arising under Article 2 of the European Convention on Human Rights

('the right to life'), by ensuring as far as possible that the full facts are brought to light and any relevant failing is exposed, any commendable action or practice is identified, and any lessons from the death are learned.

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

Clinical issues

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

Other investigations

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

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

Investigation reports

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

37. If the draft report criticises an identified member of staff, the Ombudsman will normally disclose an

advance draft of the report, in whole or part, to the relevant authority in order that they have the opportunity to make representations (unless that requirement has been discharged by other means during the course of the investigation).

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

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

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

Follow-up of recommendations

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

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