# Annual Report 2014–15

# Prisons & Probation Ombudsman

## Annual Report 2014–15

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

September 2015

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# The role and function of the PPO

The Prisons and Probation Ombudsman (PPO) is appointed by and reports directly to the Secretary of State for Justice. The Ombudsman's office is wholly independent of the services in remit, which include those provided by the National Offender Management Service; the National Probation Service for England and Wales; the Community Rehabilitation companies for England and Wales; Prisoner Escort and Custody Service; the Home Office (Immigration Enforcement); the Youth Justice Board; and those local authorities with secure children's homes. It is also operationally independent of, but sponsored by, the Ministry of Justice (MOJ).

The roles and responsibilities of the PPO are set out in his office's Terms of Reference (ToR). The PPO has three main investigative duties:

- complaints made by prisoners, young people in detention, offenders under probation supervision and immigration detainees
- deaths of prisoners, young people in detention, approved premises' residents and immigration detainees due to any cause
- using the PPO's discretionary powers, the investigation of deaths of recently released prisoners or detainees.

## Our vision

**To carry out independent investigations to make custody and community supervision safer and fairer.**

## Our values

**We are:**

**Impartial:** we do not take sides
**Respectful:** we are considerate and courteous
**Inclusive:** we value diversity
**Dedicated:** we are determined and focused
**Fair:** we are honest and act with integrity

# Putting suicide prevention centre stage

> The number of self-inflicted deaths in custody remains unacceptably high and, in 2014–15, there were still 38% more than in 2012–13.”

In the introduction to last year's annual report, I expressed dismay at the tragic and still largely unexplained rise in self-inflicted deaths in custody.[1] Mercifully, in 2014–15 there was a 16% reduction in the number of such deaths reported to me compared to the previous year. I very much hope my office can play its part in sustaining this reduction, by identifying life-saving lessons which must be learned and implemented.

However, there is no room for complacency. The number of self-inflicted deaths in custody remains unacceptably high and, in 2014–15, there were still 38% more than in 2012–13. I am, therefore, pleased that the review of the Prison Service's suicide and self-harm prevention (ACCT) procedures, which I called for in last year's annual report, has begun. I am also pleased that Lord Harris' important review of self-inflicted deaths among 18–24-year-olds in prison has been published. Together, these reviews should put suicide prevention in prisons centre stage and ensure that ACCT procedures – now over a decade old – are fit for purpose in a prison system with many more prisoners and fewer staff.

[1] For our analysis of the causes of this increase, see *Learning Lessons From PPO Investigations: self-inflicted deaths of prisoners – 2013/14* (March 2015)

## Managing death in prison

The number of self-inflicted deaths may have reduced, but the overall number of deaths in custody rose by 5% in 2014–15. This was driven by a 15% rise in deaths from natural causes. While these deaths were not exclusively among older prisoners, most were (the average age at death was 58), reflecting a rapidly ageing prison population. It is remarkable that the fastest growing segment of the prison population is prisoners over 60 and the second fastest is prisoners over 50. Longer sentences and more late in life prosecutions for historic sex offences, mean that this ageing prisoner profile – and rising numbers of associated natural cause deaths – will become an ever more typical feature of our prison system.

"

It is remarkable that the fastest growing segment of the prison population is prisoners over 60 and the second fastest is prisoners over 50."

My caseload provides some stark examples of the consequences of this changing population profile. I recently investigated the death of a 94-year-old prisoner who had been removed from his care home to serve his prison sentence. He died after falling out of bed in his cell. I commended the prison for the care of this man, as well as for learning from his death by purchasing crash mats and electronic beds to protect against such falls in future. However, the case also exemplified for me the way that prisons, designed for fit young men, have had to adjust to the largely unplanned roles of care home and even hospice.

As a result, my investigations into deaths from natural causes have identified some lessons which have not previously been of such widespread importance. For example, the need for improved health and social care for infirm prisoners; the obligation to adjust accommodation and regimes to the requirements of the retired and immobile; the demand for more dedicated palliative care suites for those reaching the end of their lives (these are now available in at least 10 prisons); and the call for better training and support for staff who must now routinely manage death itself.

While progress has certainly been made, this has been variable. Sometimes, the treatment of seriously ill prisoners is still shockingly poor. In one case last year, we obtained CCTV of an apparently very unwell prisoner being dragged from his cell to reception for a court appearance, by staff who disbelieved his claims of illness and his cries of pain. He was then forcibly stripped of his prison clothes and dressed for court, before his limp body was forced by staff into a cubicle

on an escort vehicle. Only then did escort staff discover that he had died. I believe this was an aberrant case and I know it shocked Prison Service senior managers when I drew it to their attention. However, it was also a reminder of the capacity of prisons, particularly when under pressure and faced with an increasingly ailing and ageing population, to slip into inhumane treatment.

The tension between traditional prison policies and the new geriatric penal reality is also reflected in my frequent criticism of prisons for failing to balance security with humanity when using restraints on the terminally ill. Protecting the public is fundamental, but this is not achieved by inappropriately chaining the infirm and dying. With an ageing prison population, visits to hospitals and hospices will only increase, and with them daily tests of the humanity of our prison system.

## Still challenging times

In my last two annual reports, I listed the challenges facing the prison system and these have not gone away. The prison population remains proportionally the highest in Western Europe, while efficiencies and recruitment and retention issues have significantly reduced the number of available staff. As a result, prison regimes have had to be curtailed and crowding is commonplace. Compounding these challenges, new threats to safer custody have emerged, such as the greater availability of new psychoactive substances and increased incidents of misbehaviour and violence.

"The tension between traditional prison policies and the new geriatric penal reality is also reflected in my frequent criticism of prisons for failing to balance security with humanity when using restraints on the terminally ill."

Prisons are resilient places, well used to crisis management, but the strains have been showing. Prisoners are, of course, at the sharp end of all this and should have legitimate outlets for their frustrations. It is now 25 years since Lord Woolf published his seminal report into the 1990 prison disturbances, in which he made clear that the ability to complain effectively is integral to a civilised prison system. He also made clear that an independent complaint adjudicator, such as my office, was key to the credibility of the complaint process. With prisoner litigation curtailed by reductions in legal aid, the importance of being able to complain to the Ombudsman, is perhaps more important than ever.

The result has been an increase in my complaint caseload. In 2014–15, the overall number of complaints rose 2%, but, more significantly, eligible cases accepted for investigation increased by 13%. Not only were there more complaints investigated,

but there was also an increase in the proportion of complaints upheld in favour of the complainant, because the authorities had got things wrong (39% in 2014–15, compared to 34% in 2013–14). Rather than any change in my office's approach, this is more likely to have been an indicator of the strains in the system.

> “... the ability to complain effectively is integral to a civilised prison system.”

The types of complaint I am called upon to investigate vary year to year, although property complaints consistently predominate. Last year, there were more complaints about regime issues and transfers, which was predictable at a time of cutbacks and crowding. Less easy to explain were reductions in complaints about adjudications, although these are quite technical issues which might previously have involved legal aided lawyers advising prisoners how to complain to us. Perhaps of greatest concern was the 23% increase in complaints about staff behaviour, including allegations of assault and bullying. It is indicative of the seriousness of some of these complaints that, in 17 cases, we recommended a disciplinary investigation.[2]

Almost all my recommendations (99%) were accepted. While this is no more than I would expect, evidence of effective implementation is harder to gauge. My colleagues in the Prisons Inspectorate now routinely inspect progress on improvements called for in my fatal incident investigations, but they report that results are variable. There are also examples of some improvements that I have called for, even in basic decency, being currently unaffordable. For example, I recently upheld a complaint about the lack of toilet screening in some single cells, which left prisoners with no privacy from passing prisoners or male and female staff. The chief executive of the National Offender Management Service accepted the recommendation 'in principle' but said it was currently unaffordable. He agreed to keep the position under review.

At least I am able to report that my staff have responded well to the increasing demands. In 2014–15, not only were almost all draft fatal incident reports on time (97%, compared to only 15% in 2010–11), but we also eradicated a substantial historic backlog of complaints which has enabled a gradual improvement in complaint timeliness. These improvements have been achieved by changing the way we work, for example by being more proportionate and declining to investigate more minor complaints so we can focus on more serious cases, and – of course – by the sheer hard work of my staff. The consequence has been a better service, evidenced by improved satisfaction rates in our stakeholder and complainant surveys.

There is much more to do, but we are well placed to deliver on our vision of supporting improvement in safety and fairness in prisons, immigration detention and probation, even at this particularly challenging time.

[2] Two further recommendations for disciplinary action were made in fatal incident investigations.

## Learning lessons

A key part of this drive to support improvement is my office's growing agenda of learning lessons publications. These build on the analysis and recommendations in individual investigations to look thematically and more broadly at areas for improvement. Given inevitable concern over self-inflicted deaths in prison, five of this year's seven publications focused on this area. These included reviews of how to improve risk assessment and suicide prevention procedures; a study of why self-inflicted deaths increased by so many in 2013–14; and two learning lessons bulletins on self-inflicted deaths among prisoners aged 18–24 and of self-inflicted deaths among Travellers.

"A key part of this drive to support improvement is my office's growing agenda of learning lessons publications."

Learning was also identified from my busy prisoner complaint caseload. One review explored the difficulties that prisoners reported in maintaining family ties and what lessons might be learned to avoid legitimate complaints in future. Another publication explored why some groups of prisoners, for example women and children, rarely complain to my office and what might be done to ensure that all prisoners have equal access.

However, trying to influence and support improvement when services are under strain is difficult and requires innovation. In a new departure, my office last year held a series of learning lessons seminars for managers from some 50 prisons to discuss learning from my investigations into self-inflicted deaths, natural cause deaths and complaints. These events were well received and will be repeated.

## Enhancing independence

It is disappointing that I conclude this introduction without being able to report progress on the repeated Ministerial commitments to place my office on a statutory footing. As the Harris report recently argued, this would buttress my office's actual and perceived independence. I will continue to press the case for this change.

Nevertheless, the independence of mind of my staff and I should not be in any doubt. Indeed, the commitment to contribute robustly and impartially to improving safety and fairness in custody and for those under probation supervision is visible throughout this report.

**Nigel Newcomen CBE**
Prisons and Probation Ombudsman
September 2015

# The year in figures

# Fatal incidents

- There were 250 deaths in 2014–15, 11 (**5%**) more than the year before. The increase was predominantly among adult male prisoners.
- There were **7** deaths in approved premises, a decrease from **11** last year.
- There was **1** self-inflicted death and **1** death from natural causes in the immigration removal estate.
- Continuing the trend of recent years, we began **15%** more investigations into deaths from natural causes (**155** deaths). This appears to be a consequence of rising numbers of older prisoners; on average the people who died of natural causes were **58** years old, compared to **37** years old for all other deaths.
- There were **76** self-inflicted deaths. This is a welcome decrease (**16%**) from 2013–14, but remains high relative to recent years.
- We were notified of **4** apparent homicides, the same number as the previous year.
- A further **7** deaths were classified as 'other non-natural' and **8** await classification.
- We issued **245** draft reports and **253** final reports, compared to **224** and **258** last year. Our new website has an improved search feature for anonymous reports and during 2014–15 we added **419** reports.
- Despite the increased numbers of deaths we continued to improve our timeliness, with **97%** of our draft reports issued in time compared to **92%** last year. We also improved our performance for final reports, **57%** of which were in time compared to **43%** last year.
- The average time taken to produce a natural cause death draft report was **18** weeks and **25** weeks for other cases, including self-inflicted deaths (compared to **20** and **27** weeks in 2013–14).
- In the 2014 stakeholder survey, **9** out of **10** stakeholders rated the overall quality of the PPO's work to be satisfactory or better.

## Draft reports issued

**245**
2014–15

**224**
2013–14

## Draft reports issued in time

**97%**
2014–15

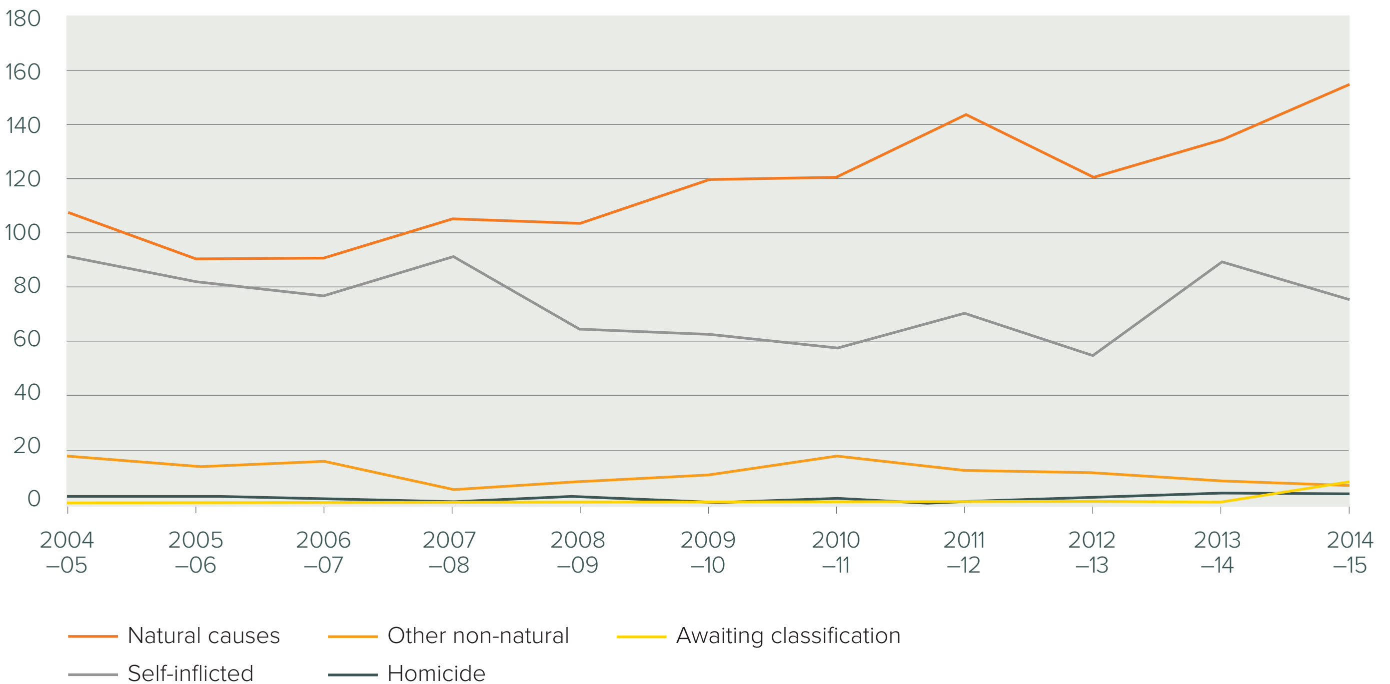
**92%**
2013–14

## Total deaths

**250**
2014–15

**239**
2013–14

## Fatal incident investigations



# Complaints

- We received **4,964** complaints in 2014–15, a **2%** increase on the previous year.
- However, cases actually accepted for investigation increased by **13%** on the previous year. In 2014–15, we started **2,380** investigations, compared to **2,111** the year before.
- Most (**92%**) of the complaints received were about prisons.
- We received **318** complaints about probation, **15%** less than last year and there was also a **6%** decline in complaints from immigration detention (with just **62** received this year).
- Overall, we completed **2,159** investigations, an **11%** improvement compared to 2013–14.
- Complaints about lost, damaged and confiscated property made up **28%** of these investigations. The next most common complaint categories were issues about administration[3] (**9%**) and adjudications (**7%**).
- We found in favour of the complainant in **39%** (**851**) of our cases, compared to **34%** the previous year.
- Complaints from the high security estate accounted for **27%** of the completed investigations in prison. This represents **3** complaints per **100** prisoners, compared to **1** complaint per **100** prisoners outside high security prisons.
- Complaints from high security prisons were also slightly less likely to be upheld: we found in favour of the complainant in **36%** of cases compared to **41%** in other prisons.
- This year we improved the time taken to investigate: **34%** of cases were completed within 12 weeks of being allocated to an investigator, compared to **29%** last year. Overall, the average time taken from assessment to the end of the investigation was **25** weeks, **1** week shorter than in 2013–14.

[3] The administration category is about the processes and records of the prison or other establishment. The complaints include problems with record keeping, reports about prisoners, the complaints system, sentence calculation, and other similar procedural issues.

- In 2014–15, we focused on clearing a backlog of complaint investigations from previous years. In April 2014, there were **692** cases which had been waiting over 12 weeks, compared to **490** cases in April 2015.
- However, we completed fewer eligibility assessments within our target of 10 working days of receiving the complaint. Previously, **64%** were completed in time but just **28%** this year. On average it took 21 days to assess whether a complaint was eligible for investigation.
- Faced with an increase in complaints, and an increase in the number accepted for investigation, we have had to focus our resources more tightly. We accepted **2,380** complaints for investigation this year, but we also declined to investigate **441** complaints, under Paragraph 15 of our Terms of Reference, because they did not raise a substantive issue, or no worthwhile outcome was likely.
- Our survey of complainants showed some improvements in satisfaction. However, this remains closely tied to the outcome of the complaint.

## Complaints received

**4,964** 2014–15

**4,879** 2013–14

## Investigations started

**2,380** 2014–15

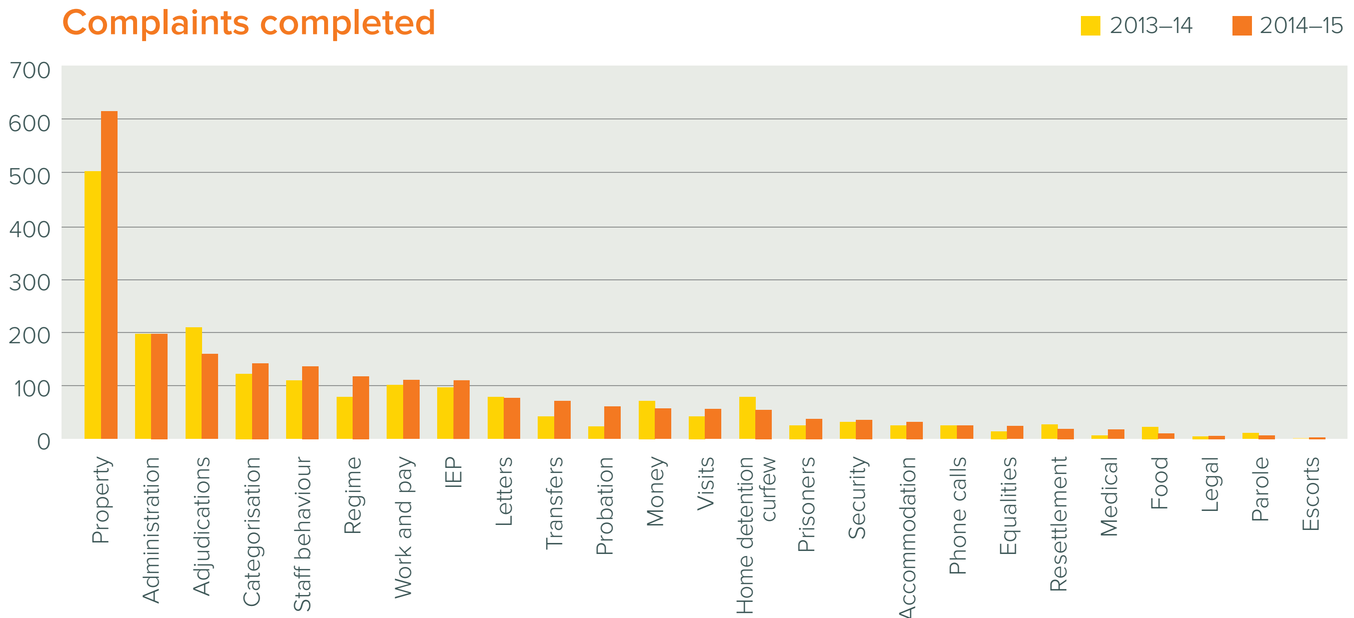
**2,111** 2013–14

## Investigations completed

**2,159** 2014–15

**1,941** 2013–14

## Complaints completed



# Investigating fatal incidents

# Learning lessons about fatal incidents

Our publications this year have focused on learning lessons from self-inflicted deaths in prison, following the significant rise in such deaths in the previous year. In April 2014, we published two thematic reports that looked at identifying risk of self-harm and suicide, and the management of prisoners in crisis. We found that, when assessing risk, prison staff often placed too much weight on how the prisoner seemed, or 'presented', rather than on indicators of known risk, even when there had been recent acts of self-harm. The second report looked at prisoners, who at the time of their deaths were being managed under ACCT, the prison suicide and self-harm prevention procedures. We judged that the ACCT process was not correctly implemented in half the cases.

In August 2014, we published a learning lessons bulletin on self-inflicted deaths among 18–24-year-olds in prison and submitted this to the Harris Review. We explored themes of bullying, antisocial behaviour, the assessment and management of risk, disruption caused by transfers, mental ill health and problems faced by young foreign national prisoners. We concluded that managing risk, treating mental health and responding to poor behaviour needed to be better integrated to ensure a balanced and consistent approach to young adult prisoners at risk.

In January, we published a bulletin on the increased prevalence of physical ill health and self-inflicted deaths among Gypsies and Travellers, who are also believed to be over-represented among the prison population. Only a small number of our fatal incident investigations identified the deceased as a Traveller. We concluded that prisons needed to improve their recording of these ethnicities and be aware of their increased risk of suicide, as well as being alert to the possibility of Travellers being bullied. Literacy among prisoners is generally low and is even lower for Travellers, with research indicating that over half the population of Travellers in prison have serious problems with literacy. Not being able to read and write is a huge barrier to accessing information and taking part in prison life and the bulletin found that more support is needed for illiterate prisoners to access health and other services in prison.

> “We found that, when assessing risk, prison staff often placed too much weight on how the prisoner seemed, or 'presented'.”

At the end of the reporting year we published a review of learning from 84 of the 89 investigations into self-inflicted deaths in 2013–14. There was no simple, well-evidenced explanation as to why self-inflicted deaths increased so sharply, so quickly. However, we found those who died in 2013–14 were more likely than the year before to have been in their first month of custody, but less likely to have been convicted or charged with violent offences. We raised many familiar issues, including inadequate risk assessment in prison receptions, weak implementation of ACCT for those at risk, and delays in emergency responses. We also saw a number of deaths of vulnerable men in segregation units, of men subject to restraining orders and of men using hard to detect new psychoactive substances.

In the autumn, we held two learning seminars for operational staff on fatal incident investigations. One looked at risk assessment and management of prisoners in crisis, while the other focused on end-of-life care. The chief executive of the National Offender Management Service provided a response at the first seminar and a deputy director of custody did so at the second. Delegates discussed their experiences with their colleagues, questioned our investigators, and shared examples of the approach at their prisons. The slides from the sessions are available on our website.

“We also saw a number of deaths of vulnerable men in segregation units, of men subject to restraining orders and of men using hard to detect new psychoactive substances.”

# Individual investigations: self-inflicted deaths

In 2014–15, we began investigations into 76 self-inflicted deaths, a decrease of 16% on 2013–14, but still substantively higher than 2012–13, when there were 55. In the 2013–14 Annual Report, we identified several areas, which we considered the Prison Service needed to improve, to help prevent suicide and self-harm. These areas have also emerged from our thematic research and, sadly, they have remained a feature of our investigations into self-inflicted deaths throughout this year.

## Early days in custody – first night, reception and induction

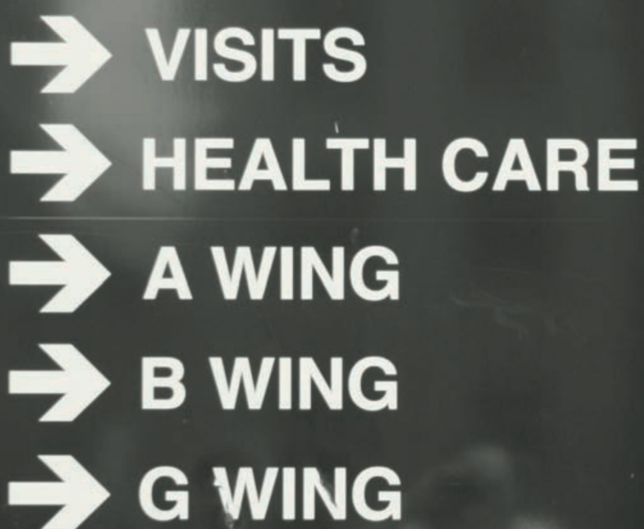
The first days in custody are often a particularly difficult time for prisoners. Reception, first night and induction processes have all been introduced to help identify and reduce the risk of prisoners harming or killing themselves. However, we remain concerned about the number of prisoners who kill themselves shortly after arriving in prison. Often these prisoners have obvious factors that indicate they are at heightened risk of suicide and self-harm, yet prison staff fail to recognise them.

“

… we remain concerned about the number of prisoners who kill themselves shortly after arriving in prison.”

Mr A was charged with rape. He was a young man, had not been to prison before and faced possible deportation. Reception staff did not identity that these were risk factors for suicide and self-harm and did not consider beginning ACCT procedures. Instead, they accepted Mr A's assurances that he would not harm himself. Staff offered him vulnerable prisoner status for his own protection because of his offence and he eventually accepted. However, this actually made matters worse and meant that Mr A could not have any interaction with other prisoners in the prison's first night centre. He was locked in his cell on his own without support during the evening. He was not allowed to take a shower to help him feel better, and not allowed to call his family because staff misunderstood public protection procedures. Staff did not put any additional measures in place to support him. Mr A was found hanged in his cell in the first night centre, six hours after arriving in prison.

We found that staff in reception had not appropriately considered Mr A's risk factors, including his youth, offence and lack of experience of prison. Staff accepted his assurances that he was fine. Several members of staff said they had not received ACCT training for years, and they seemed unsure about how to assess risk. Because he was regarded as vulnerable to attack from other prisoners, Mr A was isolated and did not have the facilities available to other prisoners in the first night centre, including the opportunity to shower or use a telephone, which can help newly arrived prisoners settle. Officers did not understand the public protection guidance and incorrectly denied Mr A the opportunity to phone his mother, when he was anxious to speak to her. No one identified that this isolation further increased his risk.




Mr B was 17 years old when he was convicted of murder. After his conviction, he returned to the young offenders institution (YOI), where he had been held on remand. Staff at the YOI had intended he should go back there after he was sentenced and transfer from the juvenile to the young adult part of the YOI, because he had turned 18 between the time he was convicted and sentenced, but there was no effective transition planning. Because of communication failures by the agencies involved, Mr B was taken to an adult prison on the day he was sentenced. He had just received a long sentence for a heinous offence, which had attracted a lot of publicity, he was new to the adult prison environment, had a history of mental health problems and had previously self-harmed. Court staff were concerned about him and completed a suicide and self-harm warning form, they even telephoned the prison to alert them to his risk. Despite all of these risk factors, reception staff at the prison did not begin ACCT procedures to help safeguard Mr B. Mr B was identified as being at risk from the general prison population and classed as a vulnerable prisoner. However, the vulnerable prisoner unit was full and he was placed on a wing where he could not mix with the other prisoners. He received little or no support from officers, had very little time out of his cell and did not have any time in the open air. Five days after he arrived at the prison, he was found hanged in his cell.

Mr B should not have been taken to the adult prison, and we made several recommendations about the process that led him to be there. However, the prison owed Mr B a duty of care which, in the short time he was there, it did not fulfil. Reception staff missed obvious risk factors when he arrived and did not act on the warnings they had been given. Despite his obvious vulnerability, he was effectively kept in isolation, without the safeguards that would have been applied if he had been formally segregated. He had no meaningful interaction or support from staff and, contrary to Prison Rules, did not even have the opportunity to spend any time in the open air during this time.

“Several members of staff said they had not received ACCT training for years, and they seemed unsure about how to assess risk.”

## Assessment of risk

Throughout the year, we continued to investigate a number of deaths where we found that the staff had not assessed the level of a prisoner’s risk appropriately and had not opened ACCT procedures when it appeared appropriate. On occasions, prison reception staff, in particular, put too much emphasis on the prisoner’s presentation, rather than fully taking into account known risk factors.

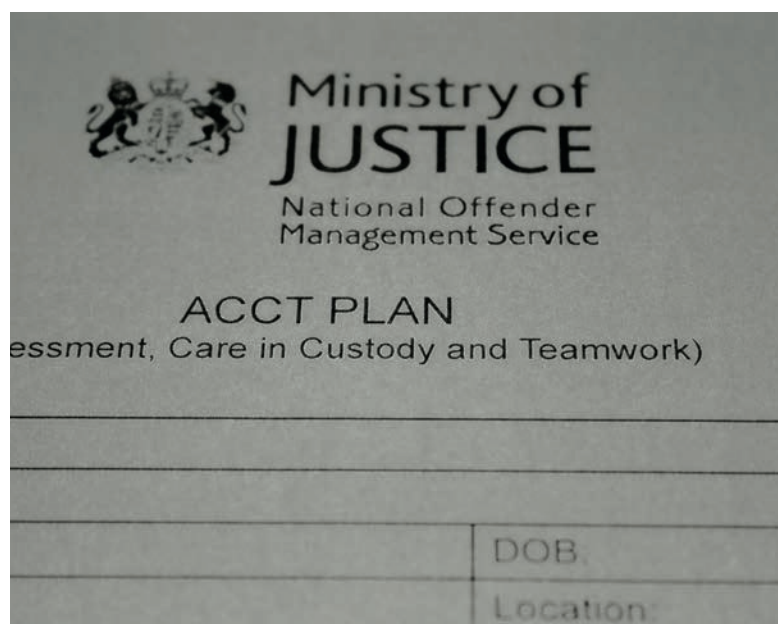
Mr C was suicidal because of marital problems and had been briefly detained under the Mental Health Act as a risk to himself. Afterwards, he set fire to his home, apparently intending to kill himself, and was charged with arson. Mr C had never been to prison before. Court staff had completed a suicide and self-harm warning form drawing attention to his risk. Despite all these risk factors, reception staff were reassured by how he appeared and did not begin ACCT procedures. A prison GP later read his community medical record, which identified his risks but also did not begin ACCT procedures. After nine days in prison, Mr C wrote a strange letter apologising to the fire service, which prompted a nurse to make a mental health referral, which was not marked as urgent. After two weeks in prison, Mr C was served with an order preventing him from contacting his wife. Two days later at court, he was convicted of arson and learned that he could expect a lengthy sentence and would not be allowed to have any contact with his daughter. No one regarded him as at risk of suicide and he hanged himself two days later.

Mr D was arrested for committing sexual offences against a family member. While in police custody, Mr D expressed suicidal thoughts, which staff noted in his police medical record. This document accompanied him to the prison, but poor reception processes meant that the reception nurse never saw it. The reception supervising officer saw the police medical record but did not read it properly and was reassured by Mr D's mood. None of the reception staff fully considered Mr D's risk factors and nobody began ACCT procedures. The next day, an offender supervisor saw the police medical record but assumed this information had already been considered. Sometime during the night, six days after he had arrived at the prison, Mr D suffocated himself with a plastic bag. He was not found until lunchtime because the officer who unlocked him that morning did not check on his welfare. Although Mr D had died, the emergency response was disorganised and healthcare staff tried to resuscitate him without removing the bag from his head.

In both these cases, we found that staff had given too much weight to the prisoner's presentation and had not fully taken into account their known risk factors, such as their offences or mental health history. We recommended that staff should be given clear guidance about procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them.

## ACCT

When officers identify that a prisoner is at risk of suicide and self-harm, they should be managed under ACCT procedures. However, in many cases, we found that staff did not follow national guidance and did not complete ACCT procedures properly, which meant that prisoners did not receive appropriate support. Our ACCT thematic report identified where lessons could be learned, including improving ACCT caremaps, identifying triggers, taking a multi-disciplinary approach and ensuring that staff are appropriately trained. We continued to encounter problems in all these areas during our investigations this year.



Mr E was 18 when he arrived in custody for the first time, charged with a serious sexual offence. He had a history of mental health problems, and had recently taken an overdose after his father had committed suicide. Staff identified that he was at risk of suicide and opened an ACCT. However, the caremap did not mention his bereavement issues or his age. The issues staff did identify were not adequately addressed. Staff did not record observations as directed, there were frequent changes in case management, and Mr E's level of risk was assessed inappropriately as low, just a day after he had said he was having suicidal thoughts. He asked a member of staff to hold an ad-hoc review and the officer closed the ACCT at that review. The caremap actions had not been completed and the review was not multi-disciplinary. Mr E was found hanging the next day.

Mr F was remanded in custody charged with a serious offence against a former partner. He had a history of depression and had previously attempted suicide. Staff identified that he was at risk of suicide and self-harm when he arrived and opened an ACCT. They closed this ACCT when they considered he was no longer at risk. Staff opened a further three ACCTs while Mr F was at the prison. The final ACCT was closed without any healthcare staff present, and before caremap actions designed to reduce his risk were completed. He was not on an ACCT when he was found hanging.

In both these cases, we found that staff did not operate the ACCT documents in line with national instructions. Reviews were often not multi-disciplinary, caremap actions did not always address the most pressing risks, or were not always completed before the ACCTs were closed, which are mandatory requirements of the ACCT process. The assessed level of risk of suicide and self-harm did not always reflect the current evidence, and observations were not always done as they should have been. Sadly, we have found many similar examples during the year when staff did not follow mandatory procedures or did not offer an appropriate level of support in line with the prisoner's risk of harm.

## Mental health

Our review of self-inflicted deaths in 2013–14, found that too often prisoners died before referrals for mental health assessment or treatment could be acted upon. We also found that there was little continuity in mental healthcare from the community into prison. Such changes can be difficult for prisoners who are already vulnerable and at heightened risk of suicide and self-harm. There were similar issues in deaths we investigated this year. Many of the prisoners whose cases we have used in this report had extensive mental health issues, which were often not considered in a holistic way.

“Many of the prisoners whose cases we have used in this report had extensive mental health issues, which were often not considered in a holistic way.”

Ms G was remanded to prison after her arrest for arson and criminal damage. It was her first time in prison. She had a long history of mental health problems and had been an inpatient in hospital. Ms G was impulsive and unpredictable and had threatened violence towards staff and other patients in mental health settings. She suffered from paranoia, sometimes heard voices and had a diagnosis of emotionally unstable personality disorder. She often self-harmed by tying ligatures around her neck, by cutting herself and taking overdoses of medication. When she arrived in prison, healthcare staff began ACCT procedures and admitted her to the prison's inpatient unit. Despite a complex and extensive history of mental health problems, healthcare staff did not refer Ms G to a consultant psychiatrist, although she had been under a psychiatrist's care in the community. Over the next few days, she tried to harm herself five times using different methods. On her fourth evening in prison, Ms G threw a cup of hot water at an officer. The next day, prison staff took her to the segregation unit to face a charge of assault. Prisoners should not be segregated if they are potentially suicidal or being assessed for a transfer to a secure mental health unit, (Ms G was due for an assessment later that day). Although both of these caveats applied to Ms G, members of the mental health team found her fit for segregation. A manager did not hold an ACCT review after Ms G relocated to the segregation unit, as should have happened. Twenty-five minutes after her disciplinary hearing for the assault charge, which was adjourned, an officer found her with a plastic bag over her head. Staff could not resuscitate her.

In Ms G's case, we found that staff did not assess her mental health needs appropriately and, as a result, did not take these into consideration when making decisions about her location or treatment. The inpatient unit was principally run by prison staff rather than mental health nurses, who had little input. We identified that the prison needed to improve communication, information sharing and planning between healthcare staff, specialists and uniformed staff about women's care and their risks. We were concerned that Ms G was segregated although she was being managed under suicide and self-harm prevention procedures and was waiting for an imminent assessment to determine whether she should go to a secure mental health unit. There were also a number of shortcomings in the ACCT procedures. We recommended that women with complex and long-standing mental health issues should have a named care coordinator and be referred immediately to the mental health in-reach team and a psychiatrist for an urgent assessment when they arrive at the prison. We also recommended that there should be sufficient mental health staff in the inpatient unit.

## Segregation

We have continued to investigate a number of deaths of prisoners in segregation units, including some where the prisoners, such as Ms G, were being managed under ACCT procedures. Prison Service Instructions recognise that there are a disproportionately high number of self-inflicted deaths in segregation units. The Instructions require that prisoners on an ACCT should only be segregated when they are such a risk to others that no other suitable location is appropriate and then only in exceptional circumstances. We are concerned that too many prisoners identified as at risk of suicide and self-harm are segregated without exceptional reasons. We are also concerned that some prisoners are kept in segregation units too long, resulting in a deterioration in their mental health. The following case study is an example of the effect this can have on a prisoner, especially one already at a heightened risk of suicide and self-harm.

Mr H suffered from Asperger Syndrome and mild learning disabilities. He was recalled to prison for a breach of the conditions of his licence. He had previously self-harmed in the community and in prison, and had tried to hang himself after being told he could not have contact with his son. Officers opened an ACCT, but this was closed immediately after he moved to another prison. Three months later, Mr H told a mental health nurse that he felt under threat from other prisoners and he wanted to go to the segregation unit for his own protection. He moved that day. An investigation found no evidence of the threat, but Mr H refused to move from the segregation unit. He remained there for over three months until staff recognised that his mental health had deteriorated and moved him to the healthcare unit. Staff opened an ACCT and assessed him as high risk of suicide, but a week later he was found hanged in his cell.

We were concerned that Mr H remained in the segregation unit for over three months without the activity he needed to distract him. He said that going to the gym had helped him cope with prison in the past, but he was not allowed to attend because of his situation. There was no evidence of any coherent plan to help him reintegrate back to a standard wing or to give him any meaningful occupation, other than a television. This led to a severe deterioration in his mental health. Staff also did not take into account when managing him, the fact that Mr H had Asperger Syndrome and learning disabilities.

Mr I had a long history of offending and substance misuse problems. Several months after being remanded to prison, Mr I told his cellmate that he was in debt to another prisoner. The prisoner was pressuring him to throw lines of material over the prison wall to bring contraband items into the prison to pay off the debt. Mr I and his cellmate did not tell staff about this. Some weeks later, officers found Mr I and another prisoner in an interview room. There was a line of material hanging from the window and Mr I tried to conceal another one in his trousers. Mr I appeared distressed. The officers took him to the segregation unit but did not tell staff there about his distressed reaction. Mr I protested about the condition of his cell and being segregated, and cut his wrist. He said he would smash up his cell and hurt or kill himself. The supervising officer in charge of the segregation unit decided to remove the furniture from the cell and give him tear-resistant clothing and a blanket. Staff opened an ACCT but did not complete it properly. Mr I covered the observation panel in his cell door. Officers did not remove it and CCTV footage showed that they did not check him properly. Less than four hours after Mr I had been taken to the segregation unit, an officer found him hanging in his cell.

The investigation found that managers and staff in the segregation unit had little awareness of national instructions designed to safeguard segregated prisoners. They did not hold an enhanced case review, as they should have done when Mr I was given alternative clothing. The staff did not know that prisoners in special accommodation, such as Mr I, should be checked at least five times an hour. We were concerned that staff interpreted Mr I's distress solely as aggression and that they did not properly consider that he might be vulnerable. We were so concerned about the lack of knowledge of staff and managers working in the segregation unit that we recommended that the Deputy Director of Custody for the area should satisfy himself of its safe operation.

> "The investigation found that managers and staff in the segregation unit had little awareness of national instructions designed to safeguard segregated prisoners."

## Bullying

Bullying and debt continue to feature in a number of our investigations into self-inflicted deaths in prisons. In particular, we were concerned about the availability of illicit substances, which not only increase the risk of suicide and self-harm in themselves, but can also lead to a culture of bullying and debt, which leaves some prisoners especially vulnerable. Too often, we find that prisons do not identify these concerns, or take appropriate action to address them.

Mr J had a history of self-harm and mental health problems. He told staff that he often harmed himself because of a lack of external support, money issues and to prevent prison transfers. Prison staff usually regarded his behaviour as manipulative. Mr J had a substantial amount of private money in his prison account and several intelligence reports noted that large sums of money were being transferred from his account (£4,000 in five months) suggesting the possibility that he was being bullied. However, no one investigated. Two months before his death, he was taken to hospital after swallowing a razor blade. He told an officer he was being bullied but the officer took no action. Two subsequent security reports indicated that Mr J was distressed about being bullied and being forced by other prisoners to transfer money to them. There was no further investigation or action taken before Mr J was found hanged in his cell. At the time of his death, he had less than £250 left in his account.

Although the prison had a number of intelligence reports highlighting the unusual activity on Mr J's account, and that he was being bullied, no one investigated this properly. Mr J was managed under ACCT procedures but staff did not adequately assess whether Mr J harmed himself because he was being bullied or link these incidents. We recommended that the prison take a coordinated approach to intelligence handling. Mr J lived in the prison's wing for vulnerable prisoners and we were concerned that not all the prisoners allocated there were suitable for the environment, and therefore a risk to other prisoners. We recommended that allegations of bullying should be thoroughly investigated and victims protected.

In another case, Mr K was recalled to prison after breaching his licence conditions. After six weeks, he was due to move prisons. When he was leaving the first prison, officers found a quantity of mamba (a new psychoactive substance) which Mr K said he had been given to pass to a prisoner at the second prison. After arriving at the second prison, he said that he was threatened when he could not produce the drugs. Other prisoners demanded £500 from him. Eight days later, an officer found him trying to hang himself. Mr K said he was worried about being attacked because of his debt. Officers moved him to a different wing. Mr K continued to say that he was being threatened about debts, and officers submitted nine security or violence reduction incident reports about his fears, and he moved cells six times. A week before his death, Mr K said he was frightened for his life and wanted to move to another wing, but this was not dealt with properly and staff did not speak to the prisoners that Mr K named. He later told his offender supervisor that he was being threatened all around the prison and was scared to leave the wing. Mr K told his father that he was frightened, but safer custody staff did not take any action. Two days later, he was found hanging in his cell.

We did not consider that Mr K was appropriately supported after he first tried to kill himself. We were concerned that staff assessed his risk as low the day after this serious suicide attempt and closed suicide and self-harm support measures too soon. We were concerned that Mr K's allegations of bullying were not fully investigated. The prison's response to the threats was inadequate and failed to protect Mr K. No one identified that his situation increased his risk of suicide and self-harm although he had previously tried to kill himself after being bullied in prison.

"We recommended that allegations of bullying should be thoroughly investigated and victims protected."

# Individual investigations: natural causes

Investigations into deaths from natural causes continue to make up the majority of fatal incident investigations. In 2014–15, we started investigations into 155 deaths attributed to natural causes, 15% more than in 2013–14. With an ever-increasing older prisoner population, these numbers are likely to continue to rise. Deaths from natural causes in prisons usually do not attract as much attention as self-inflicted deaths. However, it is equally important to explain what happened to their families, and assure them, where possible, that their family member received an appropriate standard of care.

“

… the quality of end-of-life care in prison appears to be improving.”

Commendably, in most of the deaths we investigated, our clinical reviewers judged that the standard of healthcare was equivalent to that which the prisoner might have expected to receive in the community. In particular, the quality of end-of-life care in prison appears to be improving. However, provision remains variable and, occasionally, unacceptable. We also continued to find too many cases where seriously ill and immobile prisoners were restrained without adequate justification, when they were no longer a risk of escape or risk to the public. It is also disappointing that there remain occasions when prison staff do not follow national guidelines that say an ambulance should be called immediately in a life-threatening situation.

## Poor care

Mr L became ill after his arrest and spent four days in hospital. He was then remanded to prison. He told a reception nurse that he had a history of a duodenal ulcer and had no usable main arteries in either leg. A doctor did not examine him when he arrived. The next day, an officer found Mr L collapsed in his cell. He was taken by ambulance to hospital but was discharged after tests. A hospital doctor said there was no evidence of a perforated duodenal ulcer. The nurse gave Mr L paracetamol and booked a GP appointment. The next day, Mr L did not collect his meals and said he felt unwell. No one from the healthcare team saw him. That night, Mr L set fire to his cell. Officers put out the fire and took him from the cell. Mr L asked for help and to go to hospital but as he appeared to have no ill effects from the fire, officers put him in another cell. Mr L asked staff for medication three times in the night but they did not call a nurse and told him to wait until the morning. Mr L was due to go to court the next day and a nurse assessed him as fit to attend court, but did not see or examine him. In the morning, Mr L said he was not well enough to go to court and he fell on the floor. Officers carried him to a holding room, and forcibly changed his clothes before taking him to the escort van. With his legs dragged behind him, the officers forced him into a cellular compartment on the van.

An escort officer was concerned about Mr L's appearance and insisted a nurse examine Mr L before they left for court. The nurse found Mr L slumped on the floor and could not find any signs of life. Paramedics and hospital staff were unable to resuscitate him. A post-mortem found that he had died from peritonitis caused by a perforated duodenal ulcer.

We found that healthcare and other staff at the prison missed several opportunities to identify that Mr L was unwell. In particular, staff should have ensured that he received medical treatment in the hours after he set fire to his cell, when he had asked for help. We were critical of the process to assess prisoners' fitness to attend court. Overall, we found that the standard of care given to Mr L fell far short of that he could have expected in the community. In particular, we were seriously concerned that officers had used an unjustified, and therefore unlawful, level of force on the morning of his death when they dragged Mr L to the escort van. We recommended a disciplinary investigation.

## Delays in diagnosis

Mr M was sentenced to three months imprisonment. When he arrived, he told a nurse that he was dependent on alcohol and drugs. The nurse noted he looked jaundiced and unwell. Although staff prescribed medication for his drug issues, no one considered the cause of his jaundice, which can be a symptom of liver problems. Mr M did not have a secondary health screen, which should be offered to all prisoners within a week of arrival, to allow a more in-depth assessment. Twelve days later, Mr M became ill. A doctor examined him and intended that Mr M should go to hospital as an emergency, but this did not happen. Mr M was taken to hospital later that day but died two weeks later from liver failure.

The clinical reviewer concluded that the care Mr M received in prison was not equivalent to that he could have expected to receive in the community. The prison did not offer him a full health assessment as part of the standard screening procedure to ensure continuity of care, and healthcare staff did not address his immediate health needs when it was evident that he had jaundice. It was also a concern that he was not taken to hospital as an emergency when he became ill.

## Delays in calling an ambulance

In 2013, after repeated PPO recommendations, the Prison Service issued a new Instruction for staff setting out their responsibilities in emergencies. This includes clear directions on when staff should call an emergency medical code, resulting in an ambulance being called immediately. Unfortunately, we continue to find that staff fail to follow these instructions when responding to emergencies, in all types of fatal incidents. In one prison, we repeated the same recommendation – that the governor should ensure that staff understand and follow the national instructions – in seven consecutive investigations before comprehensive changes, instructions and training were introduced. This pace of learning lessons is unacceptable.

Mr N had a history of heart disease and took medication to control his blood pressure and cholesterol. Two months after he moved prisons, an officer unlocking his cell found Mr N unresponsive with white liquid running down the side of his face. He immediately radioed a medical emergency. Other officers and a nurse arrived quickly, but the nurse had to ask for an ambulance to be called, as the control room had not called one automatically. Paramedics arrived and took Mr N to hospital, but he died that evening of a brain haemorrhage.

We were very concerned about the slow emergency response. Not only did the control room not call an ambulance automatically, it then took 10 minutes for the first paramedic to get from the prison gate to the cell, which is too long in an emergency.

Mr O had a number of chronic conditions including epilepsy, heart disease and high blood pressure. An officer unlocked Mr O's cell one morning and found him unresponsive. The officer did not call an emergency medical code but asked a nurse to assess Mr O. The nurse said that it looked as if Mr O was in a deep sleep and he would discuss with colleagues and come back later. Officers were unhappy with the nurse's assessment. Another prisoner, who was a trained nurse, told officers that he thought Mr O had suffered a stroke. The nurse told the orderly officer in charge of the prison that Mr O did not need an ambulance. Officers then asked another nurse to look at Mr O who decided that he needed to go to hospital immediately. He died in hospital from a stroke that evening.

While we do not know whether the delay affected the outcome for Mr O, the emergency response was very poor. The officer, who first found Mr O unresponsive, should have radioed an emergency medical code and the prison should have called an ambulance immediately. The nurse who first assessed Mr O should also have called an emergency code and his poor assessment led to a significant delay in the ambulance being called.

## Restraints

The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraint used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility.

A judgement in the High Court in 2007, made it clear that prison staff need to distinguish between the prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgement indicated that prison staff must take into account medical opinion about the prisoner's ability to escape and keep this under review as circumstances change. However, we continue to investigate deaths where prisons have not taken into account medical opinion or the prisoner's level of mobility as part of their risk assessments.

“… we continue to investigate deaths where prisons have not taken into account medical opinion or the prisoner's level of mobility as part of their risk assessments.”

Mr P had been in prison for 29 years. He had many chronic health problems, including rheumatoid arthritis, ischaemic heart disease, diabetes and obesity. He had a history of heart attacks, and had a defibrillator fitted to regulate his heartbeat. Mr P was often admitted to the prison's healthcare unit for closer monitoring and support. Shortly before his death, Mr P was taken to hospital after becoming acutely unwell. Doctors diagnosed a blood infection and Mr P's condition deteriorated significantly and he was immobile. He agreed that hospital staff should turn off his heart defibrillator, and should not resuscitate him if his heart or breathing stopped. Mr P was still chained to an officer when he died.

We found that prison staff had initially used restraints for Mr P after assessing that he was a high risk to the public, based on his index offences from 30 years earlier. Healthcare staff did not comment on how Mr P's illness impacted on his ability to escape, although they noted that his mobility was poor. Prison staff discussed the use of restraints in the hours leading to his death. The duty governor visited the hospital and discussed Mr P with the deputy governor, who in turn spoke to a senior manager in the Directorate of High Security Prisons. Despite Mr P's serious condition and lack of mobility, they decided that restraints should remain in place because nurses had said he was not close to death. We considered that this decision was not in accordance with the 2007 judgement; managers should have based their decision on his risk at the time and not his prognosis.

Mr Q had a history of drug misuse and hepatitis C. He had a series of blood tests, which showed he had poor liver function. One morning, a nurse examined Mr Q who had been vomiting during the night. A GP said he would see Mr Q after a sputum sample was tested. That afternoon, another prisoner found Mr Q collapsed in his cell. Officers called an emergency code, but the control room did not call an ambulance. Healthcare staff arrived and requested an ambulance at 2.10pm when Mr Q's condition deteriorated. Security staff assessed that an escort chain should be used to restrain Mr Q. Mr Q died in hospital the next day. He had been suffering from liver cancer and died from a variceal haemorrhage.

The clinical reviewer found that Mr Q's medical care was not satisfactory. We were also concerned that staff used restraints when Mr Q went to hospital for the final time. The assessment did not include any information about Mr Q's risk of escape and there was no healthcare input about Mr Q's condition or whether this would impact on his risk of escape, as the 2007 High Court judgement requires.

## Delays in telling the family when a prisoner is critically ill

Prison Rule 22 requires Governors to inform the prisoner's spouse or next of kin and 'any person who the prisoner may reasonably have asked should be informed' when a prisoner is seriously ill. Prison Service Instruction (PSI) 64/2011, Safer Custody, also requires that prisons should have arrangements to engage with the next of kin, or other nominated person, of prisoners who are either seriously or terminally ill.

Unfortunately, we continue to investigate cases where prisons have not contacted families as soon as they should have done. This sometimes means that prisoners' families do not have the opportunity to see their family member before they die.

Mr R was given a 26-week sentence for breach of licence. Almost immediately on arrival at the prison, he began to feel unwell. A doctor referred him to hospital as he thought he might have liver cancer. Some weeks later, staff were concerned that Mr R was dehydrated, emaciated, jaundiced and in pain. He went to hospital but his condition deteriorated and he died five days later. Although he was seriously ill when he went to hospital, no one contacted his next of kin until after his death.

We considered that the prison should have contacted Mr R's next of kin about his condition, at the very latest, when he went to hospital five days before his death. Staff had noted on a risk assessment that he had been given a terminal diagnosis, but officers considered that his hospital admission was routine. No one considered this again when Mr R deteriorated in hospital and this meant his next of kin did not get the chance to spend time with him before his death.

"Unfortunately, we continue to investigate cases where prisons have not contacted families as soon as they should have done."

## End-of-life care

Although our investigations have found cases where the standard of care has not been equivalent to that available in the community, we have also seen examples in prisons of very good end-of-life care for prisoners with terminal illnesses. As prisons continue to house more and more older prisoners, responsibilities in this area are likely to increase, and it is important that prisons understand what good end-of-life care is, and how they can implement it.

Mr S had several chronic health problems and developed dementia in prison. When staff noticed that his health had significantly deteriorated, he agreed to go to hospital and they made a prompt referral. Hospital tests showed that Mr S had widespread cancer and doctors estimated that he had up to six months to live. When he returned to prison, healthcare staff spoke to the hospital and a local hospice to ensure that they provided appropriate palliative care. A specialist nurse implemented an end-of-life care plan. Healthcare staff at the prison, who knew Mr S well, realised that the initial prognosis was unrealistic and Mr S only had days to live. Because he did not want to die in prison, staff arranged for him to transfer to an end-of-life care facility in the community, where he died a few hours later.

We found that Mr S's condition was well managed. He had appropriate care plans in place and prison healthcare staff worked well with community health care providers and Macmillan nurses to ensure that he received a good standard of care.

"it is important that prisons understand what good end-of-life care is, and how they can implement it."

Mr T was serving a life sentence but was not suitable for early release. He was diagnosed with terminal lung cancer and secondary cancers to his spine. The prison palliative care team was involved in informing both Mr T and his family of his diagnosis. Mr T's son was also a prisoner on the same wing as Mr T and Mr T wanted to remain living on the wing for as long as possible, which prison staff arranged. As his illness progressed he moved to the healthcare unit as an inpatient and staff agreed that his son could move to the cell next door to support him. When his condition became critical he moved to the palliative care suite, which had good facilities for end-of-life care. Mr T had a portable cell bell so he could summon help easily when he needed it. Staff again moved his son to the cell next door and he was able to help his father and be with him for most of the day and evening.

We found exemplary practice in Mr T's palliative care management. Nurses and GPs considered his pain management almost daily as part of effective care planning. Mr T received well-structured, evidence based, holistic care with specialist input from a palliative care specialist nurse and there was close communication with Macmillan Cancer Support services and the hospital palliative care team. There was good liaison with his family who were able to visit him at their request. His ex-wife attended hospital appointments with him and arrangements were made to allow his family to visit during the night if necessary, as he reached the end-of-life stage. The team appropriately discussed and addressed his palliative care needs with him and his son. There were regular multi-disciplinary meetings at which Mr T and his son were able to participate in decisions about his end-of-life care. There were no problems with attending hospital appointments and there was good communication between healthcare staff at the prison and hospital clinicians. Mr T died in the early hours of the morning, three months after his terminal diagnosis. His son was with him at the time.

We commended the high standard of end-of-life care Mr T received in prison. There was good communication between healthcare staff and hospital specialists, and good multi-disciplinary cooperation.

# Investigating complaints

# Learning lessons about complaints

In September, we published a learning lessons bulletin examining complaints from prisoners about maintaining their family ties, an important factor in helping rehabilitation. Prisons need to strike the right balance between maintaining security and allowing prisoners contact with their families, and we found that better adherence to Prison Service Instructions was required when making these decisions. For example, key information needs to be up-to-date, applications should be processed promptly, particularly regarding funerals, and responses should give as full an explanation as security allows. Finally, visit arrangements should accommodate, as far as possible, prisoners' different family circumstances.

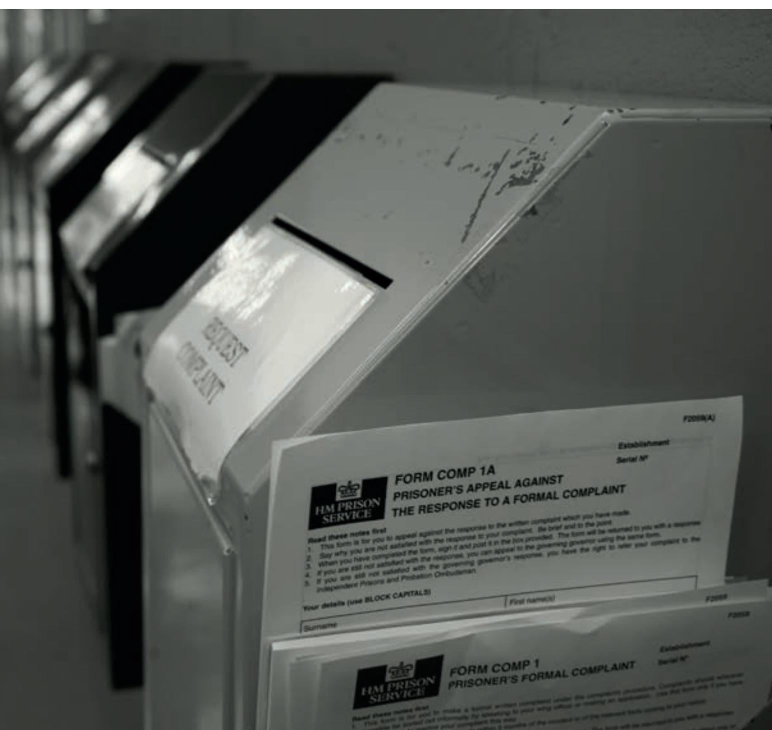
Given the make up of the prison population, it is not surprising that the majority of complaints to the Ombudsman come from adult male prisoners. However, the number we receive from women's prisons, young offender institutions and secure training centres is lower than would be expected from their proportions in the prison population. During the year, we held focus groups in these settings to ensure that the low levels of complaints were for legitimate reasons and not because of inappropriate barriers to accessing our services. We published a thematic report setting out our findings and the actions we are taking to improve our communications with women and young people.

In November 2014, we held a learning lessons seminar for operational staff looking at issues arising from the most common complaints – about prisoners' property – and the much smaller number of serious complaints about use of force by staff. We shared our learning and a Deputy Director of Custody gave a response from the National Offender Management Service (NOMS). Delegates discussed their experiences, questioned our investigators, and shared examples of their practice. The slides from the session are available on our website.

> "Prisons need to strike the right balance between maintaining security and allowing prisoners contact with their families ..."

# Individual complaints investigations

In 2014–15, we received 2% more complaints than the year before, but, more significantly, 13% more complaints were accepted for investigation. As in previous years, the majority of complaints (92%) were about prisons and covered a huge variety of subjects, ranging from relatively minor issues to serious allegations of misbehaviour by staff. We allocated more of our resources to the most serious complaints during the year. Nevertheless, we never forget that even apparently small matters can mean a lot to people in detention, and the importance of knowing there is someone independent to turn to when people feel they have been treated unfairly.




> “The majority of upheld complaints resulted in recommendations designed to achieve redress, or at least an apology, for the complainant.”

We upheld 39% of the complaints we investigated (compared with 34% in 2013–14 and 31% in 2012–13). The majority of upheld complaints resulted in recommendations designed to achieve redress, or at least an apology, for the complainant. However, individual complaints often highlight more widespread problems, and many of our recommendations were, therefore, designed to bring about more general improvements, either in individual establishments or at a national level. While we cannot require the services we investigate to accept recommendations, in practice nearly all are accepted and implemented.

## The internal complaints process

The ideal, of course, is for complaints to be resolved locally without needing to come to us. An effective and trusted local complaints system can act as an important pressure valve in prisons, particularly during a time of change and financial pressures. Unfortunately, we saw a worrying increase during the year in the number of complaints about local complaints handling. As in previous years, we received a number of complaints that could – and should – have been resolved locally (often by a simple apology) without ever needing to come to us. But we also saw an increase in cases where complainants had received very late or inadequate responses locally, including cases where respondents did not receive a substantive response at all. For example:

> Mr A complained that he had received the wrong medication. The prison initially sent him a holding response. When he heard nothing further, he submitted an appeal and was told that his complaint had unfortunately been overlooked and that the prison would now investigate what had happened. When he had still heard nothing after another month, he submitted a second appeal. He was told that staff had already answered his complaint twice and, if he wanted to pursue it, he should contact the Ombudsman.

We asked the prison for the outcome of their investigation into the mix-up over the medication. Despite chasing twice more, we did not receive a reply. We concluded from this that no investigation had been carried out. We recommended that the Governor apologise to Mr A for the unacceptably poor handling of his complaint and ensure that an investigation was carried out quickly. We also recommended that the Governor remind staff of the importance of providing full and prompt responses to prisoners' complaints and of providing information to my office on request. Our recommendations were accepted and we hope that these important lessons will have been learnt.

> "As in previous years, we received a number of complaints that could – and should – have been resolved locally (often by a simple apology) without ever needing to come to us."

## Prisoners' property

This office always receives a high number of complaints about property, reflecting a lot of poor practice in this area in prisons. Indeed, one of our thematic studies[4] illustrated that many of these complaints could be avoided if prison staff merely followed the procedures for handling prisoners' property and accepted responsibility when things go wrong. Unfortunately, lessons remain to be learned and 28% of all the complaints we investigated during the year were about property, half were upheld and many need never have come to this office. Although this is an area where we make a real difference for individuals, property complaints can be time-consuming to investigate and take up resources that could be better used on more serious issues.

> Mr B complained that all his property (clothes, toiletries, a CD player, family photos and books) went missing when he transferred from one prison to another. The sending prison told him that they had sent his property to his new prison about a fortnight after he had transferred and, if it had not arrived, he should complain to the company that had transported it.

> "... 28% of all the complaints we investigated during the year were about property, half were upheld and many need never have come to this office."

We found that there was no record of Mr B's property arriving at his new prison and that the sending prison did not have any records to show what they had done with it. We concluded that the sending prison was responsible for the loss and we recommended that Mr B receive compensation for the items he had lost (minus a sum for wear and tear). We also reminded the Governor that the prison had been responsible for safeguarding Mr B's property during the transfer, irrespective of whether they had contracted its transport out to a third party, and that they should not, therefore, have told him to complain to the contractors.

Mr B subsequently wrote to thank us. He said he had received the compensation shortly before he was released from prison and had put it towards a deposit on a rented flat. He hoped that having secure accommodation would help him to avoid re-offending in future.

Mr B's complaint was a genuine one, but, of course, this is not always the case. Some are false or involve over-inflated claims.

[4] PPO (2014) Learning Lessons from PPO Investigations: Prisoners' Property Complaints.

One such case was that of Mr C who complained that a large quantity of property (which he valued at nearly £1000) had gone missing during a transfer. We found that there was no evidence that Mr C had owned most of the items, apart from an extension lead which we were satisfied had been lost during the move. The prison agreed to our recommendation to replace the lead and the complaint was resolved.

Most property complaints affect one individual. The case of Mr D, however, raised a wider issue.

Instead of approaching this office, Mr D took legal action over a substantial amount of lost property and the prison had agreed, in an out-of-court settlement, to pay him compensation to enable him to replace what he had lost. The prison paid the money into Mr D's private cash account. Mr D then complained to us that he was not able to access this money to replace his lost property.

We found that under Prison Service policy prisoners are only allowed to make purchases from their spending accounts and are only allowed to add small amounts of money from their private cash account to their spends account each week (in line with their IEP level). As a result, Mr D was not able to use his compensation to replace his lost property quickly (which was what he wanted) but would have had to replace it bit by bit over a long period. Although the policy does allow for exceptional spending from the private cash account in exceptional circumstances, the prison had not exercised that discretion in Mr D's case.

We accept that there must be tight controls over the way prisoners can access and spend money. However, where the Prison Service pays compensation because it has lost a prisoner's property, the prisoner should be able to replace that property quickly and without fuss. We recommended that NOMS amend the policy to make it clear that prisoners should be allowed exceptionally to make use of compensation money to replace lost or damaged property. This was accepted and the Prison Service issued special guidance to Governors asking them to use their discretion in relation to compensation for lost or damaged property, while the policy was reviewed.

## Incentives and earned privileges

Under the new IEP arrangements there is a sharper distinction than before between the privileges at the different IEP levels, and a new requirement that prisoners cannot be placed on the Enhanced (highest) level unless they demonstrate commitment to reducing their risk of re-offending. It is not surprising, therefore, that there was a significant increase in complaints from prisoners about their IEP level. Some were straightforward cases of prisoners being downgraded by mistake when they transferred, but others questioned whether the downgrade was justified.

A typical case was that of Mr E who complained about being downgraded from Standard to Basic level. After investigating, we concluded that the decision to downgrade Mr E was not unreasonable in light of his poor behaviour. We were, however, concerned that there was no evidence that the proper procedures had been followed before he was downgraded – in particular, there was no evidence that the reasons had been explained to him, or that he had been given an opportunity to make representations at the time or told how to appeal against the decision. We recommended that the Governor remind staff of the importance of following procedures.

A case that raised more substantive issues was that of Mr F.

Mr F complained that he had been downgraded from Enhanced directly to Basic because he was maintaining his innocence. We found that Mr F had been convicted of serious sexual offences, which he denied. Mr F's behaviour in prison was very good and, before he was downgraded to Basic, he had been on the Enhanced IEP level for six years. He had completed all the work set in his sentence plan to reduce his risk, apart from the Sex Offenders Treatment Programme (SOTP) which he was unable to undertake because he denied that he had committed his offence.

The prison told us that they hoped that the downgrade to Basic would act as an incentive to Mr F to reduce his risk by accepting his guilt and undertaking the SOTP. They said it had worked with other prisoners in similar circumstances.

We accepted that the prison had acted with good intentions. However, we considered that PSI 30/2013 was contradictory and that it was not clear whether it had been intended that well-behaved prisoners, like Mr F, should be placed on the Basic IEP level solely because their denial of guilt meant they could not complete their sentence plan. We concluded that the downgrade from Enhanced to Basic (which involved a very significant drop in privileges) was too severe in Mr F's case and we were concerned that he could spend months or even years on a very basic regime. We recommended that he should be raised to Standard and that the Prison Service should review and amend the PSI. The recommendations were accepted.

## Regime

During the early part of the year prisons were making changes to staffing levels as part of the 'benchmarking' process. This was reflected in an increase in complaints about the prison regime. In a number of cases we found that prisoners were not receiving their minimum statutory entitlements, particularly in relation to exercise in the open air and library access. Following our recommendations, these entitlements were restored.

Mr G raised a different issue. He complained that his access to the gym had been restricted because he was unemployed. Under Prison Rules, adult prisoners must have the opportunity of at least one hour of physical exercise a week. Our investigation found that the weights session in the gym, which Mr G wanted to attend, was only open to prisoners who were working or in education. Unemployed prisoners, like Mr G, were, however, able to attend the gym for one and a half hours one day a week.

We were satisfied that Mr G was receiving the statutory minimum requirement and that it was reasonable for the prison to provide an incentive to work by restricting certain activities to employed prisoners. We did not, therefore, uphold the complaint.

## Links with the outside world

The year also saw a rise in complaints from prisoners who were unable to secure a transfer to a prison closer to home. This was disappointing as maintaining family contact while in prison reduces isolation and the pain of imprisonment for both prisoners and families, and can help to prevent prisoners re-offending on release. In the majority of cases, however, we were satisfied that prison staff were doing what they could in difficult circumstances to facilitate transfers as quickly as possible.

“

… maintaining family contact while in prison reduces isolation and the pain of imprisonment for both prisoners and families, and can help to prevent prisoners re-offending on release.”

An exception was the case of Mr H who complained that he was still waiting for a transfer to a Category C prison, a year after being re-categorised from B to C. Our investigation found that staff shortages and a breakdown in communication between staff had resulted in an unjustifiable delay of nine months in processing Mr H's transfer request. We, therefore, upheld Mr H's complaint, although we were satisfied that his transfer was being progressed by the time we became involved. We recommended that the Governor apologise to Mr H for the long delay and review local procedures and responsibilities to ensure the problems did not recur.

Visits and phone calls are both important ways in which prisoners can maintain their links with family and friends. It can be difficult at times for prison staff to strike the right balance between the potential benefits of maintaining family ties and the need to ensure security and public safety.

“

## It can be difficult at times for prison staff to strike the right balance between the potential benefits of maintaining family ties and the need to ensure security and public safety.”

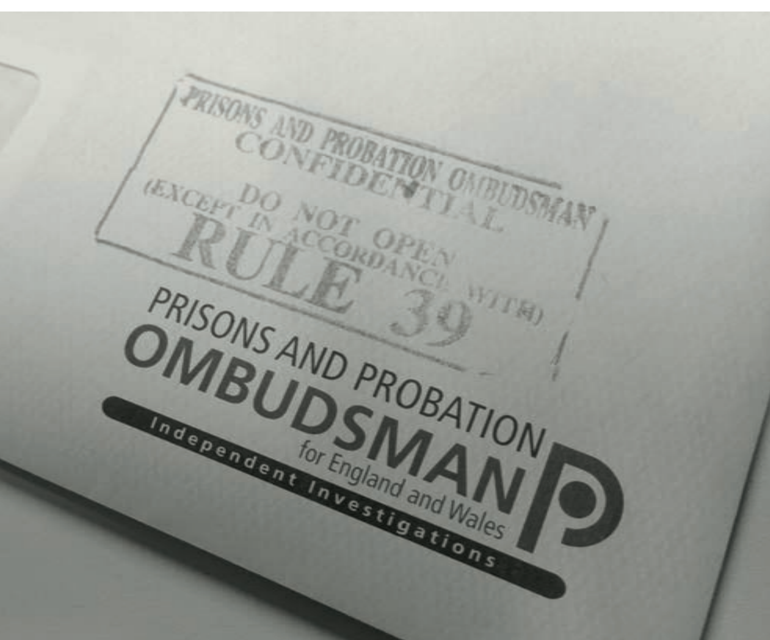
Mr I complained that his partner had been banned from visiting him and that he had been placed on closed visits, even though, he said, they had done nothing wrong.

When we investigated we found that there was strong intelligence and CCTV evidence (which we saw) that Mr I and his partner were involved in attempts to smuggle prohibited items into the prison. In the light of this, we were satisfied that the prison had not acted unreasonably in imposing closed visits on Mr I and a general visiting ban on his partner, and we did not uphold this part of Mr I’s complaint. However, Mr I had moved to a different prison a few months after he first complained and the closed visits and the ban on his partner were still in place there some months later. We were concerned that there was no evidence that the restrictions had been reviewed regularly at the new prison (as they should have been) and we recommended that the Governor put this right straightaway.

## Legally privileged mail

We have continued to receive complaints about another issue concerning contact with the outside world – the opening of legally privileged mail (generally known as Rule 39 mail). PSI 49/2011 (which covers prisoners' correspondence) provides that letters from solicitors and other privileged sources should not be opened or read by staff. If there is any doubt that the letter is from a privileged source, it must only be opened in the presence of the prisoner. If a Rule 39 letter is accidentally opened by prison staff (for example, because the source of the letter is unclear), a record must be made in the prisoner's correspondence log. We have continued to see many cases where these provisions had not been followed and where clearly marked Rule 39 mail had been opened by staff.

Mr J complained that large numbers of letters from his solicitors were being opened and read by the prison. The prison told him in reply that they processed a very large volume of mail and Rule 39 letters were sometimes opened by mistake. They said this should not happen and they apologised if it had. Mr J then complained to us saying that 'every second letter' from his solicitors was being opened. Our investigation found that one of Mr J's Rule 39 letters had been opened. We were satisfied that this had been a genuine error and that there was nothing to suggest that this was a widespread problem in Mr J's case, or at the prison generally. We recommended that the Governor send Mr J a written apology and remind the post room staff of the importance of checking letters carefully.




Although we receive a steady stream of complaints about the opening of Rule 39 mail year after year, it remains the case that we have not seen anything to suggest that this is being done deliberately – although we obviously remain alive to this possibility. It appears, rather, to be down to poor staff training and poor management. However, when we do identify recurrent problems at a particular prison, we generally recommend that the Governor commissions a review of mail processing.

## Adjudications

The number of complaints we investigated about adjudications dropped by 49 compared to the previous year. This may be because reductions in legal aid have made it harder for prisoners to get legal assistance with framing complaints to us.

When we consider complaints about adjudications, our role is not to rehear the evidence but to satisfy ourselves that the adjudicator followed the proper procedures, made sufficient inquiry into the prisoner's defence to ensure a fair hearing, and imposed a proportionate punishment. Some of the procedural failings we identified were relatively minor, but others amounted to fatal flaws that compromised the fairness of the adjudication and, in these cases, we recommended that the findings be quashed.

> "Some of the procedural failings we identified were relatively minor, but others amounted to fatal flaws that compromised the fairness of the adjudication …"

An example of a very poorly conducted adjudication involved Mr K, an immigration detainee being held in prison after serving a prison sentence. He was very distressed about his immigration status and climbed onto an overhead walkway with a noose around his neck. Immediately afterwards he was placed on suicide prevention arrangements (known as ACCT). He was also charged under the Prison Rules with being in a place where he was not authorised to be.

The adjudication took place the following morning and Mr K was found guilty after an extremely short hearing at which he admitted that he had gone onto the walkway. The adjudicator imposed a punishment which included 21 days cellular confinement and 28 days forfeiture of privileges including association, canteen and use of private cash, gym and television.

We found no evidence that the prison had considered whether it was appropriate to proceed with the charge when Mr K was on an ACCT, and no evidence that the adjudicator had confirmed with healthcare whether Mr K was fit to attend the hearing. The hearing itself was exceptionally brief by any standards. In this case, apart from being on an ACCT, Mr K had received no legal advice and did not speak English as a first language. He pleaded not guilty, but his defence – such as it was – raised serious doubts about whether he actually understood the charge or the adjudication process. There was nothing to suggest that the adjudicator had considered this.

In addition, the adjudicator failed to explore Mr K's defence adequately himself, and failed to explore Mr K's motivation or to consider for himself whether Mr K's behaviour should have been considered an act of attempted self-harm.

We concluded that the finding of guilt was unsafe and that the punishment was excessive. We upheld Mr K's complaint and recommended that the finding be quashed. We also recommended that the Governor remind adjudicators about the proper conduct of adjudications.

"Equality and diversity remains a priority area for the Ombudsman and complaints about these issues are taken very seriously."

## Equality and diversity

Equality and diversity remains a priority area for the Ombudsman and complaints about these issues are taken very seriously.

Mr L (who is black and a foreign national) complained that he had been dismissed from his job as a wing cleaner after a quantity of fermenting liquid ('hooch') was found in his cell. He said that a number of white British prisoners had been found in possession of hooch but had not been dismissed and that he had been the victim of discrimination.

A senior manager replied to Mr L's complaint. He accepted that not all prisoners found in possession of hooch had been dismissed from positions as wing workers, but said that there was no information to explain why they had been treated differently. He went on to say that there was no evidence of discrimination in Mr L's case.

As a wing cleaner, Mr L held a position of trust and we were satisfied that it was not unreasonable for him to have been summarily dismissed when he was found in possession of hooch. We did not, therefore, uphold this part of his complaint.

However, we were satisfied that Mr L had been treated differently and less favourably than a number of other prisoners after being found in possession of hooch. We, therefore, upheld this part of his complaint and recommended that Mr L receive an apology.

We also recommended that the Governor introduce equality and diversity monitoring of employment and dismissals and that the statistics should be regularly reviewed at a senior level.

An investigation had, at least, been carried out into Mr L's complaint. This was not typical of many of the complaints we saw claiming discrimination. In far too many cases, the prisoner was either given a bland assurance that there had been no discrimination, or this aspect of the complaint was ignored altogether.

One example was the case of Mr M who complained that managers were turning a blind eye to racist behaviour by other prisoners, by staff in general and by one officer in particular. We found that the Governor had himself taken a proactive role in the investigation of some of these complaints and had shown a genuine commitment to addressing racism. However, a number of the complaints had not been investigated at all and Mr M had simply been told that managers had full confidence in the staff concerned. We could, therefore, understand why Mr M believed that his complaints were not being taken seriously.

We recommended that the prison undertake an analysis of all complaints about discrimination received during a two-month period, with the help of staff from NOMS headquarters, and identify any action necessary to improve the handling of such complaints.

We also investigated a number of complaints about a failure to meet the requirements of prisoners with special needs. One example was this case:

Mr N is severely visually impaired. Following an assessment of his needs by social services, he was provided with a walking cane and a special lamp but was told that the recommended CD player for audio books could not be allowed on security grounds. When Mr N complained, the prison told him that they would investigate suitable alternatives. Mr N was willing to pay for a suitable machine himself. However, by the time we became involved six months later, he had heard nothing more, and despite repeated requests still did not have a CD player.

We were satisfied that the security concerns about the recommended machine were genuine. However, we found no evidence that anything had been done to identify a suitable alternative and we considered the delay in dealing with Mr N's requests had been unacceptable. We recommended that the Governor apologise to Mr N. We also recommended that the new prison where he had recently been transferred to should identify a suitable CD player as a matter of priority.

## Categorisation

Another frequent subject of complaints was security categorisation, although we received fewer complaints about this than in 2013–14. Most of these complaints were about being refused Category D status (and, therefore, not being considered suitable for an open prison) or about being re-categorised from D to C (and, therefore, being returned from an open prison back to a closed prison).

One such case was that of Mr O who complained about losing his Category D status and being transferred back to closed conditions. We found that there was security intelligence to suggest Mr O was involved in bringing drugs into the prison. In the light of that we were satisfied that the decision to re-categorise Mr O was not unreasonable. However, we also found that Mr O had not been given sufficient information to enable him to appeal against his re-categorisation and that the prison had not replied to his complaints. We made recommendations on both points.

## Security intelligence

The question of whether a prisoner or detainee has been given enough information to enable him to appeal arose in several contexts during the year. Particular problems can arise when a decision is made on the basis of security intelligence. Revealing that intelligence in full may put individuals or sources at risk and threaten security. Nevertheless, a balance needs to be struck between security and fairness, especially for those who are subject to the most serious restrictions on their liberty.

Mr P, a Category A prisoner, complained that he did not know why he had been segregated for three months. He had been told only that he was considered a risk to the good order and safety of the establishment. After discussion with the Prison Service, we were able to disclose sufficient information, consistent with security considerations, to enable Mr P to mount a meaningful appeal if he chose to do so.

We recommended that the Director of High Security Prisons ensure that this is done in future. We also recommended that prisoners in similar circumstances should be allowed hobby materials, following a risk assessment, to mitigate some of the negative effects of such a long period of segregation.

A different issue was raised by Mr Q who complained that the decision to maintain his Category A status was based on inaccurate security intelligence.

We obtained Mr Q's security file, which ran to nearly 1000 pages and covered 10 years. We were concerned that such a large file was difficult to manage and that decisions were being made about Mr Q on the basis of old intelligence that had little or no recent verification. We recommended that Mr Q's next categorisation review should be based on intelligence supported by recent examples.

"… a balance needs to be struck between security and fairness, especially for those who are subject to the most serious restrictions on their liberty."

## Decency

The organisations we investigate have always accepted the vast majority of the recommendations this office has made. One of the few exceptions this year involved the case of Mr R.

Mr R complained that there was no toilet screen in the single cells at his prison and that, as a result, staff of both sexes and passing prisoners could see him using the toilet. This was not the first time the issue has arisen but the relevant PSI (17/2012, certified prisoner accommodation) only requires that toilet screens are provided in double cells not single cells.

Having considered Mr R's complaint, we concluded that unscreened single cells do not afford an adequate level of decency in a modern prison system. In our view, the lack of toilet screening is inherently degrading for both prisoners and staff. Toilet screens (often in the form of a low-cost curtain) have been installed in single cells in other prisons, and even in parts of Mr R's prison, without compromising safety or security. We therefore upheld Mr R's complaint, but given the financial pressures, couched our recommendations in terms of a gradual programme of work, to install toilet screens in all single cells in Mr R's prison, within 12 months. We also recommended that NOMS should amend the PSI to require that toilet screens are installed in all single cells across the prison estate, for reasons of decency, and should commission a timetabled programme of work to achieve this.

> In our view, the lack of toilet screening is inherently degrading for both prisoners and staff."

The Chief Executive of NOMS said in response that he accepted the principle of installing toilet screening in single cells, but had concluded that it was not affordable in the current financial climate. He was, therefore, unable to accept the recommendations. This response was regrettable as it means that a degrading situation for prisoners and staff will continue for the foreseeable future, but we will ensure that NOMS is reminded of its commitment to keep matters under review.

## Staff behaviour

In 2013–14, we set up a special team to investigate serious complaints against staff. In 2014–15, we investigated 134 complaints about staff behaviour towards prisoners and immigration detainees, 25 more cases than the previous year.

One such case was that of Mr S.

Mr S, a prisoner in his late 50s complained that staff had assaulted him in the segregation unit for no reason. Staff justified the use of force, either on the grounds that Mr S had been aggressive, or on the grounds that he had refused an order to return to his cell, or both. To investigate we watched the CCTV footage of the incident, read the accounts staff had written at the time and interviewed Mr S and the staff involved. We found that the CCTV did not support the officers' accounts that Mr S had behaved aggressively before force was used. There was no sound track on the CCTV footage so we could not say whether or not Mr S had been given an order to return to his cell. However, if he was, it was clear from the CCTV that he would have had no time even to begin complying with it before he was restrained and taken to the floor. In addition, we were satisfied that failure to obey would not have justified this use of force as Mr S posed no risk of harm at this point. We also found that, while Mr S was on the floor, excessive and unnecessary force was used on him, even though it was clear from the CCTV that he was not struggling or being aggressive.

We concluded that the use of force on Mr S had not been necessary, reasonable or proportionate. We recommended that the Governor initiate a disciplinary investigation into the actions of three of the officers involved and of a manager who watched without intervening.

We also found serious failings in the way the prison responded after the incident. For example, although Mr S complained of injuries immediately after the use of force, no arrangements were made for him to be examined by a doctor until two weeks after the incident; his repeated written requests to report the incident to the police were not actioned; and he had to wait seven months before his repeated requests for copies of the officers' statements were met. It was difficult to avoid the conclusion that the prison had been deliberately obstructive.

Given the serious nature of Mr S's complaint, the prison should have commissioned a formal investigation. Instead, Mr S's complaint was initially simply dismissed without any investigation, and, when he persisted, there was an inadequate informal investigation: Mr S was not interviewed, no record was kept of whether the CCTV was viewed, what evidence was considered, or which members of staff were interviewed or what they said; and the key question of whether the use of force was reasonable, necessary and proportionate was not addressed. The prison's investigator concluded that the use of force had been justified.

We could not understand how anyone who had viewed the CCTV could have reached that conclusion. We could only think that it was because everyone involved – officers, managers and Governors – mistakenly believed that force is automatically justified if a prisoner refuses to obey an order, irrespective of context. PSO 1600 makes it clear that this is not the case. We found it extremely worrying that this misunderstanding appeared to have existed at all levels of the prison at that time and we made a number of recommendations designed to address this.

The prison accepted our findings and told us that significant changes had been made in the segregation unit since the incident with Mr S.

Our investigation into Mr S's case was greatly helped by the existence of the CCTV footage. In other cases, where the use of force has been planned, the incident will normally have been filmed with a hand-held DVD camera and there will be a sound track as well as visual evidence. We are also beginning to see evidence from cameras worn by staff in some situations. In such cases we can usually reach a clear conclusion about whether the use of force was justified or not – and, where it was not, we will generally recommend disciplinary action against staff.

In many cases, however, there is no CCTV or DVD footage and the only evidence is the different accounts given by the staff and the prisoner or detainee. This will not usually be sufficient for us to reach a conclusion about what happened or to uphold the complaint. However, we will still make recommendations for improvements in the way the prison responds to similar complaints in future if, as is often the case, there has been an inadequate internal investigation or the prisoner was not able to report the incident to the police.

## Complaints from female prisoners

Female prisoners made up around 5% of the total prison population, but accounted for only 2% of prison complaints received. During the year we held focus groups in women's prisons to try to understand this better.

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Female prisoners made up around 5% of the total prison population, but accounted for only 2% of prison complaints received.”

One unusual case was that of Ms T who complained that the prison was failing to protect her from bullying by other prisoners (who targeted her because of the nature of her offence). She wanted to be permanently segregated.

Our investigation found that, apart from being spat at, Ms T had not been physically assaulted and in that very important sense the prison had kept her safe. However, she had experienced bullying of a more subtle kind, in the form of verbal abuse, hostility and social ostracism. Although one incident had been investigated and action taken against the perpetrator, most of Ms T's concerns were not recorded or investigated, and staff seemed to have lacked the confidence to challenge low level bullying. There was no evidence of a formal support plan for her, either generally or at specific times (such as when she returned to normal location after spending nearly three months in the segregation unit at her own request).

We concluded that the prison had not done enough to protect Ms T from non-physical bullying and we partially upheld her complaint.

However, we did not agree with Ms T that segregation was the answer. Segregation for long periods is inevitably damaging, and should not be used unless there is no alternative – which was not the case here. In addition, segregation would make it more difficult for Ms T to address her offending behaviour and, so, to progress through her sentence. Since making her complaint,

Ms T had transferred to another prison where she felt safer and more supported. We were satisfied that this would enable her to address her offending behaviour in a supportive environment, and that it offered her the best opportunity to begin to form positive relationships with other prisoners. Although we recognised that this would be painful and uncomfortable for her at times, we took the view that it offered her a better long-term outcome than ignoring the issues in segregation.

"During the year we also investigated three complaints that unlawful force had been used on detainees in secure training centres (STCs)."

## Young people

We also received a disproportionately small number of complaints from young people – those aged 18 and under made up less than 1% of all complaints received. When young people did complain, property, adjudications, regime and staff behaviour were the most frequent topics. We also investigated some serious complaints.

Mr U complained that he had been subjected to two unnecessary full (strip) searches in a month. We were extremely concerned to find that there was virtually no documentation about these two searches. Strip searches are intrusive and unpleasant for both staff and prisoners, and perhaps particularly so for young people. Where they are not properly authorised and conducted they might also constitute an assault. For these reasons, it is vital that strip searches should be fully documented and that records should be retained securely. This did not happen in this case.

We did not consider that either search was justified and we also found that the searches were not carried out in line with national procedures. We recommended that Mr U receive a written apology. We also recommended that NOMS should amend the relevant PSI (8/2012, care and management of young people) to require establishments to document risk assessments leading to full searches, together with the searches themselves.

During the year we also investigated three complaints that unlawful force had been used on detainees in secure training centres (STCs). It was frustrating that these complaints were already very old by the time they reached us as this placed significant limits on our investigations and reduced the value of any recommendation we could make.

One of these cases was that of Mr V who was restrained on two occasions in 2007. We found that force was used on the first occasion to stop Mr V assaulting another detainee. We were satisfied that this was justified. However, we found that force was used on the second occasion, not to prevent harm but to maintain good order and control. This is not a lawful reason for the use of force in STCs. We also considered that the response of the Youth Justice Board's monitor was inadequate in failing to recognise, acknowledge and act upon this.

## Immigration detainees

Complaints from immigration detainees have always made up a small proportion of our caseload and the number dropped in 2014–15. We will be doing more to publicise our work in immigration removal centres (IRCs) in the coming year to ensure that as many detainees as possible are aware of our role.

The most frequent subject of complaint from immigration detainees was staff behaviour, and some complainants raised serious issues about the use of force.

Ms W complained that she was assaulted by escort staff and that her children suffered distress and injury during a failed attempt to remove them from the UK.

We found that Ms W and her children were escorted onto a commercial flight. Before take off, Ms W became distressed and attempted to leave the plane. We were satisfied that it was necessary and reasonable to use force to restrain her. However, we found that during the restraint Ms W bit one of the escort officers, causing injury. We found no evidence to support Ms W's complaints that the officers hit her hard in the chest, grabbed her by the throat, stopped her breathing by covering her mouth and beat her, or that they threw her to the ground when they left the plane. We did not, therefore, uphold the key elements of Ms W's complaint.

We did, however, find on the balance of probabilities, that one of the escorts briefly pulled Ms W's hair during the restraint, although we saw no evidence that Ms W suffered any injury as a result. We were also concerned that handcuffs were incorrectly applied on the plane. This could have resulted in significant injuries (although we were satisfied that it had not done so).

Although Ms W's children were naturally distressed by what happened on the plane, we were satisfied that they were not hurt and that staff had looked after them appropriately. We were, however, concerned that none of the staff had received specific child protection training. We were also concerned that there was no CCTV on the coach used to transport Ms W and her children to and from the airport.

The Home Office Professional Standards Unit[5] had investigated Ms W's complaints before she approached my office. We were satisfied that they had conducted a prompt and thorough investigation into Ms W's complaints and had reached fair and reasonable conclusions.

[5] Home Office Immigration Enforcement was formerly the UK Border Agency.

We made a number of recommendations, including that the Home Office should begin discussions with the most frequently used airlines about the use of body cameras by escort staff.

## Probation

Probation services went through a major re-organisation in 2014–15. The total number of complaints we received from probation supervisees in the community dropped by 15% during the year and we will be exploring the reasons for this. By contrast, there was an increase in the number of complaints about probation services from prisoners.

As in previous years, most of the complaints we received about probation were about the behaviour of the complainant's offender manager or about the content of reports written on the complainant, or both.

A different issue was raised by Ms X who complained about the community payback work she had been allocated to. One of the principles of community payback is that it must provide genuine benefit to members of the local community or disadvantaged people. Ms X complained that the work she had been required to do had benefitted private individuals rather than the wider community.

We were satisfied that one of the tasks Ms X had worked on – clearing a stream – had clearly benefitted the local community and, although a landowner had benefitted from the clearance of some of his land, this was minor and incidental. However, the other task – helping to cultivate allotments – was less clear-cut as at least some of the allotment holders went on to sell produce from their plots for a profit. We recommended that the community rehabilitation company (CRC) re-assess the work that was carried out on the allotments to ensure that it fully met the community payback criteria.

A more significant issue was raised by the case of Mr Y, a 65-year-old life sentence prisoner, who complained that several of his planned releases on temporary licence (ROTL) had been cancelled. Mr Y was seven years over a 20-year tariff and he was concerned that his inability to undertake ROTL was affecting his prospects for release.

We found that Mr Y had had a number of ROTLs cancelled at short notice because no places were available in approved premises hostels. Although we could not say what effect this might have had on his prospects for release, we upheld his complaint. We recognised that the probation trust had to give priority in the allocation of hostel places to offenders who had been released from prison, but were concerned that our investigation suggested that the approved premises estate in the area was at times not adequate for the needs of both those released from prison and those in need of ROTL. We recommended that the new National Probation Service undertake a review of approved premises in the area and, if necessary, develop a strategy to ensure that current and future demands can be met.

# Appendices

# Statistical tables

| Fatal incident investigations started | Total 2013/14 | % of total (13/14) | Total 2014/15 | % of total (14/15) | Change 13/14 – 14/15 | % change year on year |
|---|---|---|---|---|---|---|
| Natural | 135 | 56% | 155 | 62% | 20 | 15% |
| Self-inflicted | 90 | 38% | 76 | 30% | -14 | -16% |
| Other non-natural** | 9 | 4% | 7 | 3% | -2 | * |
| Homicide | 4 | 2% | 4 | 2% | 0 | * |
| Awaiting classification | 1 | 0% | 8 | 3% | 7 | * |
| **Total** | **239** | **100%** | **250** | **100%** | **11** | **5%** |

* The % changes in small numbers are not meaningful.

** Other non-natural includes investigations where post-mortem and toxicology reports have been unable to establish cause of death.

| Fatal incident investigations started | Total 2013/14 | % of total (13/14) | Total 2014/15 | % of total (14/15) | Change 13/14 – 14/15 | % change year on year |
|---|---|---|---|---|---|---|
| Male prisoners | 214 | 90% | 225 | 90% | 11 | 5% |
| Female prisoners | 6 | 3% | 10 | 4% | 4 | * |
| Young offenders (under 21) | 6 | 3% | 6 | 2% | 0 | * |
| Approved premises residents | 11 | 5% | 7 | 3% | -4 | -36% |
| IRC residents** | 2 | 1% | 2 | 1% | 0 | * |
| **Total** | **239** | **100%** | **250** | **100%** | **11** | **5%** |

* The % changes in small numbers are not meaningful.

** In 2013/14 one IRC resident was female. In 2014/15 one death was of a man held under immigration powers at The Verne, which was transitioning to an IRC.

| Fatal incident investigations started 2014/15 | Male prisoners | Female prisoners | Young offenders (under 21) | Approved premises residents | IRC residents** | Total |
|---|---|---|---|---|---|---|
| Natural | 143 | 7 | 0 | 4 | 1 | 155 |
| Self-inflicted | 66 | 2 | 6 | 1 | 1 | 76 |
| Other non-natural* | 6 | 0 | 0 | 1 | 0 | 7 |
| Homicide | 4 | 0 | 0 | 0 | 0 | 4 |
| Awaiting classification | 6 | 1 | 0 | 1 | 0 | 8 |
| **Total** | **225** | **10** | **6** | **7** | **2** | **250** |

* Other non-natural includes investigations where post-mortem and toxicology reports have been unable to establish cause of death.

** In 2013/14 one IRC resident was female. In 2014/15 one death was of a man held under immigration powers at The Verne which was transitioning to an IRC.

| Fatal incident reports issued | Total 2013/14 | % in time* | Total 2014/15 | % in time* | Change 13/14 – 14/15 | % change year on year |
|---|---|---|---|---|---|---|
| Draft reports | 224 | 92% | 245 | 97% | 21 | 9% |
| Final reports | 258 | 43% | 253 | 57% | -5 | -2% |
| Anonymised reports | 348 | | 419 | | 71 | 20% |

* In time for draft reports is 20 weeks for natural causes deaths and 26 weeks for all others (including those that are unclassified at the time of notification). In time for final reports is 12 weeks following the draft.

| Complaints received | Total 2013/14 | % of total (13/14) | Total 2014/15 | % of total (14/15) | Change 13/14–14/15 | % change year on year |
|---|---|---|---|---|---|---|
| Prison | 4438 | 91% | 4582 | 92% | 144 | 3% |
| Probation | 375 | 8% | 318 | 6% | -57 | -15% |
| Immigration detention | 66 | 1% | 62 | 1% | -4 | -6% |
| Secure training centre | 3 | 0% | 2 | <1% | -1 | * |
| Total | 4879 | 100% | 4964 | 100% | 85 | 2% |

* The % changes in small numbers are not meaningful.

| Complaints accepted for investigation | Total 2013/14 | % of total (13/14) | Total 2014/15 | % of total (14/15) | Change 13/14–14/15 | % change year on year |
|---|---|---|---|---|---|---|
| Prison | 2033 | 96% | 2310 | 97% | 277 | 14% |
| Probation | 46 | 2% | 37 | 2% | -9 | -20% |
| Immigration detention | 32 | 2% | 32 | 1% | 0 | 0% |
| Secure training centre | 3 | 0% | 1 | <1% | 2 | * |
| Total | 2111 | 100% | 2380 | 100% | 269 | 13% |

* The % changes in small numbers are not meaningful.

| Complaints investigations completed | Total 2013/14 | % of total (13/14) | Total 2014/15 | % of total (14/15) | Change 13/14–14/15 | % change year on year |
|---|---|---|---|---|---|---|
| Prison | 1881 | 97% | 2079 | 96% | 198 | 11% |
| Probation | 22 | 1% | 51 | 2% | 29 | 132% |
| Immigration detention | 38 | 2% | 29 | 1% | -9 | -24% |
| Total | 1941 | 100% | 2159 | 100% | 218 | 11% |

| Prison complainants 2014/15 (completed complaints) | Number of complainants | % of complainants | Number of complaints | % of complaints |
|---|---|---|---|---|
| Male prisoners | 1455 | 97% | 2026 | 97% |
| Female prisoners | 22 | 1% | 33 | 2% |
| Young offenders (under 21) | 18 | 1% | 20 | 1% |
| Total | 1495 | 100% | 2079 | 100% |

| Complaints completed per prison complainant (2014/15) | Number of complainants | % of complainants | Number of complaints | % of complaints |
|---|---|---|---|---|
| 11+ | 5 | 0% | 77 | 4% |
| 6 to 10 | 28 | 2% | 202 | 10% |
| 2 to 5 | 220 | 15% | 558 | 27% |
| 1 | 1242 | 83% | 1242 | 60% |
| Total | 1495 | 100% | 2079 | 100% |

## Prison fatal incident investigations started in 2014–2015

| Prisons | Natural | Self-inflicted | Other non-natural* | Homicide | Awaiting classification | Total |
|---|---|---|---|---|---|---|
| Wandsworth | 3 | 3 | 1 | 0 | 1 | 8 |
| Whatton | 8 | 0 | 0 | 0 | 0 | 8 |
| Elmley (Sheppey) | 3 | 3 | 1 | 0 | 0 | 7 |
| Hewell | 4 | 2 | 1 | 0 | 0 | 7 |
| Northumberland | 6 | 1 | 0 | 0 | 0 | 7 |
| Peterborough | 4 | 3 | 0 | 0 | 0 | 7 |
| Wymott | 7 | 0 | 0 | 0 | 0 | 7 |
| Altcourse | 3 | 1 | 1 | 1 | 0 | 6 |
| Leeds | 4 | 2 | 0 | 0 | 0 | 6 |
| Liverpool | 1 | 3 | 0 | 0 | 2 | 6 |
| Norwich | 5 | 1 | 0 | 0 | 0 | 6 |
| Preston | 3 | 3 | 0 | 0 | 0 | 6 |
| Doncaster | 2 | 2 | 0 | 1 | 0 | 5 |
| Exeter | 4 | 1 | 0 | 0 | 0 | 5 |
| Hull | 3 | 2 | 0 | 0 | 0 | 5 |
| Manchester | 5 | 0 | 0 | 0 | 0 | 5 |
| Parc | 3 | 2 | 0 | 0 | 0 | 5 |
| Winchester | 3 | 2 | 0 | 0 | 0 | 5 |
| Birmingham | 3 | 1 | 0 | 0 | 0 | 4 |
| Bristol | 2 | 2 | 0 | 0 | 0 | 4 |
| Holme House | 2 | 2 | 0 | 0 | 0 | 4 |
| Isle of Wight | 4 | 0 | 0 | 0 | 0 | 4 |
| Long Lartin | 1 | 3 | 0 | 0 | 0 | 4 |
| Risley | 2 | 2 | 0 | 0 | 0 | 4 |
| Usk and Prescoed | 4 | 0 | 0 | 0 | 0 | 4 |
| Wakefield | 3 | 1 | 0 | 0 | 0 | 4 |
| Woodhill | 1 | 3 | 0 | 0 | 0 | 4 |
| Channings Wood | 3 | 0 | 0 | 0 | 0 | 3 |

| Prisons | Natural | Self-inflicted | Other non-natural* | Homicide | Awaiting classification | Total |
|---|---|---|---|---|---|---|
| Dartmoor | 2 | 1 | 0 | 0 | 0 | 3 |
| Frankland | 2 | 1 | 0 | 0 | 0 | 3 |
| Full Sutton | 2 | 0 | 0 | 0 | 1 | 3 |
| Gartree | 3 | 0 | 0 | 0 | 0 | 3 |
| High Down | 3 | 0 | 0 | 0 | 0 | 3 |
| Highpoint | 1 | 2 | 0 | 0 | 0 | 3 |
| Leyhill | 3 | 0 | 0 | 0 | 0 | 3 |
| Moorland | 2 | 1 | 0 | 0 | 0 | 3 |
| Pentonville | 1 | 1 | 0 | 0 | 1 | 3 |
| Ranby | 1 | 2 | 0 | 0 | 0 | 3 |
| Swaleside (Sheppey) | 2 | 0 | 0 | 1 | 0 | 3 |
| Whitemoor | 2 | 1 | 0 | 0 | 0 | 3 |
| Bedford | 1 | 1 | 0 | 0 | 0 | 2 |
| Belmarsh | 2 | 0 | 0 | 0 | 0 | 2 |
| Brixton | 1 | 1 | 0 | 0 | 0 | 2 |
| Bure | 2 | 0 | 0 | 0 | 0 | 2 |
| Durham | 0 | 1 | 1 | 0 | 0 | 2 |
| Eastwood Park | 2 | 0 | 0 | 0 | 0 | 2 |
| Humber | 0 | 2 | 0 | 0 | 0 | 2 |
| Featherstone | 0 | 2 | 0 | 0 | 0 | 2 |
| Forest Bank | 2 | 0 | 0 | 0 | 0 | 2 |
| Glen Parva | 0 | 2 | 0 | 0 | 0 | 2 |
| Haverigg | 1 | 1 | 0 | 0 | 0 | 2 |
| Holloway | 1 | 1 | 0 | 0 | 0 | 2 |
| Leicester | 1 | 1 | 0 | 0 | 0 | 2 |
| Lewes | 2 | 0 | 0 | 0 | 0 | 2 |
| Nottingham | 1 | 1 | 0 | 0 | 0 | 2 |
| Rochester | 1 | 0 | 0 | 1 | 0 | 2 |

| Prisons | Natural | Self-inflicted | Other non-natural* | Homicide | Awaiting classification | Total |
|---|---|---|---|---|---|---|
| Stafford | 2 | 0 | 0 | 0 | 0 | 2 |
| Styal | 2 | 0 | 0 | 0 | 0 | 2 |
| Thameside | 1 | 0 | 0 | 0 | 1 | 2 |
| The Mount | 1 | 1 | 0 | 0 | 0 | 2 |
| Bronzefield | 1 | 0 | 0 | 0 | 0 | 1 |
| Bullingdon | 0 | 1 | 0 | 0 | 0 | 1 |
| Chelmsford | 0 | 1 | 0 | 0 | 0 | 1 |
| Dovegate | 1 | 0 | 0 | 0 | 0 | 1 |
| Drake Hall | 1 | 0 | 0 | 0 | 0 | 1 |
| Erlestoke | 0 | 0 | 1 | 0 | 0 | 1 |
| Ford | 1 | 0 | 0 | 0 | 0 | 1 |
| Foston Hall | 0 | 0 | 0 | 0 | 1 | 1 |
| Lincoln | 0 | 1 | 0 | 0 | 0 | 1 |
| Littlehey | 1 | 0 | 0 | 0 | 0 | 1 |
| North Sea Camp | 1 | 0 | 0 | 0 | 0 | 1 |

* Other non-natural includes investigations where post-mortem and toxicology reports have been unable to establish cause of death.

## IRC fatal incident investigations started in 2014–15

| IRCs | Natural | Self-inflicted | Other non-natural* | Homicide | Awaiting classification | Total |
|---|---|---|---|---|---|---|
| Morton Hall | 0 | 1 | 0 | 0 | 0 | 1 |
| The Verne** | 1 | 0 | 0 | 0 | 0 | 1 |

* Other non-natural includes investigations where post-mortem and toxicology reports have been unable to establish cause of death.

** At the time of the death The Verne was in transition from prison to IRC. The man was held under immigration powers.

## Approved premises fatal incident investigations started in 2014–2015

| Approved premises | Natural | Self-inflicted | Other non-natural* | Homicide | Awaiting classification | Total |
|---|---|---|---|---|---|---|
| Bowling Green | 1 | 1 | 0 | 0 | 0 | 2 |
| Ellison House | 0 | 0 | 0 | 0 | 1 | 1 |
| Howard House | 1 | 0 | 0 | 0 | 0 | 1 |
| Stonnall Road | 1 | 0 | 0 | 0 | 0 | 1 |
| Tulse Hill | 1 | 0 | 0 | 0 | 0 | 1 |
| Milton Keynes | 0 | 0 | 1 | 0 | 0 | 1 |

* Other non-natural includes investigations where post-mortem and toxicology reports have been unable to establish cause of death.

## Prison complaints completed 2014–2015

| Prison | Upheld | Not upheld | Total | Uphold rate* | Population** | Upheld complaints per 100 prisoners |
|---|---|---|---|---|---|---|
| Full Sutton | 37 | 86 | 123 | 30% | 592 | 6.3 |
| Frankland | 39 | 76 | 115 | 34% | 820 | 4.8 |
| Wakefield | 30 | 60 | 90 | 33% | 730 | 4.1 |
| Long Lartin | 25 | 48 | 73 | 34% | 621 | 4.0 |
| Whitemoor | 26 | 47 | 73 | 36% | 447 | 5.8 |
| Isle of Wight | 18 | 54 | 72 | 25% | 1070 | 1.7 |
| Gartree | 23 | 36 | 59 | 39% | 707 | 3.3 |
| Moorland | 18 | 30 | 48 | 38% | 994 | 1.8 |
| Lowdham Grange | 13 | 30 | 43 | 30% | 916 | 1.4 |
| Woodhill | 25 | 18 | 43 | 58% | 723 | 3.5 |
| The Mount | 13 | 26 | 39 | 33% | 882 | 1.5 |
| Oakwood | 15 | 21 | 36 | 42% | 1588 | 0.9 |
| Stocken | 12 | 24 | 36 | 33% | 837 | 1.4 |
| Whatton | 13 | 23 | 36 | 36% | 837 | 1.6 |
| Swaleside (Sheppey) | 15 | 19 | 34 | 44% | 1091 | 1.4 |
| Bure | 9 | 21 | 30 | 30% | 642 | 1.4 |
| Garth | 8 | 21 | 29 | 28% | 733 | 1.1 |
| Manchester | 12 | 17 | 29 | 41% | 1105 | 1.1 |
| Rye Hill | 10 | 19 | 29 | 34% | 622 | 1.6 |
| Highpoint | 9 | 19 | 28 | 32% | 1337 | 0.7 |
| Humber | 8 | 19 | 27 | 30% | 1029 | 0.8 |
| Hewell | 14 | 13 | 27 | 52% | 1253 | 1.1 |
| Doncaster | 9 | 17 | 26 | 35% | 1116 | 0.8 |
| Lindholme | 17 | 9 | 26 | 65% | 992 | 1.7 |
| Erlestoke | 8 | 17 | 25 | 32% | 516 | 1.6 |
| Littlehey | 16 | 9 | 25 | 64% | 1202 | 1.3 |

| Prison | Upheld | Not upheld | Total | Uphold rate* | Population** | Upheld complaints per 100 prisoners |
|---|---|---|---|---|---|---|
| Ranby | 10 | 15 | 25 | 40% | 1089 | 0.9 |
| Risley | 13 | 12 | 25 | 52% | 1105 | 1.2 |
| Dartmoor | 12 | 12 | 24 | 50% | 641 | 1.9 |
| Dovegate | 14 | 9 | 23 | 61% | 1103 | 1.3 |
| Channings Wood | 7 | 15 | 22 | 32% | 714 | 1.0 |
| Holme House | 7 | 15 | 22 | 32% | 1169 | 0.6 |
| Parc | 5 | 17 | 22 | 23% | 1512 | 0.3 |
| Wandsworth | 15 | 7 | 22 | 68% | 1634 | 0.9 |
| Bullingdon | 10 | 10 | 20 | 50% | 1102 | 0.9 |
| Northumberland | 9 | 11 | 20 | 45% | 1312 | 0.7 |
| Coldingley | 7 | 12 | 19 | | 515 | 1.4 |
| Wymott | 9 | 10 | 19 | | 1121 | 0.8 |
| Ashfield | 5 | 13 | 18 | | 391 | 1.3 |
| Elmley (Sheppey) | 12 | 6 | 18 | | 1086 | 1.1 |
| Liverpool | 2 | 15 | 17 | | 1160 | 0.2 |
| Rochester | 9 | 8 | 17 | | 721 | 1.2 |
| Wealstun | 8 | 9 | 17 | | 818 | 1.0 |
| Brixton | 9 | 7 | 16 | | 795 | 1.1 |
| Featherstone | 7 | 9 | 16 | | 676 | 1.0 |
| Guys Marsh | 5 | 10 | 15 | | 549 | 0.9 |
| Leicester | 7 | 8 | 15 | | 337 | 2.1 |
| Leyhill | 7 | 8 | 15 | | 475 | 1.5 |
| North Sea Camp | 6 | 9 | 15 | | 329 | 1.8 |
| Belmarsh | 5 | 9 | 14 | | 884 | 0.6 |
| High Down | 4 | 10 | 14 | | 1138 | 0.4 |
| Lincoln | 8 | 6 | 14 | | 592 | 1.4 |

| Prison | Upheld | Not upheld | Total | Uphold rate* | Population** | Upheld complaints per 100 prisoners |
|---|---|---|---|---|---|---|
| Maidstone | 5 | 9 | 14 | | 591 | 0.8 |
| Onley | 6 | 8 | 14 | | 739 | 0.8 |
| Sudbury | 9 | 5 | 14 | | 444 | 2.0 |
| Peterborough | 7 | 6 | 13 | | 1191 | 0.6 |
| Stafford | 5 | 8 | 13 | | 736 | 0.7 |
| Wayland | 5 | 8 | 13 | | 973 | 0.5 |
| Winchester | 5 | 8 | 13 | | 678 | 0.7 |
| Leeds | 9 | 3 | 12 | | 1207 | 0.7 |
| Nottingham | 6 | 6 | 12 | | 1043 | 0.6 |
| Pentonville | 6 | 6 | 12 | | 1311 | 0.5 |
| Altcourse | 2 | 9 | 11 | | 1108 | 0.2 |
| Forest Bank | 4 | 7 | 11 | | 1430 | 0.3 |
| Birmingham | 3 | 7 | 10 | | 1425 | 0.2 |
| Exeter | 7 | 3 | 10 | | 538 | 1.3 |
| Portland | 3 | 7 | 10 | | 525 | 0.6 |
| Stoke Heath | 4 | 6 | 10 | | 728 | 0.5 |
| Buckley Hall | 3 | 6 | 9 | | 445 | 0.7 |
| Foston Hall | 8 | 1 | 9 | | 286 | 2.8 |
| Hull | 4 | 5 | 9 | | 1024 | 0.4 |
| Kirkham | 2 | 7 | 9 | | 598 | 0.3 |
| Thameside | 7 | 2 | 9 | | 889 | 0.8 |
| Swansea | 0 | 8 | 8 | | 428 | 0.0 |
| Swinfen Hall | 3 | 5 | 8 | | 565 | 0.5 |
| Bedford | 3 | 4 | 7 | | 482 | 0.6 |
| Durham | 4 | 2 | 6 | | 949 | 0.4 |
| Huntercombe | 0 | 6 | 6 | | 419 | 0.0 |
| Isis | 2 | 4 | 6 | | 613 | 0.3 |

| Prison | Upheld | Not upheld | Total | Uphold rate* | Population** | Upheld complaints per 100 prisoners |
|---|---|---|---|---|---|---|
| Lewes | 5 | 1 | 6 | | 657 | 0.8 |
| Preston | 4 | 2 | 6 | | 676 | 0.6 |
| Wormwood Scrubs | 1 | 5 | 6 | | 1268 | 0.1 |
| Drake Hall | 1 | 4 | 5 | | 300 | 0.3 |
| Haverigg | 3 | 2 | 5 | | 625 | 0.5 |
| Kennet | 2 | 3 | 5 | | 234 | 0.9 |
| Standford Hill (Sheppey) | 4 | 1 | 5 | | 455 | 0.9 |
| Blantyre House | 2 | 2 | 4 | | *** | |
| Bristol | 2 | 2 | 4 | | 578 | 0.3 |
| Chelmsford | 1 | 3 | 4 | | 732 | 0.1 |
| Ford | 3 | 1 | 4 | | 514 | 0.6 |
| Norwich | 3 | 1 | 4 | | 763 | 0.4 |
| Aylesbury | 2 | 1 | 3 | | 394 | 0.5 |
| Blundeston | 2 | 1 | 3 | | *** | |
| Grendon / Springhill | 0 | 3 | 3 | | 538 | 0.0 |
| Hollesley Bay | 1 | 2 | 3 | | 351 | 0.3 |
| Holloway | 2 | 1 | 3 | | 527 | 0.4 |
| New Hall | 2 | 1 | 3 | | 356 | 0.6 |
| Cardiff | 2 | 0 | 2 | | 795 | 0.3 |
| Feltham | 1 | 1 | 2 | | 552 | 0.2 |
| Glen Parva | 1 | 1 | 2 | | 535 | 0.2 |
| Thorn Cross | 2 | 0 | 2 | | 332 | 0.6 |
| Warren Hill | 1 | 1 | 2 | | 124 | 0.8 |
| Brinsford | 1 | 0 | 1 | | 399 | 0.3 |
| Bronzefield | 0 | 1 | 1 | | 509 | 0.0 |

| Prison | Upheld | Not upheld | Total | Uphold rate* | Population** | Upheld complaints per 100 prisoners |
|---|---|---|---|---|---|---|
| Cookham Wood | 1 | 0 | 1 | | 168 | 0.6 |
| Downview | 0 | 1 | 1 | | *** | |
| East Sutton Park | 0 | 1 | 1 | | 92 | 0.0 |
| Hatfield | 0 | 1 | 1 | | 250 | 0.0 |
| Lancaster Farms | 1 | 0 | 1 | | 543 | 0.2 |
| Low Newton | 0 | 1 | 1 | | 266 | 0.0 |
| Send | 0 | 1 | 1 | | 275 | 0.0 |
| Styal | 0 | 1 | 1 | | 481 | 0.0 |
| Total | 826 | 1253 | 2079 | 40% | 82024 | 0.0 |

* Only given when 20 or more complaints were completed.

** Prison Population Bulletin – Monthly, March 2015.
https://www.gov.uk/government/statistics/prison-population-figures-2015

*** Blantyre House and Downview were both empty due to temporary closures. Blundeston closed in 2013.

## Probation complaints completed 2014–2015

| Probation | Upheld | Not upheld | Total | Uphold rate* |
|---|---|---|---|---|
| Wales | 4 | 5 | 9 | |
| South Yorkshire | 2 | 3 | 5 | |
| Greater Manchester | 1 | 2 | 3 | |
| Humberside | 0 | 3 | 3 | |
| Northamptonshire | 2 | 1 | 3 | |
| Hertfordshire | 1 | 1 | 2 | |
| Kent | 0 | 2 | 2 | |
| London Probation Area | 1 | 1 | 2 | |
| Surrey and Sussex | 1 | 1 | 2 | |

| Probation | Upheld | Not upheld | Total | Uphold rate* |
|---|---|---|---|---|
| West Mercia | 0 | 2 | 2 | |
| Wiltshire | 0 | 2 | 2 | |
| Avon and Somerset | 0 | 1 | 1 | |
| Cambridgeshire | 0 | 1 | 1 | |
| Cheshire | 0 | 1 | 1 | |
| Cumbria | 0 | 1 | 1 | |
| Dorset | 1 | 0 | 1 | |
| Durham Tees Valley | 1 | 0 | 1 | |
| Exeter | 0 | 1 | 1 | |
| Hampshire and Isle of Wight CRC | 1 | 0 | 1 | |
| Norfolk and Suffolk | 0 | 1 | 1 | |
| North East Area Office | 0 | 1 | 1 | |
| Northumbria | 0 | 1 | 1 | |
| Staffordshire and West Midlands CRC | 0 | 1 | 1 | |
| Thames Valley | 0 | 1 | 1 | |
| Thames Valley CRC | 0 | 1 | 1 | |
| Wales and Wessex Area Office | 1 | 0 | 1 | |
| West Yorkshire | 0 | 1 | 1 | |
| Total | 16 | 35 | 51 | 31% |

* Only given when 20 or more complaints were completed.

## Categories of complaints completed 2014–2015

| Complaint category | Upheld | Not upheld | Total | Uphold rate* |
|---|---|---|---|---|
| Property | 327 | 288 | 615 | 53% |
| Administration | 74 | 122 | 196 | 38% |
| Adjudications | 53 | 106 | 159 | 33% |
| Categorisation | 32 | 108 | 140 | 23% |
| Staff behaviour | 45 | 89 | 134 | 34% |
| Regime | 44 | 74 | 118 | 37% |
| Work and pay | 49 | 60 | 109 | 45% |
| IEP | 33 | 72 | 105 | 31% |
| Letters | 30 | 45 | 75 | 40% |
| Transfers | 9 | 61 | 70 | 13% |
| Probation | 18 | 41 | 59 | 31% |
| Money | 35 | 23 | 58 | 60% |
| Visits | 17 | 40 | 57 | 30% |
| HDC | 7 | 48 | 55 | 13% |
| Prisoners | 15 | 26 | 41 | 37% |
| Security | 11 | 27 | 38 | 29% |
| Accommodation | 9 | 23 | 32 | 28% |
| Phone calls | 11 | 12 | 23 | 48% |
| Equalities | 11 | 11 | 22 | 50% |
| Resettlement | 4 | 14 | 18 | |
| Medical | 6 | 9 | 15 | |
| Food | 7 | 3 | 10 | |
| Legal | 1 | 3 | 4 | |
| Parole | 1 | 3 | 4 | |
| Escorts | 2 | 0 | 2 | |
| Total | 851 | 1308 | 2159 | 39% |

* Only given when 20 or more complaints were completed.

# Financial data

| Finance | 2013/14 | % of total (13/14) | 2014/15 | % of total (14/15) | Change 13/14–14/15 | % change year on year |
|---|---|---|---|---|---|---|
| Budget allocation | £5,144,000 | | £5,524,000 | | £380,000 | 7% |
| Staffing costs | £4,695,365 | 92% | £5,156,991 | 93% | £461,626 | 10% |
| Non-staff costs | £388,433 | 8% | £376,727 | 7% | -£11,705 | -3% |
| Total spend | £5,083,798 | 100% | £5,533,718 | 100% | £449,920 | 9% |

# Recommendations

The Ombudsman's vision for the organisation is that his independent investigations should contribute to making custody and offender supervision safer and fairer. An important part of fulfilling this ambition is the making of influential recommendations for improvement.

We may make recommendations in both individual fatal incident and complaint investigations. These are nearly always accepted by the organisations concerned, who – in the case of fatal incident recommendations – are obliged to provide action plans and evidence the implementation of recommendations. In the few cases where a recommendation is rejected by the National Offender Management Service, the Chief Executive will write personally to the Ombudsman with his reasons.

HM Inspectorate of Prisons routinely follow up progress on the implementation of fatal incident investigations during their inspections. Discussions are also underway with IMBs about following up progress on the implementation of recommendations.

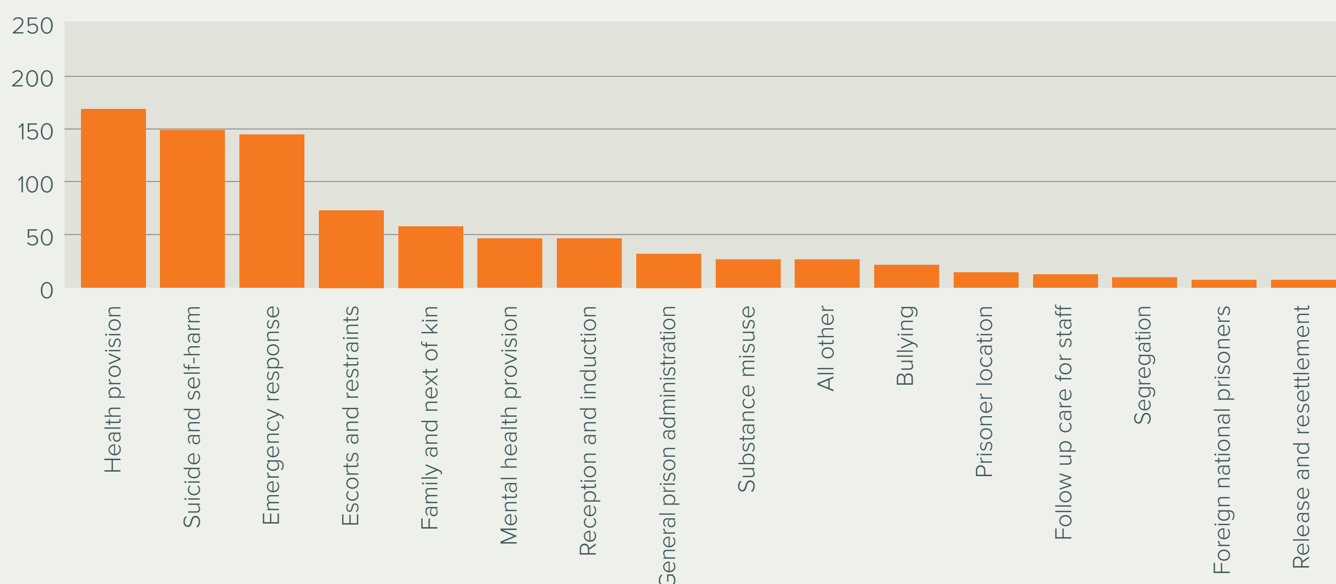
While our individual investigations provide transparency to those affected by a death and a means to obtain redress to those with a complaint, recommendations also have the potential to ensure that specific and broader national lessons are learned. This is also complemented by our Learning Lessons publications agenda.

In 2012, the Ombudsman issued instructions that recommendations should be prescriptive and clear about what is expected. In particular, they should be specific, measurable, realistic and time-bounded, with tangible outcomes. Also from 2012, all recommendations began to be collated in a single database. In July 2013, a thematic review, Making Recommendations, was published covering one year's recommendations and the themes emerging. This exercise is repeated annually and is now included as an annex to the annual report.

## Fatal incidents

- In 2014–15, we made 828 recommendations following deaths in custody. Almost all were accepted (818, 99%). Only eight were rejected (1%) and two are awaiting a response.
- There were three main issues that prompted recommendations: healthcare provision (20%), suicide and self-harm prevention (18%), and emergency response (17%).
- Healthcare recommendations covered a wide range of issues including: palliative care, continuity of care, accurate record keeping, health screening, timely diagnosis, referral and treatment.
- Recommendations relating to self-inflicted deaths related particularly to the quality of risk assessment, the adequacy of ACCT monitoring and reviews, and safer custody strategies.
- Emergency response recommendations focused on staff first aid response, use of emergency codes, calling and giving access to ambulances, and adequacy of emergency equipment.
- We recommended disciplinary action against staff twice (2%, included under 'all other' in the figure below).

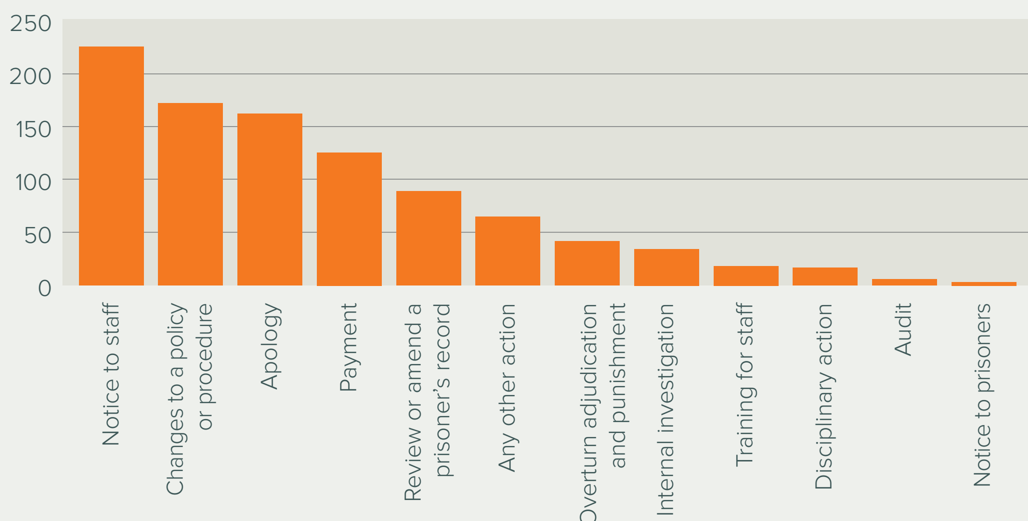
## Recommendations following deaths, by issue



## Complaints

- During 2014–15, we made 959 recommendations following investigations into complaints. Of these, just three were rejected, most (730, 76%) were accepted, and we are awaiting a response to the remaining 226 (24%).
- The most frequent recommendation (23%) was that a Governor or Director should issue a notice reminding staff to adhere to policy. The second most frequent (18%) was to make changes to an existing policy, or to introduce a new policy.
- 17% of recommendations required an apology to the complainant. Often a written apology was recommended alongside another action intended to ensure the issue which led to the complaint is not repeated.
- Recommendations to pay the complainant compensation were made in 13% of cases, predominantly because of lost or damaged property, or for underpayment of wages.
- In 17 cases (2%), a disciplinary investigation about staff behaviour was recommended. At other times – where incidents fell below the threshold for disciplinary action – we recommended that managers share our report and discuss our findings with specific employees.

### Recommendations following complaints, by action



# Stakeholder feedback

Feedback from stakeholders is essential to delivering a high quality service that is in line with our values of impartiality, respect, inclusiveness, dedication and integrity. Over the course of the year we have solicited feedback from complainants, bereaved families, institutional stakeholders, coroners and other stakeholder groups. Reports of the findings of the stakeholder surveys can be found on our website.

## General stakeholder survey

- Towards the end of 2014 we surveyed stakeholders across the prison, probation and immigration removal centre estates, as well as a range of other actors including HM Coroners, IMB members, and Inspectorate staff.
- We asked stakeholders to share their experiences of our investigations and publications over the last 12 months.
- We received 84 responses.
- All but one of the 19 respondents who were involved in a complaints investigation in both 2013 and 2014 felt that the time taken to complete the investigation had stayed the same or got quicker. All 23 respondents who had been involved in a fatal incident investigation in both years reported completion time had stayed the same or improved. This reflects the PPO's efforts to improve the timeliness of reporting.
- PPO publications were widely read. All three of the learning lessons thematic reports published in 2014 were seen by two-thirds or more of respondents, and four in five had read the annual report.
- More than nine in 10 stakeholders who had experience of the PPO in the last year rated the overall quality of the PPO's work to be satisfactory or better, with about six in 10 rating it as good or very good. Of the 39 respondents who had experienced the PPO in both 2013 and 2014, 37 felt that overall quality had stayed the same or improved.
- The PPO strives to ensure that all of the work that it conducts is professional, independent, accessible and influential. More than eight out of 10 stakeholders rated the PPO as 'quite' or 'very' for each of these characteristics.

## Complainants' survey

- Each month paper questionnaires are sent to a sample of people who have complained to the Ombudsman. We received 329 responses from 909 questionnaires (36%).
- The two most common sources of information about the PPO were other prisoners and Inside Time (the prisoner newspaper). Most had found it easy to get information about the PPO.
- Where a complaint was ineligible for investigation, 76% of complainants were able to recall the reason we had given as to why we could not investigate.
- Where complaints were eligible, 76% of complainants whose case was upheld felt we had provided them with the right amount of detail when we contacted them with the result. This fell to 48% when the complaint was not upheld.
- 73% of complainants felt the complaint had been treated seriously if it had been upheld, but this fell to 29% when it had not been.
- Satisfaction with the investigation and report was closely related to the outcome of the complaint but it was notable that compared to the previous year, there were improvements for not upheld complaints.
- We improved the overall scores for each of the measures of satisfaction for not upheld complaints and for two measures for upheld complaints (which were already much higher). For example, in 2013–14, 43% of complainants whose case was not upheld felt treated with respect, up from 33% previously.

## Bereaved families' survey

- A questionnaire is sent to bereaved families when they are sent the final version of the report into our fatal incident investigation. The data is analysed biennially and a report of the results of the 2013/14 – 2014/15 survey will be published in 2015.

## Post-investigation survey

- In early 2014, we began collecting feedback from the prison liaison officers, Governors, heads of healthcare and coroners at the end of each fatal incident investigation. The survey asks about their experience of the specific case. The results from the first year of the survey will be published in 2015.

# Learning lessons publications 2014–15

| Learning lessons publications | Title | Publication date |
|---|---|---|
| Learning from PPO investigations thematic report | Self-inflicted deaths of prisoners on ACCT | April 2014 |
| Learning from PPO investigations thematic report | Risk factors in self-inflicted deaths in prison | April 2014 |
| Learning lessons bulletin – Fatal incident Investigations, issue 6: | Young adult prisoners | August 2014 |
| Learning lessons bulletin – Complaint investigations, issue 5: | Maintaining family ties | September 2014 |
| Learning lessons bulletin – Fatal incident investigations, issue 7: | Deaths of Travellers in prison | January 2015 |
| Learning from PPO investigations thematic report | Self-inflicted deaths of prisoners – 2013/14 | March 2015 |
| Learning from PPO investigations thematic report | Why do women and young people in custody not make formal complaints? | March 2015 |

# Performance against business plan 2014–15

## **Objective 1:** Maintain and reinforce our reputation for absolute independence

| Key deliverable | Measure of success | Progress |
|---|---|---|
| 1. Work with the Ministry of Justice (MOJ) to secure a statutory footing for the PPO at the next legislative opportunity. | Consideration in the next relevant Bill with resultant change in law. | **Outstanding**<br>While Ministerial commitments remain to place the Ombudsman on a statutory footing, there was no legislative opportunity this financial year. |
| 2. Secure a review of the PPO's Terms of Reference (ToR) that enhances our independence and clarifies our remit and operational scope by end March 2015. | Agreed ToR [as endorsed by Ministers and the PPO]. | **Achieved**<br>Key stakeholders were consulted on the re-drafted ToR in August 2014. Comments were received, considered and changes made. The ToR are now in the hands of MOJ officials ready for Ministerial sign off. |
| 3. Ensure an appropriately funded extension of the PPO's remit to include the investigation of:<br>▪ fatal incidents in secure children's homes (SCHs)<br>▪ serious self-harm incidents in prison custody<br>▪ deaths of transferred prisoners to secure mental health facilities. | Agreed additions to ToR [as endorsed by Ministers and the PPO]. | **Partly achieved**<br>The PPO's statutory role in the investigation of deaths in SCHs came into effect on 1 April 2015.<br>There has been no further progress on the investigation of serious self-harm. |
| 4. Increase stakeholders' confidence in the office's independence. | Improved response to independence question in annual stakeholder survey to be conducted November 2014. | **Achieved**<br>52% of respondents recorded finding the PPO to be 'very' independent in 2014, an increase from 50% in 2013 and 47% in 2012. |

## **Objective 2:** Improve the quality and timeliness of our investigations and resulting reports, ensuring a robust and proportionate approach

| Key deliverable | Measure of success | Progress |
|---|---|---|
| 1. Apply a continuous improvement approach to PPO investigation methodology and report production in order to deliver against target by end March 2015. | Delivered to time and quality [as measured by the project plan for the redesign process and endorsed by the PPO]. | **Achieved**<br>By continuing to work with Lean methods we have improved the delivery of our complaint investigations and support functions. |
| 2. Improve the quality of investigation reports through the development and application of improved quality assurance procedures by end March 2015. | Delivered to time and quality [as measured by the project plan for the redesign process and improved feedback through the surveys from stakeholders]. | **Achieved**<br>More robust quality assurance has been introduced, aided by the appointment of additional staff in both operational teams. Plain English training has been delivered to all investigators. |
| 3. Achieve year on year improvement in casework performance and quality for both complaints and fatal incident investigations by end March 2015. | Delivered to time and quality [as endorsed by the PPO]. | **Achieved**<br>There was a 5% increase in the timeliness of fatal incident draft reports compared to 2013–14 (92% to 97%) and is now at the highest level since the PPO took on this responsibility.<br>34% of complaints investigations were completed on time compared to 29% in 2013–14.<br>Both stakeholder and complainant surveys recorded improvements in perceived quality. |

| Key deliverable | Measure of success | Progress |
|---|---|---|
| **Complaints investigations** | | |
| 4. Determine the eligibility of complaints within 10 working days of receipt of necessary paperwork. | At least 80% delivered to time and quality [as indicated by management information and endorsed by the PPO]. | **Not achieved**<br>28% of assessments were completed on time. |
| 5. Provide a substantive reply to new complaints within 12 weeks of accepting the complaint as eligible. | At least 60% delivered to time and quality [as indicated by management information and endorsed by the PPO]. | **Not achieved**<br>34% of complaints were delivered on time in 2014–15, though a higher proportion (48%) of new complaints investigations were completed within the target timeline. The average time from eligibility assessment to completion was 16 weeks. |
| 6. Ensure that:<br>▪ all the unallocated complaints cases in the backlog are under investigation by March 2015, and<br>▪ 60% of backlog cases have their investigations completed before March 2015. | Delivered to time and quality [as indicated by management information and endorsed by the PPO]. | **Achieved**<br>All cases in the backlog (cases which were unallocated in November 2013) were under investigation on 27 January 2015, ahead of target.<br>97% of backlog investigations are complete. |
| **Fatal incident investigations** | | |
| 7. Complete the investigation into a self-inflicted death and distribute the draft report for consultation within 26 weeks of initial notification. | At least 70% delivered to time and quality [as indicated by management information and endorsed by the PPO]. | **Achieved**<br>The target was significantly exceeded with 96% of self-inflicted reports delivered on time. |
| 8. Complete the investigation into a death due to natural causes and distribute the draft report for consultation within 20 weeks of initial notification. | At least 70% delivered to time and quality [as indicated by management information and endorsed by the PPO]. | **Achieved**<br>The target was significantly exceeded with 98% of natural cause reports delivered on time. |
| 9. Finalise all fatal incident investigation reports within 12 weeks of issue of the draft report. | At least 70% delivered to time and quality [as indicated by management information and endorsed by the PPO]. | **Not Achieved**<br>57% of final reports were delivered on time but this was an increase on 43% in 2013–14. |

## **Objective 3:** Improve our influence through the identification and sharing of lessons learned from our investigations

| Key deliverable | Measure of success | Progress |
|---|---|---|
| 1. Improve the impact of investigation recommendations by challenging rejected recommendations and following up progress. | High acceptance of recommendations by the investigated bodies as indicated, following the production of the final reports; PPO challenge of inappropriately rejected recommendations as indicated on the action plan response to draft reports; high implementation of PPO recommendations as measured by HM Inspectorate of Prisons on the Ombudsman's behalf during their inspections; and high implementation of PPO recommendations as evidenced during PPO thematic fieldwork. | **Achieved**<br>An analysis of the response to our recommendations indicates that 99% of recommendations made in 2013–14 were accepted by the investigated body.<br>HM Inspectorate of Prisons continues to report back on the progress made against our recommendations. |
| 2. Hold three Learning Lessons seminars in year focused on sharing the learning from investigations of:<br>▪ self-inflicted deaths<br>▪ natural causes deaths<br>▪ complaints. | Delivered to time and quality [as endorsed by the PPO]. | **Achieved**<br>Seminars took place on:<br>▪ 22 Oct – self-inflicted deaths<br>▪ 4 Nov – natural causes deaths<br>▪ 25 Nov – use of force and property complaints.<br>Feedback from attendees proved the seminars were well-received. We will repeat the format again in 2015–16. |
| 3. Promote timely learning from individual investigations through the publication of themed *Learning Lessons bulletins* for both fatal incidents and complaints investigations on:<br>▪ foreign national prisoners<br>▪ young adults 18–24 years of age)<br>▪ complaints from the high security estate<br>▪ Travellers<br>▪ cell fires. | Delivered to time and quality [as measured by the agreed publication timelines and the PPO's endorsement]. | **Achieved**<br>Three bulletins have been published in 2014–15 following a re-prioritisation of topics. |

| Key deliverable | Measure of success | Progress |
|---|---|---|
| 4. Share wider learning from individual investigations through the publication of Learning Lessons thematic reviews on:<br>▪ ACCT<br>▪ risk factors in self-inflicted deaths<br>▪ family ties<br>▪ mental health issues in deaths<br>▪ complaints from young people and women<br>▪ recommendations<br>▪ administrative errors<br>▪ small vs. large and public vs. private prisons. | Delivered to time and quality [as measured by the respective project plan timelines and the PPO's endorsement]. | **Achieved**<br>Four thematics have been published in 2014–15 following a re-prioritisation of topics. |
| 5. Complete the planning stage for a full joint thematic with HM Inspectorate of Prisons on redress by end March 2015. | Delivered to time and quality [as measured by the respective project plan timelines and the PPO's and HMCIP's endorsement]. | **On-going**<br>Discussions will continue into 2015–16. |
| 6. Identify topics for learning lessons analysis through internal and external consultation on learning lessons themes by January 2015. | Delivered to time and quality [as endorsed by the PPO]. | **Achieved**<br>List of topics agreed and consultation complete. |
| 7. Maintain and improve the positive feedback on the PPO's performance through post-investigation and annual surveys of complainants and other stakeholders. Publish the feedback findings and related actions on the PPO website by March 2015. | Delivered to time and quality [as endorsed by the PPO]. | **Achieved**<br>Reports published on the PPO website. |
| 8. Engage with stakeholders according to the PPO's stakeholder engagement plan, incorporating the communications plan and media strategy, with quarterly review of progress. | Delivered to time and quality [as defined by the stakeholder management action plan, supported by stakeholder feedback and endorsed by the PPO]. | **Achieved**<br>Review of communications complete and new Communications Officer appointed.<br>New website launched September 2014. |

| Key deliverable | Measure of success | Progress |
|---|---|---|
| 9. Produce an annual report for April 2013 to March 2014 for publication in September 2014. | Delivered to time and quality [as defined by the publication timelines and endorsed by the PPO]. | **Achieved** Annual report 2013–14 published 11 September 2014. |

## **Objective 4:** Use our resources efficiently and effectively

| Key deliverable | Measure of success | Progress |
|---|---|---|
| 1. Complete a review of the organisational redesign ensuring it has delivered the required efficiencies and structural support to performance improvement by September 2014. | Delivered to time and quality [as measured by the PPO's endorsement]. | **Revised** The structural redesign has been superseded following a successful bid 2014–15 for further funds to resource our expanding workload. |
| 2. Hold quarterly full staff meetings in order to support strategic and organisational change and share learning across the office. | Delivered to time and quality [as measured by positive feedback on staff evaluation forms]. | **Achieved** Full staff meetings held on:<br>▪ 3 June 2014<br>▪ 16 September 2014<br>▪ 3 February 2015. |
| 3. Conduct a survey of staff views of their workplace by November 2014 and devise an action plan in response to concerns. | Delivered to time and quality [as measured by the level of response to the survey]. | **Achieved** Staff survey completed November 2014 with improved response rate and a more positive response overall. Staff engagement action group created to take forward actions. |
| 4. Implement the PPO's equality and diversity action plan. | Delivered to time and quality [as measured through quarterly monitoring by the Equality and Diversity group]. | **Achieved** The ED Group, chaired by the Ombudsman, meets quarterly to ensure delivery against the action plan. The group will change its focus from internal to external ED matters in 2015–16. |

| Key deliverable | Measure of success | Progress |
|---|---|---|
| 5. Implement the PPO's learning and development action plan. | Delivered to time and quality [as measured through improved response to the staff survey on development opportunities]. | **Achieved** Bespoke investigator training, equality and diversity training and Plain English training was delivered to all staff and the expectation set that mandatory e-learning is completed. Individual learning and development needs are discussed with line managers. |
| 6. Continue to review all internal policies/guidance to ensure cross-office coverage. | Delivered to time and quality [as endorsed by the PPO and the Equality and Diversity group]. | **Achieved** Content of PPO policies/guidance was reviewed on the basis of equality impact assessments. |
| 7. Negotiate appropriate budget allocations based on real and anticipated changes to workload by March 2015. | Delivered to time and quality [as endorsed by the PPO]. | **Achieved** Budget delegation received. |
| 8. Negotiate a replacement case management system which supports an efficient and effective investigation process. | Delivered to time and quality [as endorsed by the PPO]. | **On-going** Awaiting funding approval. |
| 9. Produce a business plan for the PPO 2015–16. | Delivered to time and quality [as endorsed by the PPO]. | **Achieved** Plan drafted, consulted on and published. |
| 10. Ensure up-to-date Memoranda of Understanding are in place with all key stakeholders to promote effective joint working by end March 2015. | Delivered to time and quality [as endorsed by the PPO]. | **On-going** MoUs agreed or awaiting sign-off. |

# Terms of Reference[6]

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. 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.

[6] The Ombudsman's Terms of Reference are being reviewed, this will include changes in terms and titles.

8. The Head of the relevant authority (or the Secretary of State for Justice, Home Secretary or the Secretary of State for Children, Schools and Families where appropriate) will ensure that the Ombudsman has unfettered access to the relevant documents. This includes classified material and information 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. trainees in secure training centres who have failed to obtain satisfaction from the STC complaints system and whose complaints are eligible in other respects;

    iii. 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;

    iv. 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 trainees in secure training centres, by prison custody officers, Youth Justice Board staff or by people acting as agents or contractors of the Youth Justice Board 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) 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;

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

### Further provisions on matters subject to investigation

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

14. The Ombudsman may not investigate complaints about:

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

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

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

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

    v. the clinical judgement of medical professionals.

### Eligibility of complaints

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

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

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

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

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

### Time limits

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

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

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

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

### Outcome of the Ombudsman's investigation

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

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

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

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

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

## Fatal incidents

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

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

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

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

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

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

30. The Ombudsman will act on notification of a death from the relevant authority and will decide on the extent of the investigation, depending on the circumstances of the death. The Ombudsman's remit will include all relevant matters for which NOMS, UKBA and the Youth Justice Board are responsible (except for secure children's

homes in the case of the YJB), or would be responsible if not contracted elsewhere. It therefore includes services commissioned from outside the public sector.

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

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

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

## Clinical issues

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

## Other investigations

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

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

## Investigation reports

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

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

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

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

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

## Follow-up of recommendations

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

# Staff list

## Ombudsman

Nigel Newcomen CBE

## Senior Personal Secretary

Jennifer Buck (left 28 February 2015)

## Deputy Ombudsmen

Louise Falshaw
Michael Loughlin
Elizabeth Moody

## Personal Secretary

Janet Jenkins

## Assistant Ombudsmen

Emma Attwell (from 15 July 2014)
Karen Cracknell
John Cullinane
Michael Dunkley
Susannah Eagle (from 1 February 2015)
Kate Eves (career break since 31 January 2015)
Karen Johnson
Wendy Martin
Olivia Morrison-Lyons
Lee Quinn (from 8 September 2014)
Nick Woodhead

## Strategic Support Team

Durdana Ahmed
Mark Chawner
Catherine Costello
Dan Crockford (Team Leader)
Rowena De Waas
Lydia Gyekye (left 30 January 2015)
Henry Lee
Esther Magaron
Susan Mehmet (Admin Staff Manager) (left 6 November 2014)
Tony Soroye
Ibrahim Suma

## Learning Lessons Team

Olly Barnes (from 19 January 2015)
Sarah Colover (left 9 February 2015)
Sue Gauge (Team Leader)
John Maggi
Samantha Rodney (left 10 July 2014)
Helen Stacey
Christine Stuart (from 5 January 2015)

## Complaints Assessors

Susan Ager (from 17 June 2014)
Maz Ahmed (from 13 Oct 2014 to 16 Jan 2015)
Veronica Beccles
Sarah Buttery (left 19 November 2014)
Antony Davies (left 1 February 2015)
Agatha Eze
David Gire-Mooring
Christine Kavanagh (from 17 June 2014)
Emma Marshall
Chris Nkwo
Melissa Thomas (left 5 September 2014)

## Family Liaison Officers

Narinder Dale
Abbe Dixon
Laura Spargo
Seema Vishram

## Senior Investigators and Investigators

Nana Acquah (from 22 April 2014)
Sharon Adonri
Terry Ashley
Georgina Beesley
Rachel Biggs (from 23 April 2014)
Diane Blyth
Tracey Booker
Nicole Briggs
Simon Buckley
Timothy Byrom (left 16 January 2015)
David Cameron
Karen Chin
Althea Clarke-Ramsey
Debbie Clarkson
Akile Clinton
Vicki Cole
Paul Cotton
Joseph Cottrell-Boyce (left 23 July 2014)
James Crean
Lorenzo Delgaudio
Rob Del-Greco
Peter Dixon
Nick Doodney
Angie Dunn
Juan Diego Garzon (from 4 August 2014)
Kevin Gilzean
Maria Gray (from 26 August 2014)
Christina Greer
Rachel Gyford
Helena Hanson
Siobhan Hillman (left 11 April 2014)
Joanne Howells
Joanna Hurst
Katherine Hutton
Mark Judd
Razna Khatun
Madeleine Kuevi
Lisa Lambert
Karl Lane
Anne Lund
Steve Lusted
Steve McKenzie
Beverly McKenzie-Gayle
Eluned Malone (left 29 October 2014)
Sonja Marsh
Kirsty Masterton
Ruby Moshenska
Anita Mulinder
Nicola Murray-Smith (from 23 June 2014)
Tamara Nelson
Amanda O'Dwyer
Caroline Parkes
Claire Parkin
Katherine Pellatt
James Peters
Jade Philippou
Amy Powell
Mark Price (from 29 September 2014)
Rachel Rodrigues
Jessica Rule
Rebecca Sanders
Andrea Selch
Anna Siraut
Sarah Stolworthy
Rick Sturgeon
Tina Sullivan
Paul Televantou
Daniel Thomas (from 29 September 2014)
Jonathan Tickner
John Unwin
Alix Westwood (from 14 April 2014)
Karl Williamson
Jane Willmott

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