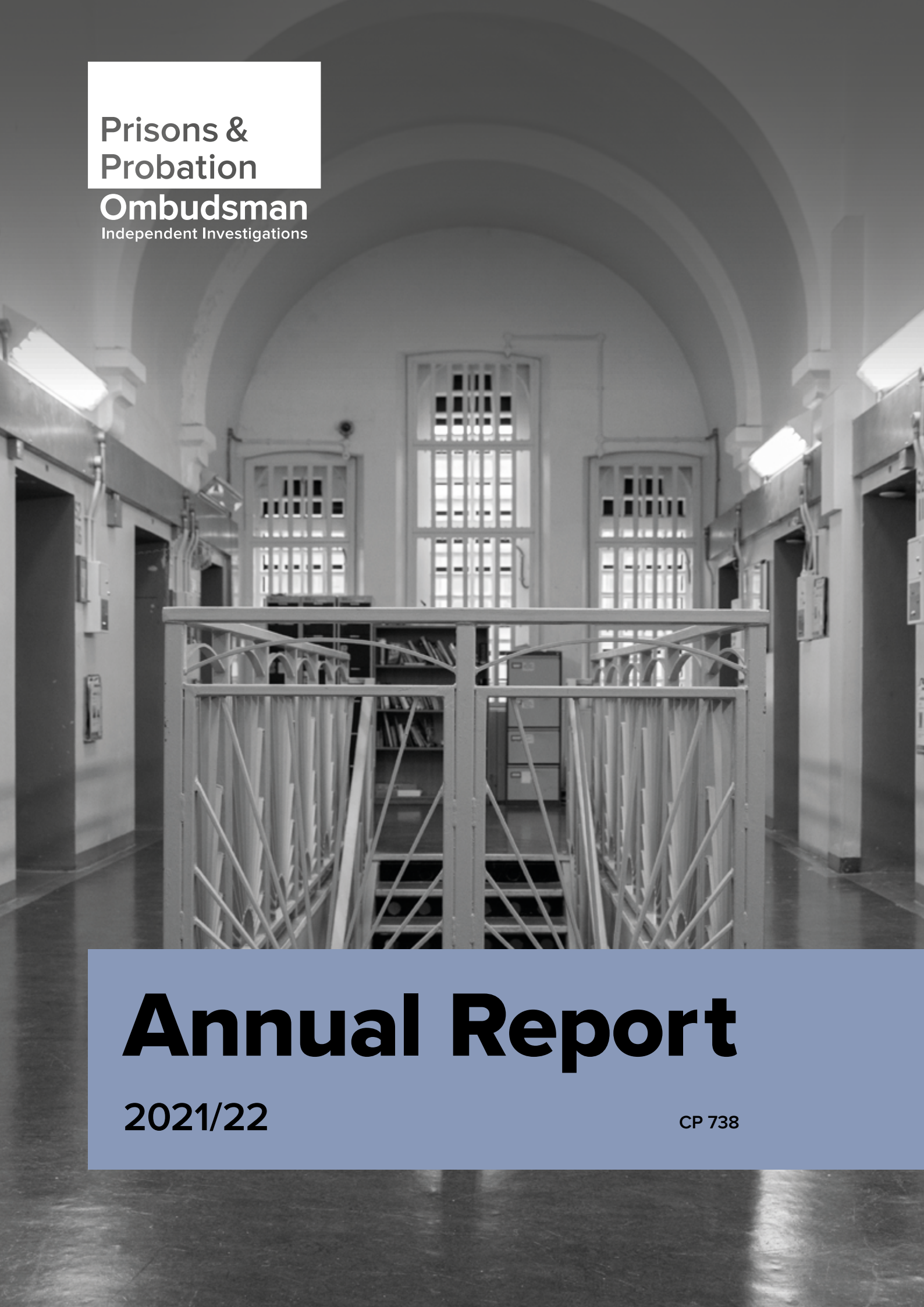

Prisons & Probation Ombudsman
Independent Investigations

Annual Report

2021/22

CP 738

Prisons & Probation Ombudsman

Annual Report 2021/22

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

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Contents

The role and function of the PPO 6

Our vision 7
Our values 7

Foreword 8

The year in figures 14

Complaints 15
Fatal incidents 18

Investigating complaints 22

COVID-19 complaints 24
Mediated cases 26
Reliance on disclaimers 27
Misapplication (or non-application) of national policies 29
The imposition of 'blanket' security measures 32
Use of force and repeat recommendations 34
National recommendations 35

Investigating fatal incidents 38

COVID-19 related deaths 40
Older prisoners 42
Adult safeguarding 44
Women 45
Young people 47
Foreign national offenders 48
Post-release deaths 50
Approved premises 52
Babies 56

Appendices 60

Recommendations 61
Stakeholder feedback – emerging findings 65
About the data 70
Financial data 76
Terms of Reference 77

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 HM Prison and Probation Service (HMPPS), the Probation Service for England and Wales, Prisoner Escort and Custody Service, the Home Office (Immigration Enforcement), the Youth Justice Board for England and Wales, 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 the Terms of Reference, the latest version of which can be found linked in the appendices.

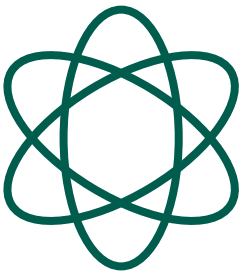
The PPO has three main investigative duties:

* The PPO investigates complaints from young people detained in secure training centres and young offender institutions (YOIs). Its remit does not include complaints from children in secure children's homes.

† During 2021/22, the PPO is running a pilot to investigate all deaths (except homicide) that occur within 14 days of release from prison.

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

Foreword

This is the fourth, and final, Annual Report of my tenure as Prisons and Probation Ombudsman, and I write this foreword as I prepare to step down at the end of June 2022.

As we transition to hybrid working arrangements, which will become the model for us and for much of the public sector, we are able to reflect on the work of the last three and a half years since I became Ombudsman in October 2018. Our investigations into complaints and fatal incidents remain at the centre of our work and have continued, despite the restrictions of lockdowns across society, the closures of our offices at the height of the pandemic and the limited access to prisons and other places of detention when regimes were at their most restricted. Some of the technology we have adopted, for example video interviews, will remain in place alongside face-to-face communication, now that we are able to resume our visits to prisons and have the in-person conversations and contact we know are so important.

Our programme of visits to prisons to meet with, and talk to, those who can complain to us has resumed. The informal, confidential conversations we have had are invaluable in raising awareness of, and building confidence in, our investigations into complaints. We have made some changes to our processes and to the way we communicate with complainants as a result of what we have heard and understood. We have now started working with staff in some prisons to share our experiences to improve the quality of complaints handling at establishment level, with the ultimate objective that more issues will be resolved locally, either via informal mediation or through the more formal complaints processes within each prison.

When I became Ombudsman, our complaints backlog (the number of complaints waiting to be allocated to an investigator more than 12 weeks after having been assessed as eligible) was consistently high, so we made it a priority to reduce it. By September 2021, it had reduced to 32 and at the end of the year covered by this Annual Report, it has reduced to 10 and has remained at that level as we have better processes for assessing, triaging and allocating cases across our teams of investigators. We know that complainants want our investigations to be swifter and that they value a prompt response over a lengthy one which goes into detail on every aspect of their complaint, and so we are working to make sure we use that feedback and make our complaints investigations even more proportionate.

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>
> ...we have better processes for assessing, triaging and allocating cases across our teams of investigators. We know that complainants want our investigations to be swifter and that they value a prompt response over a lengthy one.

During my time in post, we have worked on making our fatal incident investigations more proportionate. We have focused on impact and outcomes, rather than maintaining the emphasis on outputs which sometimes missed making the most of where we could add most value and genuinely contribute to making prisons safer and more decent. For those deaths from natural causes which we class as foreseeable, for example where a prisoner has a terminal illness or dies of old age, we have adopted a different approach to our investigations, which considers the end of life care provided in prison with consideration of some non-clinical aspects of care. In contrast, in our more complex case investigations where deaths are unexpected and, arguably, preventable, we have been able to devote more resources to considering every aspect of the deceased person's care and what went wrong, so that repeat failings and, potentially, future deaths can be prevented.

Another of my priorities has been building and strengthening the relationships we have with our partners and stakeholders, so that we can look beyond our own organisational boundaries and work collaboratively with others to improve outcomes for people in custody. This has included working with organisations in the voluntary sector, for example with those concerned with the care of women and babies in prison, to inform our investigations into the tragic deaths of two babies whose mothers were in prison. In another example, we have used the networks developed by colleagues in the Prison Reform Trust and Revolving Doors Agency to engage with serving and former prisoners who have been able to talk to us about how our work is perceived and what we could improve.

As I step down as Ombudsman, I am encouraged by some of the improvements I have led and I know that they have made the office of the PPO a better place to work, enabling us to be more efficient and inclusive, and to have greater impact on the services in our remit.

Our Terms of Reference were extended this year so that our remit now covers investigations into the deaths of babies and children which occur in prison and deaths of people within 14 days of release from custody. Although we have investigated such deaths in the past, this was either at the request of ministers or, in the case of post-release deaths, by exercising our discretion in exceptional cases. We will now conduct those investigations within the scope of our Terms of Reference, to better reflect the importance of our findings in identifying learning and supporting improved outcomes.

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>
> ...I am encouraged by some of the improvements I have led and I know that they have made the office of the PPO a better place to work, enabling us to be more efficient and inclusive, and to have greater impact on the services in our remit.

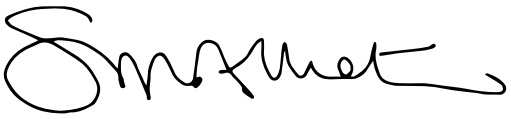
In common with other arm's length bodies, we have experienced reductions to our budget in real terms year-on-year, including the year covered by this report. We successfully mitigated the impact of a reduced budget by strengthening the controls and governance arrangements we have in place to make sure we use public money as effectively as we can. We continue to respond to the high demand for our investigative services and produce the thematic publications which complement that work and promote learning across the services in remit. In the coming year, we will receive some, albeit limited, additional funding to reflect the increase in the prison population and the new prisons which continue to open, as we expect more complaints and a likely increase in the number of deaths across the prison estate.

We have worked hard to make our organisation one which is inclusive and where people from all groups feel welcome, including in our efforts to recruit, develop and retain staff at all levels. In the areas of equality, diversity and inclusion, we have focused on all protected characteristics, including, but not limited to, race, gender and sexual orientation, but also on supporting colleagues, for example those who have caring responsibilities, for whom we have been able to show that we are a flexible and responsive employer. We know that having a diverse workforce, made up of colleagues with a wide range of skills and experiences, including lived experience of the criminal justice system, enhances the quality and credibility of our work, as well as it being the right thing to do.

As I prepare to leave this office, and in the context of all that we have achieved during my time in the role, I know that there remains more to be done and I have confidence in the abilities of the team I leave behind to continue some of the unfinished projects and to set new directions for the work of the PPO. Our work to better understand why so few women and young people complain to us, and to identify the barriers to those groups feeling empowered and supported to use our services will remain a challenge for the new Ombudsman. Colleagues are already thinking about how we can improve the ways in which we produce and publish our thematic work, including our Learning Lessons Bulletins and whether, and how, we might do more to follow up on the implementation of our recommendations when improvements have been promised.

> Our work to better understand why so few women and young people complain to us, and to identify the barriers to those groups feeling empowered and supported to use our services will remain a challenge for the new Ombudsman.

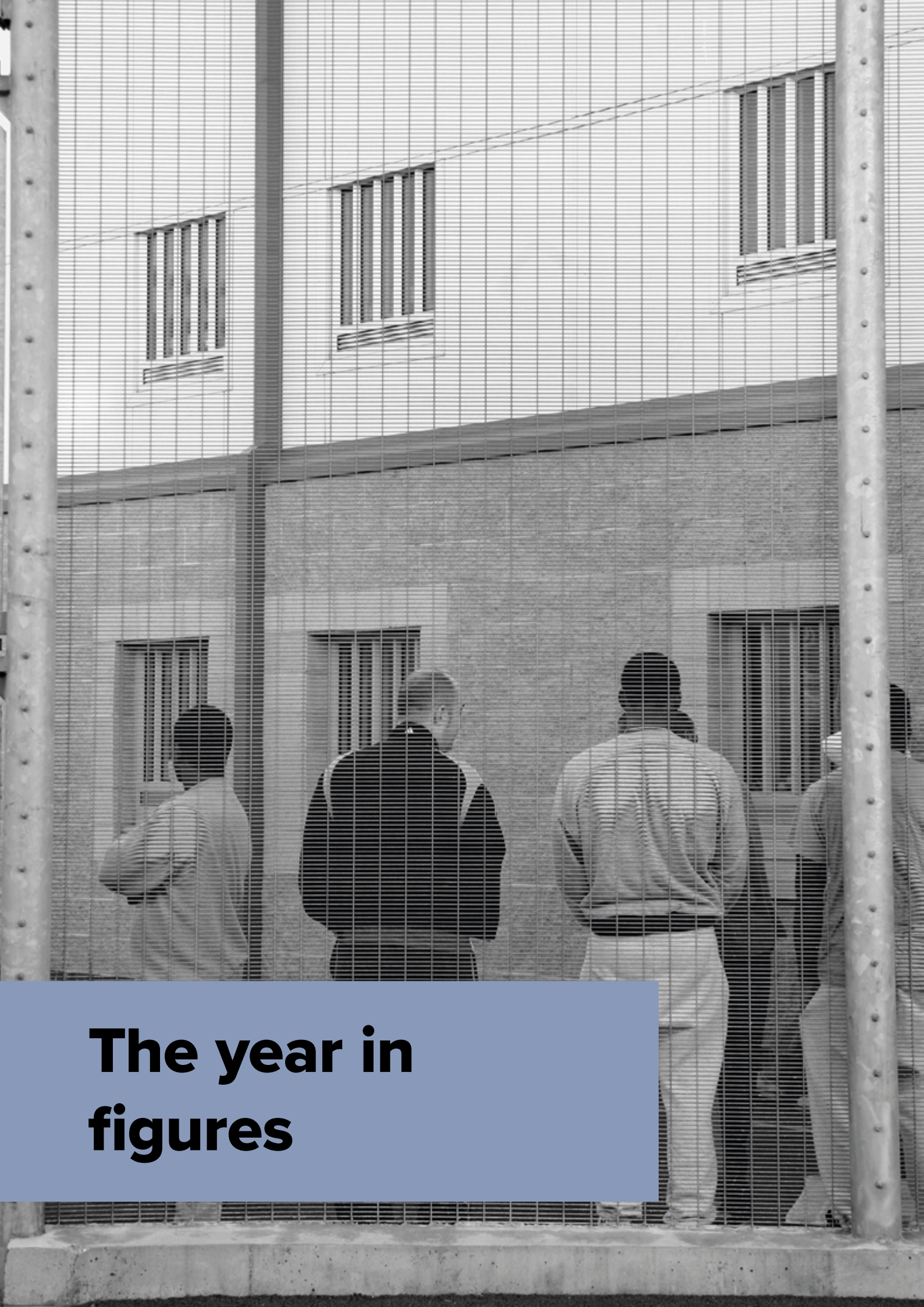
Crucially, the legislation to place the PPO on a statutory footing, long awaited and important to safeguard and underline our independence, remains yet to be delivered. I am sure that my successor will champion the case, as others have before me, and I hope that we will soon see the legislative changes that will strengthen the legal basis for the work that we do.



Sue McAllister CB

Ombudsman


HM PRISON
LEWES
This door ha
a security lock!
Pleas e ensure
tha you have
l cked it
STOP



The year in figures

Complaints

Complaints received

In 2021/22 we received **4,442 complaints**,[1] an increase of **11%** compared to last year.

Of these:

4,142
were about prisons, **420** more than last year

287
were about probation services, **5** more than last year

9
were about immigration removal centres, **5** more than last year

2
were about secure training centres, the same as last year

Eligible complaints and complaints started

We sent out:

5,059
eligibility letters to complainants in 2021/22,*
an **8%** increase compared to last year

In **2021/22** we started investigations into **1,936** cases compared to **1,682** cases in the previous year, an increase of **15%**

* Timeliness data for these letters is unavailable due to ongoing work with the case management system, however, we aim for this to be resolved in the near future. Refer to the 'About the data' section for definitions of eligibility, upheld and not upheld cases.

1 The total includes two ineligible complaints received by the PPO that do not fall into any location categories.

Complaints completed

In 2021/22 we completed **1,924** investigations compared to **1,572** in the previous year, an increase of **22%**.[2]

Of these:

Property
27%
the most common complaint category

Staff behaviour
10%

Adjudication
7%

28%
of all completed cases were found in favour of the complainant, similar to the rate of **30%** last year

We do not investigate eligible cases if, for example, the complaint does not raise a substantive issue or if there is no worthwhile outcome. This helps us to appropriately allocate resources.

Closed complaints

Of the cases we closed in 2021/22:

127 declined

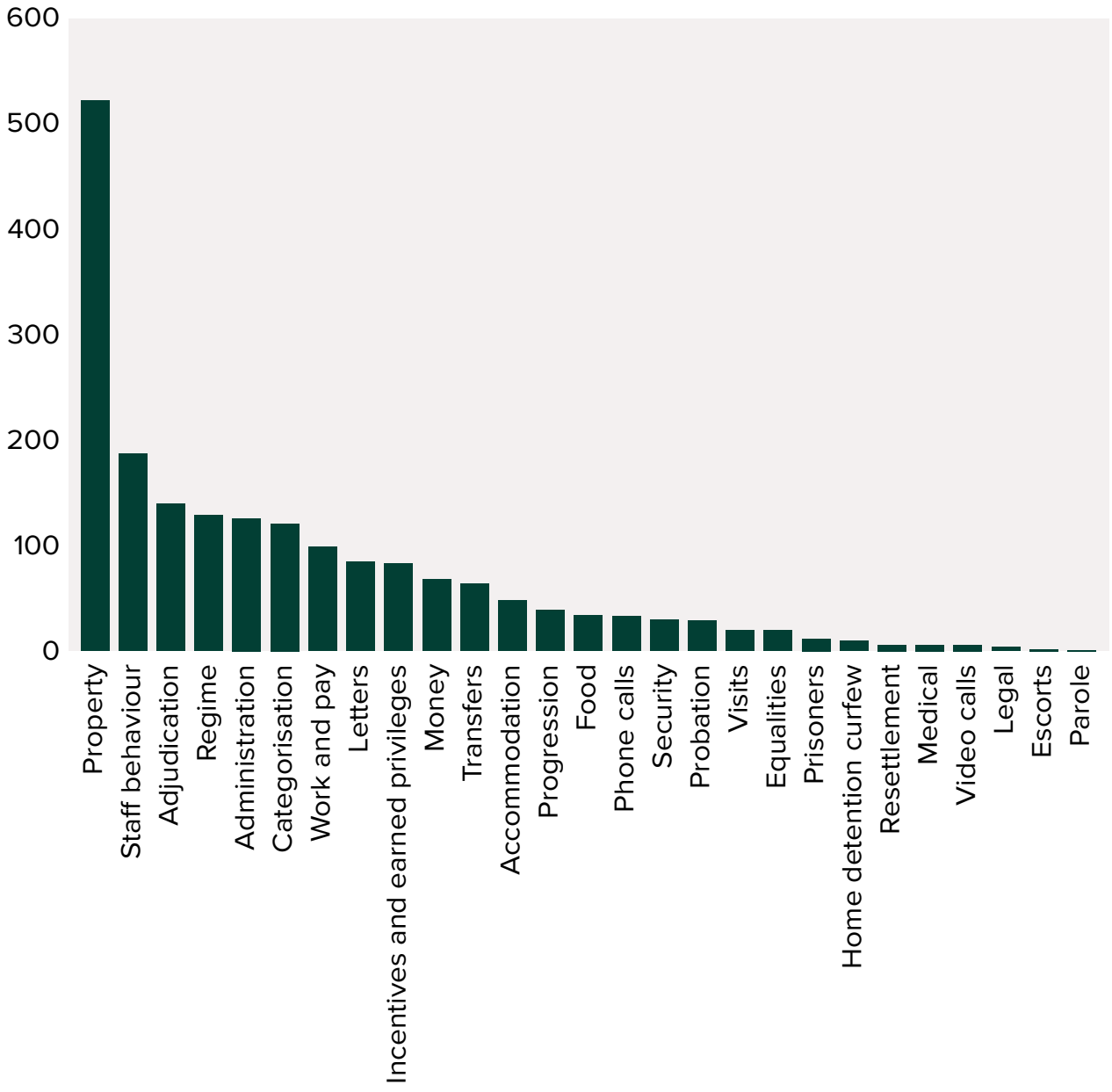
127 complaints were declined for investigation, **74** fewer than last year

48 withdrawn

48 complaints were withdrawn this year – this includes complaints withdrawn by the PPO and by the complainants themselves

2 Due to the PPO moving to a different case management system, work is ongoing to produce timeliness statistics for completed investigations.

Complaints completed in 2021/22 by category:



Fatal incidents

Investigations started

In 2021/22, we started investigations into **329 deaths**, a **23% decrease** compared to the previous year. We began investigations into:

193

deaths from natural causes, 106 fewer than last year

of these **193** deaths, **34** were related to COVID-19

33

other non-natural deaths, 7 fewer than last year.
It is important to note that, at the time of writing, there are **17 deaths** awaiting classification (which tend to be classified as other non-natural)

1

apparent homicide, same as last year

85

self-inflicted deaths, 2 more than last year

Of the **329 deaths** in 2021/22, the location of investigations started consisted of:

287

prisoner deaths, 118 fewer than last year

13

deaths of residents living in probation approved premises, 2 fewer than last year

1

death of a resident of the immigration removal estate, equal to last year

25

post-release deaths

3

discretionary cases

- the death of an individual who was found hanging in their cell but remained in hospital after being released on compassionate grounds and died after their life support machine was switched off
- the death of an individual in hospital after their sentence ended while in hospital
- the death of an individual who was released after being taken to hospital due to underlying health conditions but died shortly afterwards

Reports issued

This year we issued **391 initial** and **378 final reports** compared to **292** initial and **298** final reports last year:

45%

of initial reports were on time, compared with **70%** last year

49%

of final reports were on time, compared with **58%** last year

26 weeks

was the average time to produce an initial report for a natural cause death

34 weeks

for all other deaths

686

fatal incident investigations not yet published on our website (as of 31 March 2022). This includes:

- investigations where we have not issued a final report and we are still investigating
- cases where we have issued the final report, but we are awaiting notification that the coroner's inquest has concluded in order to publish the report
- a small number of reports waiting to be published

1,125

recommendations made by PPO following deaths in custody related to (among other subjects):

407

healthcare provision

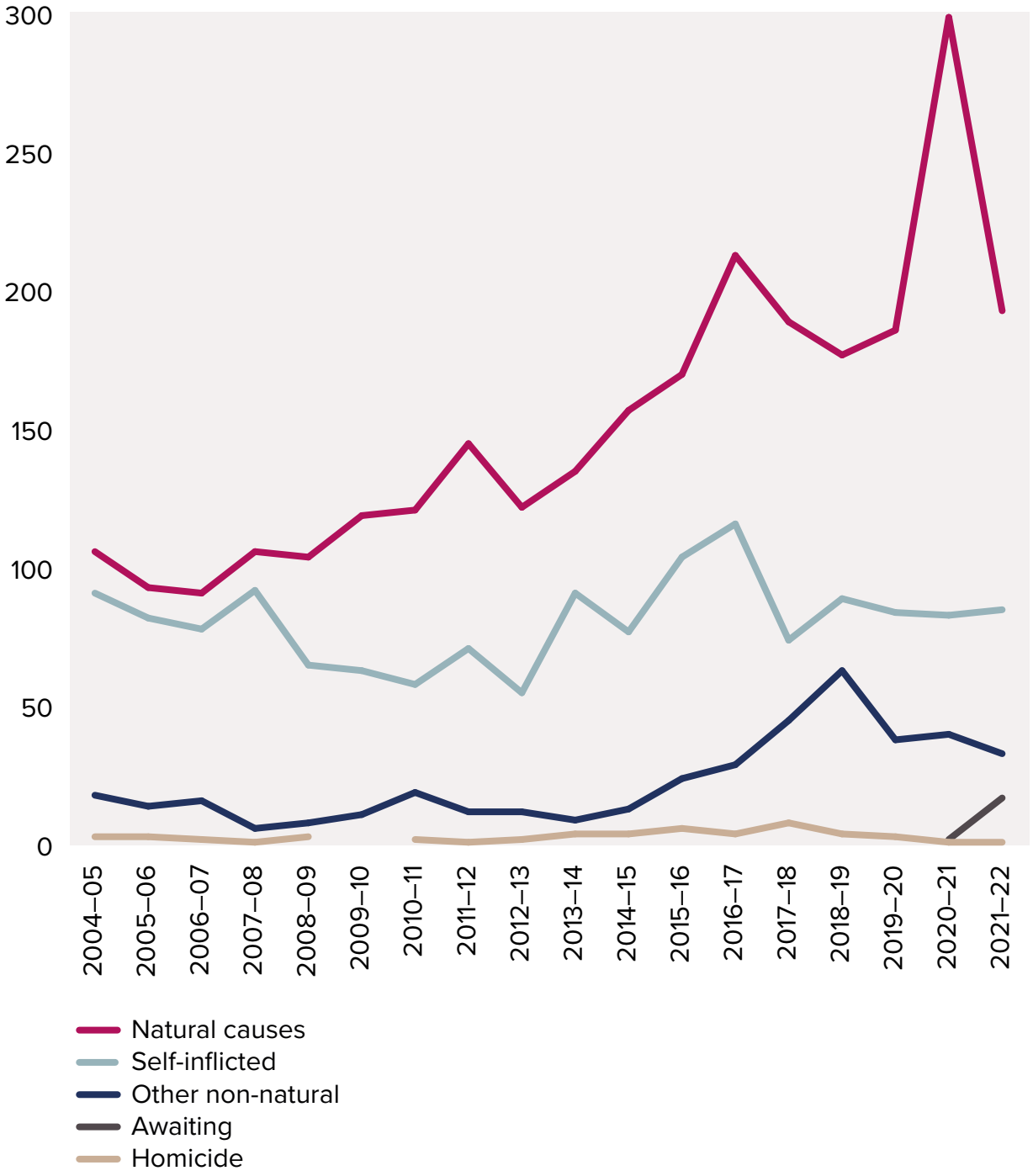
134

emergency response

111

suicide and self-harm prevention

Fatal incidents investigated

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Investigating complaints

2021/22 was another challenging year for the complaints team and, undoubtedly, for those who can complain to us. The waxing and waning of COVID-19 restrictions, while less unexpected and unprecedented than the previous year, continued to present challenges for staff – both personally, and in terms of how we carry out our core functions to assess and investigate complaints. We were keen not to lose the agility, flexibility and creativity in our approach to our work that the onset of the pandemic brought about and committed to building on some of the new ways of working we initially introduced as emergency measures in March 2020.

Life remained uncertain for those in prison, detained under immigration powers and under probation supervision in the community too. As an organisation, we had some expectations about the numbers and types of complaints we might receive as the pandemic progressed; some were realised and others not.

This reporting year, we received 4,442 complaints, 11% more than in 2020/21 (when we reported a 14% reduction from the previous year). HMPPS has also seen an 11% increase in complaints received in the last year.[3] In the 12 months to 31 March 2022, there were 198,363 complaints, compared with 178,087 in the 12 months to 31 March 2021. This recent increase represents a return to the level immediately prior to COVID-19 (2019/20).

We accepted for investigation 1,936 of those complaints (15% more than last year). This means that we continue to assess over 50% of incoming complaints as either ineligible for investigation, or while eligible, not accepted for investigation for some other reason – as set out in our Terms of Reference.

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>
> We were keen not to lose the agility, flexibility and creativity in our approach to our work that the onset of the pandemic brought.

Disappointingly, this year 77% of ineligible cases were assessed as such because the complainant had not followed the correct procedure before submitting their complaint to us. We believe that there are two key steps to reducing the levels of ineligible complaints we receive. The first is ensuring that those who can complain to us (as well as all staff in the services in remit) fully understand how to follow local complaints processes, for example the two-stage prison process or the three-stage probation process. The second is that they know when and how to escalate their complaint to us.

Last year, we forged closer working relationships with the prison newspaper, Inside Time and National Prison Radio (NPR) and used articles in the paper and adverts on the radio to raise awareness of the PPO. This year, we have continued to use both methods, and explore new avenues such as writing for the Women In Prison magazine, to highlight the complaints process, explain how we conduct

3 See the About the Data section for more details.

our investigations and, we hope, to connect with those who might want to complain to us and instil greater confidence in our work.

In 2021/22, we also began work to increase awareness of the PPO, and to support effective complaint handling among prison and probation staff. This is an important strand of work which we plan to continue and develop.

Of course, the nature of our work means that we only see those complaints where the complainant remains dissatisfied by the service in remit's response. We are working closely with HMPPS colleagues to support their efforts to drive up the quality of complaint responses and to ensure that staff understand the importance of procedural justice. For example, if someone feels they have been treated administratively fairly, they are more likely to respect the decision or outcome, even if they do not agree with it. We also continue to press for more comprehensive and transparent analysis of complaints data so that we can report PPO data within the wider context.

Sometimes, we identify really good and effective complaint handling, and we hope that with greater commitment from HMPPS to the importance of complaints, we will see tangible improvements to the responses prisoners receive from prison staff.

Under our Terms of Reference, we can decide not to investigate a complaint where we consider there is no worthwhile outcome to be achieved. Sometimes, this relates to the nature of the complaint, but we also decide not to investigate on the basis that the prison's reply is reasonable, full and thorough and that a PPO investigation would be unlikely to add anything further.

Mr A complained to the PPO, seeking compensation for the way the prison had dealt with a racially motivated fight between four prisoners. At assessment, we considered the response Mr A had received from the head of the Offender Management Unit (OMU). The head of the OMU had provided a comprehensive response, including a timeline of events and an account of how staff had responded to the fight. The prison had already carried out an internal investigation and found that there was a racial element to the incident. The prison had referred the incident to the police for further investigation, some of the prisoners involved had been moved to different prisons and their prison files had been updated to reflect the racist nature of the incident. We concluded that the prison had already comprehensively responded and taken the necessary actions following the fight and there was nothing additional we could recommend. We did not accept Mr A's complaint for investigation.

COVID-19 complaints

The impact of the COVID-19 pandemic on the number and nature of the complaints we receive has not been what we expected and throughout the pandemic, we have been surprised by the relatively low number of COVID-19 complaints received. Last year, the first year affected by the pandemic, we

reported that we had received 152 COVID-19 related complaints and highlighted some of the emerging themes.

This year we received only 69 complaints directly related to the pandemic (and upheld only 17%, compared with our general uphold rate of 28%). In truth, we do not know why the numbers have remained low. But we have not seen the increases in certain types of complaint that we anticipated as restrictions began to lift and life in prison resumed some sense of normality. One reason might be that the impact of the pandemic has been so far-reaching and enduring that it has affected almost every aspect of prison life. In this case, perhaps we should consider all complaints made during the pandemic to be COVID-19 related, even if they do not seem explicitly so.

The most common categories of complaints that we assessed as directly related to the pandemic were not particularly surprising. The biggest single category related to prison regimes, which were, of course, enormously affected by lockdowns and restrictions. We also received small numbers of complaints about staff behaviour, work and pay, and progression and categorisation.

Last year, we took the position that delays to many prisoners' sentence progression were inevitable, to some extent beyond the control of HMPPS and, therefore, largely reasonable. This year, we expected to receive more complaints about prisoners failing to progress through their sentences directly as a result of the pandemic, which put a pause on transfers and offending behaviour courses. In total, we received 75 complaints which we broadly categorised as about progression (the categorisation of complaints is subjective and not an exact science) but assessed only three of those as directly related to the pandemic.

Mr B complained that he would be eligible for release in August 2021 but because he had not yet completed an offending behaviour programme required under his sentence plan, he was unlikely to be granted parole. Mr B felt that the prison was using the COVID-19 pandemic as an excuse for why he had not yet completed the programme.

In their responses to his complaint, prison staff acknowledged the impact of the pandemic on the delivery of offending behaviour programmes. They explained that, for a period, all programmes had been paused and that while they were now running again, the numbers of prisoners who could attend each session had been reduced. Staff apologised to Mr B for the impact this might have on his release.

Staff told us that Mr B was on the waiting list for the programme but, because of the delays caused by the pandemic and the number of prisoners waiting for a place, he was unlikely to be allocated to it until 2022.

We concluded that there was no evidence to suggest Mr B had been overlooked and found that the delays were entirely due to the on-going impact of the pandemic. We concluded that the prison had done all that it could to support Mr B's enrolment in the programme and so did not uphold his complaint.

Mediated cases

While it is important that our investigations are thorough and robust, it is also important that we are proportionate and resolve complaints at the earliest possible stage, just as we urge the services in remit to do. In some cases, we are minded to uphold the complaint, but do not consider that there is much wider learning for the prison. Where possible, we resolve these complaints by proposing a solution to the prison and the complainant, without resorting to a recommendation. We call these cases mediated outcomes. Mediated cases benefit the complainant because they lead to a positive outcome for them, but more quickly than where we issue recommendations, which necessarily involve a more complicated and auditable process of agreement.

> “

...this year, we resolved 147 property cases (of a total of 522 completed property cases) by mediation.

In 2021/22, we mediated the outcome in 12% of our complaint cases. Mediation works particularly well in property cases, and this year, we resolved 147 property cases (of a total of 522 completed property cases) by mediation.

Mr C complained that the prison had lost his tie and shoes while holding them in his stored property (property that the prisoner does not keep in their cell and which, therefore, remains under the control of the prison). We did not find a tie listed on his property cards and so did not uphold that aspect of the complaint. We did find a pair of black shoes on his stored property cards and concluded that the prison had, therefore, lost them. Having researched the current cost of a similar pair of shoes and reducing the value to account for wear and tear, we asked the prison to compensate Mr C £12.50. The prison agreed and we notified Mr C of the offer and advised him that we supported the compensation figure and would not investigate the matter any further, if he chose not to accept it.

In last year’s Annual Report, we wrote about cases that could and should have been resolved at the first stage of the complaints process and, in many ways, the cases we mediate fall into that category. These cases are often simple to resolve, really only requiring a problem-solving approach – which is the approach staff are encouraged to take in the Prisoner Complaints Policy Framework.

However, we are not limited to using mediation to resolve simple complaints and, in the right circumstances, can use the same approach to resolve more complex issues.

Mr D, a paraplegic prisoner, complained that he had been restrained by handcuffs and an escort chain (a length of chain with a handcuff at each end, which attaches the prisoner to an officer) when attending hospital appointments. Mr D complained that the use of restraints was unnecessary and embarrassing, given his lack of mobility. The prison responded that the risk assessments covered not only the risk of Mr D escaping, but also, given his previous violent behaviour, the risk he posed to prison and hospital staff and the general public and that the use of restraints was justified.

We found that the relevant Prison Service Instruction included a mandatory instruction that prisoners who were paraplegic or tetraplegic must not be restrained without the approval of one of two very senior managers in HMPPS. We discovered that staff at Mr D's prison were not aware of this instruction and had not sought the correct approval to restrain Mr D during hospital visits. We suggested that the prison immediately review Mr D's risk assessment before the date of his next hospital appointment and ensure they were abiding by the policy.

The prison did so and took advice from relevant HMPPS policy colleagues. They also committed to ensuring that staff understood and followed the mandatory actions in the policy when risk assessing any other prisoner for a hospital appointment. We were satisfied that both Mr D's complaint was resolved and that the prison had taken appropriate steps to ensure the proper application of the policy in similar circumstances and that there was no need to make recommendations in this case.

Reliance on disclaimers

In our 2019/20 annual report, we raised the issue of prisons' inappropriate reliance on disclaimers or technicalities to avoid accepting responsibility, particularly for missing, damaged or lost property. We have been vocal in our disapproval of this and on the whole, we see less use of disclaimers in complaint responses. However, we do still come across some examples.

Mr E complained that his personal papers had gone missing from his cell while he was in hospital. He said that when he returned to prison from hospital, he signed a disclaimer agreeing that staff could clear his cell outside the normal process set out in the relevant prison instruction. Mr E said that had he known that his property was missing, he would not have signed it. The prison's response to Mr E's complaint was that as he had signed the disclaimer, the prison was not responsible for the lost property.

During our investigation, the prison did not respond to some of our requests for information and could not provide other evidence we asked for. They could not supply us with a copy of the disclaimer Mr E signed, or indeed any version of the disclaimer in use at the time. They could not properly explain why they had not followed the process for clearing Mr E's cell as set out in the prison instruction.

We concluded that the prison's reliance on the disclaimer was not reasonable and they assured us that they had already stopped using it. We partially upheld Mr E's complaint on the grounds that we were simply unable to establish whether the property had existed in the first place (because documents and letters do not have to be recorded on the prisoner's property card) and therefore whether any loss had occurred. However, we recommended that the prison ensure staff understood and followed the correct procedure when clearing a prisoner's cell. The prison accepted the recommendation.

This year, we have been concerned to see a small number of prisons applying maximum compensation limits in property complaints, sometimes also relying on the prisoner having signed (or been aware of) a disclaimer setting out the prison's approach to compensation. We do not consider such approaches to be fair or reasonable and, if we uphold the prisoner's complaint, will recommend compensation according to the value of the missing or damaged item.

Mr F complained that three pairs of designer sunglasses had been damaged while in stored property at the prison. The prison accepted that the damage had occurred while the sunglasses were in their care but pointed Mr F to a property compact and disclaimer (which he had not signed) which stated that the prisoner was responsible for any property he brought into the prison and that the prison would not "accept responsibility above £40", as a result, they offered Mr F £120 compensation. Mr F said that he was unhappy with the compensation offered to him. He valued the sunglasses at £1,154 but could not provide any receipts for them.

We noted that staff had recorded the three pairs of sunglasses on Mr F's property card when he arrived at the prison and had recorded the brand name against each pair (so accepting that they were genuine rather than fake). We established the value of the sunglasses, reduced the figure for wear and tear and to take into account that Mr F did not have their protective

casings. We concluded that it was not fair or reasonable for the prison to limit their offer of compensation to £120 and recommended that they pay Mr F £352 compensation. The prison agreed to pay the suggested amount.

Misapplication (or non-application) of national policies

A frequently misunderstood, but key, aspect of a PPO investigation is considering whether the prison (or service in remit) properly applied the relevant existing policies when making the decision or taking the action that led to the complaint. The PPO is not responsible for devising those policies, although we regularly use our extensive professional expertise and the learning from our investigations to contribute to policy consultations. We know that sometimes the policies are complex and not easy to follow, or do not provide quite enough clear guidance to cover any given set of circumstances. There is also a plethora of local policies, devised by individual prisons or groups of prisons, intended to better meet their specific needs. Sometimes, local polices – or the way national policies are interpreted and applied locally – diverge from national policies in ways that are unhelpful, particularly when prisoners move between prisons, as they so often do.

“

A frequently misunderstood, but key, aspect of a PPO investigation is considering whether the prison (or service in remit) properly applied the relevant existing policies when making the decision or taking the action that led to the complaint.

One such example that has proved to be problematic this year is the provision of Microsoft Xbox consoles. Prisoners' use of any devices which normally allow access to the internet is, appropriately, tightly managed and governed by HMPPS policy. The relevant policy prohibits prisoners from using Xbox 360s unless the prisoner purchased it before September 2014, and the prison governor chooses to allow them because the risk is manageable. We have received a number of complaints from prisoners who have been allowed to buy Xbox 360s since September 2014 in one prison, contrary to national policy, but have had the console or hard drive confiscated, in line with national policy, on transfer to another prison. A substantial proportion of the cases relate to the application of a separate policy, allowing Xbox 360s, by the Long Term and High Secure Estate (LTHSE).

These cases have proved complex and we have sought clarification from, and engaged in detailed liaison with, colleagues in LTHSE, responsible policy leads and the Director General of Prisons. The complexity has meant that these cases have taken us longer to investigate and resolve than we would like. Our view is that it is not fair or reasonable for prisoners to be out of pocket as a result of HMPPS failing to follow its own policy. We continue to press HMPPS to resolve the inconsistencies in approach.

The following case study did not involve LTHSE prisons, but shows the confusion caused when prisons do not follow national policy.

Mr G complained that he had bought an Xbox 360 in 2018, while at prison A. In 2019, he transferred to another prison, who said that they did not allow prisoners to buy the Xbox 360 but, because Mr G had purchased his while in another prison, he was allowed to keep it, with the hard drive.

In 2021, he transferred to prison B which did not allow prisoners to have Xbox 360s with hard drives and so confiscated Mr G's hard drive before allowing him to have the console. Mr G complained that, without the hard drive, he could not save his progress in games and that the console was essentially useless.

We considered that prison A should not have allowed Mr G to buy the Xbox 360 console and that, therefore, Mr G had two options to resolve the matter. We suggested that he could either keep the console with the hard drive removed and accept the restrictions on its use, or agree to the prison destroying the console and his games and accept compensation from prison A for the cost of the console and games he had purchased.

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While we support the introduction of legitimate processes to tackle the trafficking of drugs in prisons, it is vital that local policies do not contravene national policy.

We have also been concerned by an increase in cases relating to the provision of books to prisoners. Guidance is clearly set out in more than one national prison policy. However, as prisons try to tackle the increase in drugs entering prisons through the post (for example, paper being impregnated with psychoactive substances), some have devised local policies to address this. While we support the introduction of legitimate processes to tackle the trafficking of drugs in prisons, it is vital that local policies do not contravene national policy.

Mr H complained that the prison had refused to accept a parcel of books sent to him by his wife and had returned the package to her. He said that this was contrary to national policy and had cost his wife £24 in postage.

The prison replied that prisoners could order new books directly from approved suppliers, but due to security risks related to the trafficking of drugs and other contraband, prisoners could not receive books sent in by friends and family.

We checked existing national prison policies which made clear that prisons were obliged to allow prisoners to receive books sent to them, as long as the content of the books did not breach certain standards set out in the policy. The policy confirmed that there should be procedures to check incoming books for illicit enclosures.

We asked the prison to reconsider its policy not to allow prisoners' friends and family to send books and highlighted recent policy guidance provided in a similar case at a different prison which made clear that prisoners should not be limited to ordering new books from approved suppliers. The prison responded that their local policy clearly set out their stance and that the relevant national policy did not reflect current concerns about the trafficking of drugs through prison post. We recommended that the prison refund Mr H's wife the postal fees and issue guidance to staff clarifying the national policy on the sending in of books. Initially the prison was reluctant to accept our recommendations but have now done so. Because we were concerned by the rise in complaints related to books, we also raised the issue with the Director General of Prisons.

The imposition of 'blanket' security measures

In 2020, HMPPS extended the use of X-ray body scanners to more prisons in England and Wales as another measure to counter the importation of drugs, weapons and other contraband in prisons. Their use is set out in detailed but nuanced national policy. We were not surprised to receive complaints about the use of body scanners this year but have been struck by the complexities involved in this area of policy.

Mr I complained that he had been subject to a body scan on his arrival at the prison. Among other things, he said that he had read a notice in the prison reception area explaining that prisoners would be scanned if there was 'reasonable suspicion' but when he asked staff about this, they told him that every new prisoner was routinely scanned. In response to his complaint, the prison quoted the national policy which said that entire cohorts of prisoners could be subject to routine scans where specific intelligence identified a security risk.

Our investigation established that there was no specific intelligence indicating that Mr I might try to bring contraband into the prison. We were concerned that the prison was essentially applying a blanket policy which, we thought, went beyond what was intended by the policy.

We discussed the national policy with HMPPS policy leads who explained that a cohort of prisoners, such as all new arrivals to the prison, could be routinely scanned providing there was sufficient intelligence to support this approach, and that the prison's security committee discussed and reviewed their risk assessments each month. The prison had done so, and provided evidence supporting their position that new arrivals were responsible for increases in contraband items in the prison. They also showed us how they had adapted and amended their approach to different cohorts of prisoners over time, according to the security intelligence available. On that basis, we concluded that the decision to scan Mr I was reasonable and complied with the national policy, and we did not uphold this aspect of his complaint.

Another case raised similar issues in relation to the processing of post, which as noted earlier, has become a common route of entry for drugs.

Mr J complained that the prison had applied a blanket policy to open and photocopy all Rule 39 post (which allows prisoners confidential correspondence with their legal advisers, courts and other named organisations) before giving it to prisoners. The prison responded that they had introduced the new policy because of an increase in prisoners misusing drugs. They said that the prison was acting in accordance with national policy.

The prison told us that the majority of drugs entered the prison through post and set out the new procedure for issuing Rule 39 post to prisoners, including that all Rule 39 post would be opened by staff in the prisoner's presence, a photocopy given to the prisoner and the original document immediately confidentially destroyed.

National policy sets out the circumstances in which prison staff can open and/or read Rule 39 post and we were concerned that the prison's blanket approach contravened this. We understood and were sympathetic to the reasons why the governor had introduced the process but concluded that the prison's actions had not been proportionate or reasonable, and upheld Mr J's complaint. Since our report, HMPPS has begun piloting new handling procedures for Rule 39 post.

Use of force and repeat recommendations

We have seen a reduction in the number of use of force complaints received this year. In 2021/22, we received 30 complaints about the use of force, compared to 43 in 2020/21. As with so much of our work, without the broader context of complaints made to HMPPS, it is difficult for us to know why or how that reduction has happened. During the pandemic, many prisoners spent much more time behind their cell doors or mixing in much smaller groups, and that might account for some of the reduction.

In previous annual reports, we have highlighted our specific concerns about the number of repeated recommendations we make in relation to use of force investigations. Last year, we wrote about how the lack of CCTV or Body Worn Video Camera (BWVC) footage impacted on our investigations, and that we had made clear to HMPPS senior leaders our growing impatience. It is very disappointing that this year, we have once again made numerous recommendations about the switching on of BWVC or the retention of footage. We have used the findings from our investigations to contribute to the HMPPS review of the policy relating to BWVC.

Mr K complained that he had been assaulted by a group of staff, late one evening, leading to serious injuries.

Our investigation found that, in the days before the incident, staff made entries in Mr K's prison file detailing his aggressive and threatening behaviour. As a result, Mr K's cell could only be opened with a minimum of three staff present, one of whom should be carrying a protective shield.

On the night in question, staff recorded that Mr K was trying to smash the observation panel in his cell door with a metal flask and was threatening staff. A senior officer agreed that staff should go into Mr K's cell to remove the flask and anything else he might use to smash the panel. Four staff were sent to help with the task, one of whom carried a shield. When this officer went into Mr K's cell, staff reported that Mr K reacted aggressively and so they restrained him, using approved control and restraint techniques. Mr K said that the staff assaulted him in his cell. He was seen by a nurse shortly after the incident, who recorded that they could not see any injuries to Mr K, but that he complained of pain all over his body.

The prison provided us with CCTV footage, but there was no BWVC footage available. We identified that none of the staff were wearing BWVC, or had recorded in the incident reports why they were not – as directed by the relevant policy. We found that the incident reports wrongly described the use of force as spontaneous, when all the evidence showed that it was planned, and that staff knew (or should have known) Mr K was likely to respond aggressively, making the use of BWVC even more important. We were critical of the lack of BWVC footage and made a number of related recommendations, which the prison accepted. We concluded that there simply was not enough evidence for us to uphold Mr K's complaint that he had been assaulted.

National recommendations

We take enormous pride in the work we do to investigate and resolve complaints. We know that our investigations have the potential to make a real difference to the complainant, no matter how seemingly large or small the issue at stake. Our intention when we make a recommendation is, where possible, to put things right for the complainant but also, of course, to ensure that lessons are learned and the same mistakes are not repeated. We have been open about our frustration and disappointment, as described in the preceding paragraphs, that we often make the same recommendations time and again.

Sometimes, however, we investigate a complaint that we think could have a significant impact – either for a discrete group of prisoners, or on an important issue. In these cases, we make national recommendations with the aim of changing policy and practice across the service in remit.

Mr L complained that HMPPS staff failed to arrange an autism assessment or to manage him in a way that supported his needs as an autistic person. He said that the failure to arrange the assessment led to delays with his parole hearing and release.

Our investigation found that prison staff had identified that Mr L had autistic traits as early as 2017, but there had been multiple failures to arrange a formal assessment for autism despite this. In 2019, the Parole Board had requested that Mr L be formally assessed for autism, but this had still not taken place by 2020. Eventually, Mr L's legal representative arranged the assessment which confirmed the Autism Spectrum Disorder diagnosis.

We concluded that, between HMPPS and NHS staff, there was a lack of strategic oversight of the process for arranging formal autism assessments for people in the criminal justice system. This left individuals with autistic traits in a 'Catch-22' situation as they did not qualify for protection under the Autism Act without a formal diagnosis.

We upheld Mr L's complaint that staff had failed to arrange the assessment in a timely fashion, and considered that this might well have led to delays in his parole process. We recognised that since Mr L's complaint, there had been a government commissioned independent review of neurodiversity in the criminal justice system which had made recommendations. However, we concluded that the issues raised by Mr L's complaint merited a recommendation that senior HMPPS and NHS staff commission an end-to-end review of the assessment, management and support for prisoners with autistic traits or diagnoses of autism. The recommendation was accepted.

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We take enormous pride in the work we do to investigate and resolve complaints. We know that our investigations have the potential to make a real difference to the complainant, no matter how seemingly large or small the issue at stake.

Investigating fatal incidents

We started investigations into 329 deaths in 2021/22, 23% fewer than last year. While the COVID-19 pandemic continued to pose significant challenges to the safety and wellbeing of all those who lived and worked in prisons, the number of investigations we started into deaths from COVID-19 was smaller than in the previous year, 34 compared with 127.

We started investigations into 193 deaths from natural causes, 106 fewer than last year, and into 85 self-inflicted deaths, two more than in 2020/21. This year we issued 391 initial and 378 final reports, compared to 292 initial and 298 final reports last year.

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We started investigations into 329 deaths in 2021/22, 23% fewer than last year.

Of the 329 investigations we started, 280 related to the deaths of adult male prisoners, 182 of which were deaths from natural causes.

A fuller and more detailed breakdown of the figures for our fatal incident investigations can be found in ‘The year in figures’ section.

COVID-19 related deaths

During 2021/22, we started investigations into 34 COVID-19 related deaths.[4,5] All were people in prison. Their ages ranged from 36 to 87 years old but only two were aged under 50. With the exception of two deaths in April 2021, all occurred between August 2021 and January 2022, during the third wave of the COVID-19 pandemic. This was slightly higher than during the first wave but far lower than in the second wave, in which there were 107 deaths. We published our Learning Lessons Bulletin on second wave COVID-19 related deaths on 15 December 2021.[6] A key difference with deaths in the third wave was that COVID-19 vaccinations were available to all prisoners who wanted them. Of the 10 investigations we have completed into the third wave deaths, five had received both vaccinations, one had received the first dose but not the second, three had declined vaccination and in one, their vaccination status was unknown. In 6 of the cases, the deceased had caught COVID-19 in prison, two had caught it in hospital, one had caught it in the community before their arrest and in one we could not say where they had caught it.

Mr A, who died aged 73, had a serious lung condition which made him clinically extremely vulnerable to COVID-19. He followed advice to shield and accepted the first and second doses of the COVID-19 vaccine. In April 2021, the government advice on shielding was relaxed but they advised those who were extremely vulnerable to consider taking extra precautions. Although Mr A led a slightly less isolated life, he still spent most of his time in his cell due to his poor mobility. Despite this, he became very unwell in August 2021 and tested positive for COVID-19. He died three weeks later in hospital. The cause of death was COVID-19 pneumonitis.

Mr A had not left the prison in the six weeks before testing positive for COVID-19 so he must have caught it in prison. We found that the prison took appropriate steps to protect Mr A and the clinical reviewer was satisfied that he had received a good standard of care. Staff who delivered personal care to Mr A wore the correct Personal Protective Equipment (PPE). However, we found that it would have been impossible to eliminate all risk. It is unfortunate that despite taking up the offer of vaccination

4 The PPO categorises a death as COVID-19 related if COVID-19 is listed on the death certificate or post-mortem report as either a cause of death or as a contributory factor to the death. In some cases, other underlying health issues and illnesses may also be listed as having caused or contributed to an individual's death.

5 This includes one discretionary case: the death of an individual in hospital after their sentence ended while in hospital.

6 Prisons and Probation Ombudsman (2021), Learning Lessons Bulletin, Second wave COVID-19 related deaths. This looks at the 107 deaths during the second wave and is available online at: **https://s3-eu-west-2.amazonaws.com/ppo-prod-storage-1g9rkhjhkjmgw/uploads/2021/12/14.2_PPO_LL_Bulletin_Covid_Fatal_Incident_Investigations_Issue16_Final_v1_WEB.pdf**

and taking sensible precautions, Mr A caught the virus and due to his clinical vulnerability, did not survive it.

Mr B, who died aged 36, had no medical conditions that made him vulnerable to COVID-19. In June 2021, he was offered a COVID-19 vaccination but declined it.

Mr B was tested for COVID-19 because there were several suspected cases on his wing. The next day, staff called an ambulance for Mr B as he was having difficulty breathing. However, paramedics said he did not need to go to hospital but should be monitored closely. That afternoon, a prison nurse gave Mr B a pulse oximeter and asked him to record his blood oxygen levels.

Two days later, a nurse took Mr B's clinical observations and calculated a NEWS2 score (a tool used to assess clinical deterioration) that indicated possible sepsis. However, the nurse assessed that Mr B's symptoms were due to COVID-19 and that he did not have sepsis.

Mr B's blood oxygen levels had improved the next morning but that evening, Mr B said he needed to see a nurse because his blood oxygen levels were low. He was asleep by the time the nurse got to his cell a few hours later. The nurse asked wing staff to contact him when Mr B woke up. Mr B rang his cell bell in the early hours and when the officer responded, Mr B shouted that he needed to see a nurse. The officer did not contact the nurse. Mr B rang his cell bell again 30 minutes later and when the officer responded, he found Mr B breathing but unresponsive on his cell floor. Mr B was taken to hospital but died a week later. Mr B's COVID-19 test result came back as positive on the day he was taken to hospital. His cause of death was recorded as COVID-19 pneumonia.

Mr B had not left the prison for several months, so he clearly caught COVID-19 in the prison. At the time, there were outbreaks of COVID-19 on two of the prison wings. The investigation found that the prison's management of the risk of infection to prisoners and staff was good. However, the clinical reviewer had some concerns with Mr B's clinical care. He was not monitored by healthcare staff as he should have been after paramedics decided not to take him to hospital and he seemed unsure about how to use the pulse oximeter he was given to take his blood oxygen readings. The nurse who recorded the NEWS2 score of 5 did not respond appropriately to his clinical deterioration. The officer who responded to Mr B's cell bell should have contacted the nurse as requested. The clinical reviewer concluded that it was unlikely this affected the eventual outcome, but it could have resulted in Mr B being taken to hospital earlier and prevented his collapse on his cell floor.

Older prisoners

Ministry of Justice (MoJ) data shows that older prisoners are the fastest growing cohort within the prison population in England and Wales. The number of prisoners aged 60 or over has increased by 82% in the last decade, primarily due to the increase in older adults being sentenced for sexual offences.[7] MoJ projects that this population will stabilize over the next four years. However, this does not take into account the implementation of key government policies on increased policing resource and sentencing reform. There are specific challenges with managing older prisoners and ensuring they can access the appropriate health and social care. We began 128 investigations into the deaths of prisoners aged 60 and over in 2021/22, with 28 of these being over 80 and one being over 90. This was 69 fewer than the previous year, when 82 deaths of prisoners aged 60 or over were related to COVID-19. The 128 investigations started accounts for 39% of the total number of deaths we were notified of in 2021/22.

Both Mr C and Mr D were elderly and over 90 years old when they were sentenced for historic sex offences. Both were already frail and had existing long-term health conditions which could not be addressed by prison healthcare teams alone. Despite the challenges, both prisons and their community health and social care partners provided a good level of clinical care, which was equivalent to that which they could have expected to receive in the community. They reflect a sample of four final reports we issued in 2021/22 for prisoners aged over 90.

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> There are specific challenges with managing older prisoners and ensuring they can access the appropriate health and social care.

7 Justice Committee (2020) Ageing Prison Population: Fifth report of Session 2019-2021. House of Commons. Available at: **https://committees.parliament.uk/publications/2149/documents/19996/default/**

Mr C, who was sentenced at the age of 101, had Type 2 diabetes and osteoarthritis and had previously had a heart attack and a stroke, which had left him frail. He was also blind. A social care package was put in place to support Mr C during his time in custody, including a shielding plan to protect him from COVID-19.

Mr C was admitted to hospital twice with pneumonia. When he returned to the prison, he was so frail that he required 24-hour nursing care. However, he maintained the mental capacity to make decisions about his own care. With Mr C's consent, the prison planned a transfer to a hospice for end of life care. However, his health deteriorated significantly, and he was transferred to hospital on an emergency basis with a suspected bowel obstruction. Mr C remained in hospital and died a few days later, at the age of 105. The cause of his death was old age. He also had type 2 diabetes and chronic kidney disease, which contributed to, but did not cause, his death.

The clinical reviewer found that the healthcare Mr C received was reasonable and equivalent to that which he could have expected in the community. However, they identified that systems for recording decisions about Mr C's care in his medical records, were not sufficient. They also found that an earlier decision not to transfer Mr C to a hospice was not communicated to him. We supported these recommendations and found no further non-clinical concerns.

Mr D, who was sentenced at the age of 93, had myelodysplastic syndrome, a type of blood cancer. A few weeks into his sentence, he was admitted to hospital with COVID-19 and pneumonia. He was treated and then transferred to a different prison that could meet his 24-hour healthcare needs. Mr D was transferred to hospital several times to treat various health concerns relating to his frailty and generally poor health.

Over two years after his arrival in prison, at the age of 95, Mr D was found not breathing and with no signs of life. Staff did not attempt to resuscitate Mr D, in line with his wishes. There was no doctor in the prison at the time who could confirm his death. However, a paramedic was called and confirmed this. The cause of Mr D's death was myelodysplastic syndrome. The clinical reviewer concluded that Mr D had received good clinical care while in prison and we found no non-clinical issues of concern.

Adult safeguarding

The 2014 Care Act set out the legal requirements to safeguard adults with support or care needs from abuse or neglect. The Prison Service policy on safeguarding (PSI 16/2015) sets out the responsibilities on prison governors and staff to provide care and support to vulnerable adults.

Safeguarding in prisons is a complex issue, where the input and expertise of prison, health and social care staff, as well as NHS and local authority services, is often required. Alongside these concerns we would also highlight that the rising elderly population, as discussed above, will further contribute to the adult safeguarding challenges for the prison service and partner health and social care services.

In 2021/22, safeguarding issues appeared in a number of our investigations. This included cases where prisoners with care needs were left in unsafe conditions and engaged in self-neglecting behaviour without intervention. We found cases where prisoners with significant care and support needs were not effectively safeguarded. This included a prisoner left on a toilet for 14 hours before being taken to hospital with suspected hypothermia and sepsis and another prisoner who was returned naked under a blanket from hospital. Although he had terminal cancer and was at risk of falling, he was placed in a bed without bed guards or his fall alarm and was not assessed by prison or healthcare staff before being found dead on the floor of his cell two hours later.

Mr E, who was 58, had a history of schizophrenia (although was not on medication for this) and had a pacemaker. Mr E was described by staff as quiet and someone who kept himself to himself. His first six weeks in custody appeared to be uneventful.

After that initial period, Mr E did not leave his cell for four days and failed to collect his evening meals. When healthcare staff assessed him on the morning of the fourth day, they found him unable to stand, confused and disorientated. His meals from the previous day were uneaten.

Mr E was taken to hospital by emergency ambulance. He told the ambulance crew that he had not eaten for two days and had been on his chair for a long time. In hospital, Mr E was diagnosed with sepsis and his kidneys were failing. Mr E died in hospital two weeks later from cardiac tamponade (a build-up of fluid around the heart resulting in pressure that prevents the heart from working properly) and pneumonia.

We were concerned that staff did not seem to realise that Mr E had not been out of his cell for four days. He was not collecting his evening meal or showering for this period and yet there was nothing in his prison record that expressed any concern for his welfare. No safeguarding referral had been raised.

PSI 16/2015, Adult Safeguarding in Prison, identifies people who do not leave their cells as a trigger point for concern and consideration of intervention. We considered that staff needed to be alert to signs of self-neglect, which could indicate a decline in physical or mental health and referred to healthcare staff for clinical input.

Women

We started six investigations into the deaths of women prisoners in 2021/22, compared to ten in the previous year and six in 2019/20. Of these deaths, four were from natural causes, one was self-inflicted and one was from other non-natural causes.

Women in prison often have very complex and diverse needs, with significant co-existing issues, including mental health, substance misuse and complex, fragile relationships. There is a need for holistic, multidisciplinary care to keep them safe. Our investigations have demonstrated how much family ties, friends, support and stability can affect a women's wellbeing in prison.

Our investigations into the deaths of women in prison generally identify similar issues to those of men.

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Women in prison often have very complex and diverse needs, with significant co-existing issues, including mental health, substance misuse and complex, fragile relationships. There is a need for holistic, multidisciplinary care to keep them safe.

Ms F had a history of attempted suicide, self-harm, depression and alcohol misuse. When she arrived in prison, her behaviour was volatile. She completed an alcohol detoxification programme and was monitored under suicide and self-harm prevention procedures (known as ACCT). Over the following weeks, she became more settled and she was no longer considered at risk. The mental health team regularly reviewed her and prescribed antidepressants.

She was then sentenced to a further 12 weeks in prison. Her partner in the community was also sectioned under the Mental Health Act and told Ms F that she had tried to hang herself. Ms F did not share this distressing information with staff. A few days later, prison staff found her hanged in her cell. They tried to resuscitate her despite signs that she had been dead for some time. She was 18 years old.

After her death, notes were found in her cell in which she wrote that she thought she would be better off dead. Other prisoners said that she had been in a relationship with her cellmate and they had had an argument the night before she died.

Ms F hid the full extent of her distress from staff who saw no signs that she was at risk of suicide or self-harm at the time of her death. However, Ms F had some significant risk factors and had been monitored under ACCT procedures shortly after she arrived in prison. We had concerns about how these procedures were managed and how her risk was assessed. While we recognise the difficulties of maintaining meaningful contact with prisoners during the COVID-19 pandemic, more should have been done to engage with her in the months before her death.

Ms F received appropriate support from the mental health and substance misuse teams. However, staff did not use an emergency code when they found her hanged, and they inappropriately tried to resuscitate her, even though it was apparent that she had been dead for some time. It was not the first time we had raised these concerns with the prison.

Ms G, who was 53, had a significant number of long-term health conditions and concerns, including hepatitis C, liver cirrhosis, morbid obesity, cellulitis (a bacterial skin infection), progressive oedema (swelling caused by excess fluid), drug and alcohol misuse, and depression. She was prescribed appropriate medication and her conditions were monitored regularly. Despite this, her health began to deteriorate, and she was admitted to hospital for treatment. Discussions were held about the most appropriate location for Ms G as she needed 24-hour care which the prison could not provide. She therefore remained in hospital, where she died of sepsis caused by cellulitis of the leg, hepatitis C, liver cirrhosis and morbid obesity.

The clinical reviewer concluded that the clinical care that Ms G received was of a good standard and equivalent to that which she could have expected to receive in the community. There was evidence of good continuity of care between the prison and the hospital. The clinical reviewer identified a need for a clear pathway when prisoners are discharged from hospital, but the prison is unable to meet their healthcare needs.

Young people

Two young people aged under 21 died in 2021/22, one in a prison and one in an approved premises. This is one death fewer than in 2020/21. Both deaths were self-inflicted.

As was the case with Ms F, the self-inflicted death of Mr H also demonstrates that prisoners often hide the true extent of their distress from staff. Mr H was a complex young man and staff had made concerted efforts to assess, meet and support his needs.

Mr H was convicted at the age of 17 and was taken to a secure training centre. It was Mr H's first time in custody. It was clear early on that Mr H struggled to mix with others in custody and staff. He was assessed by a psychiatrist as having a complex mental health history and had self-harmed and attempted to take his life on several occasions. A firm diagnosis had not been made due to his young age. Mr H told staff he had plans to kill himself in the community following release. He was monitored and supported by the procedures for managing suicide and self-harm risks in young people in custody.

Following his transfer to a young offender institution (YOI) at the age of 18, Mr H's risk of self-harm and suicide continued to be monitored. Mr H told staff he had no thoughts of suicide at times, and at other times he told staff he would kill himself. He self-harmed several times. Mr H's engagement with staff, support services and the wider regime was mixed. He tended to stay in his cell. However, he had regular contact with his mother, and sometimes spoke to staff.

Four months after he had arrived at the YOI, Mr H was found hanging by a ligature made from a bed sheet in his cell. Paramedics took Mr H to hospital where he later died. In our investigation, it was unclear what might have caused Mr H to take his own life. We found that overall, Mr H had been well supported by the YOI, who made efforts to understand and respond to his complex needs with the appropriate referrals and monitoring. The healthcare Mr H received was assessed as being equivalent to that which he could have expected in the community. However, we identified failings in the sharing of risk information between the secure training centre and the YOI, when Mr H was transferred. We were also concerned about some aspects of the emergency response. These were the short delays in calling an ambulance and going into Mr H's cell.

Foreign national offenders

During 2021/22 there was one death of a resident in an Immigration Removal Centre (IRC) which was due to natural causes. We also issued our report into the self-inflicted death of an IRC resident which occurred in 2020/21.

At the end of his prison sentence, Mr I, a Czech national who was 46, was moved to an IRC pending his deportation to the Czech Republic. He was found hanging that night.

The investigation found that IRC staff did not use interpretation services when conducting Mr I's reception screen and first night assessment. Mr I's English was limited but staff said they thought he could understand them. We consider that telephone interpretation services should have been used for these important conversations and that Mr I's immediate needs were not assessed properly as a result.

We also found delays in providing access to the ambulances when they arrived as staff were unable to unlock one of the vehicle gates. We cannot say whether the delay affected the outcome for Mr I, but the IRC needs to ensure that emergency vehicles are given swift access.

Our investigations into the deaths of foreign national people in prisons similarly found that there continued to be a lack of use of interpretation services by prison staff. There were also instances where the prisoner's concerns about their immigration status were not recognised as a risk factor for suicide.

Mr J, a Romanian national who was 26, was in prison for the first time in the UK and he spoke little English. His behaviour was sometimes challenging, often fuelled by the use of psychoactive substances. In July 2019, a psychiatrist assessed that Mr J had marked anti-social and emotionally unstable personality traits. He recommended counselling but a referral was not made until March 2020, by which time no one could be seen because of the COVID-19 pandemic.

Mr J self-harmed when he was under stress and was managed using suicide and self-harm procedures, known as ACCT, on three occasions in 2019 and another three times in 2020. Staff stopped the last period of ACCT monitoring on 30 May 2020, after just one day, when they assessed that Mr J's mood was better. He was found hanging on 1 June and died three days later in hospital.

The investigation found that although Mr J was generally well supported during ACCT monitoring, there was no attempt to facilitate contact with his family in Romania, even though lack of contact was identified as one of his key concerns. It also found that many significant and sensitive discussions, such as ACCT reviews, mental health assessments and key worker sessions were held with no interpreter or with another prisoner acting as interpreter. This was unacceptable.

The severe restrictions introduced at the start of the COVID-19 pandemic appeared to have a detrimental impact on Mr J's mental health, which declined significantly from March 2020. At that time, prisoners had only one hour a day out of their cell. The COVID-19 pandemic also impacted on the availability of counselling. Mr J was not seen before he died, partly due to delays in referring him and by the time he was referred, no one was being seen because of the pandemic. The clinical reviewer considered that psychological counselling could have helped Mr J develop healthier coping strategies.

Mr K, a 34 year old Polish national and the subject of a European arrest warrant, was sent to prison in the UK in December 2019 pending his extradition to Poland. His appeal against extradition was still outstanding when he died in February 2021.

Mr K made seven self-referrals to the prison's mental health team between February 2020 and February 2021. He was not seen by anyone in the mental health team until 7 February 2021, when a mental health nurse saw him during a welfare check. The nurse referred him to the prison GP to discuss his mood and assess his sinusitis. The GP saw Mr K on 12 February and prescribed ibuprofen for the sinusitis but did not ask him about his mood. The GP had no concerns about Mr K and described his presentation as 'normal'.

Five days later Mr K was found hanged in his cell.

We found that prison staff had no meaningful interaction with Mr K during his last 11 months. No one considered that his ongoing uncertainty about his extradition may have been a risk factor for suicide.

Mr K's mental health was never properly assessed, despite him making seven self-referrals. There was also a missed opportunity to assess his mental health on 12 February, when he was seen by the GP.

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Our investigations into the deaths of foreign national people in prisons similarly found that there continued to be a lack of use of interpretation services by prison staff. There were also instances where the prisoner's concerns about their immigration status were not recognised as a risk factor for suicide.

Post-release deaths

In September 2021, we launched a year-long pilot to investigate the deaths of those who die within 14 days of their release from prison. Since the beginning of the pilot to the end of the 2021/22 financial year, we have started investigations into 25 post-release deaths. The majority of these deaths have been males (22), with the mean age of all deaths investigated so far being 41 years. Although we will report fully at the end of our pilot, the following reflects a sample of our early reports and our preliminary findings.

Both case studies reflect the vulnerability of those released from prison, and our investigations have highlighted the need for strong communication between prison, probation and other agencies to meet the complex needs and support the wellbeing of people released from prison on issues ranging from mental health, risk of suicide and self-harm, substance misuse and homelessness.

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In September 2021, we launched a year-long pilot to investigate the deaths of those who die within 14 days of their release from prison. Since the beginning of the pilot to the end of the 2021/22 financial year, we have started investigations into 25 post-release deaths.

Six months before he died, while under probation supervision, police found Mr L standing on a bridge. He denied that he was suicidal but said that he had substance misuse and relationship issues. Police passed this information to probation but his Community Offender Manager (COM) did not discuss the incident with him or update his risk assessment. Mr L was given a new COM the following month, but they were not told about the incident on the bridge.

The month before he died, Mr L was arrested for theft and given bail. Three weeks later, police again found Mr L on a bridge, and he was remanded into prison custody for breaching his licence conditions as he had breached his curfew. Police records stated that he had planned to jump from the bridge and had taken a drugs overdose. The prison managed him under ACCT until his release on bail two days later. Mr L was found hanged at his home, two days after he was released from prison. He was 34 years old.

There were several communication failures and missed opportunities to explore and try to address Mr L's risk of suicide. The prison failed to tell community probation staff that he had been monitored under ACCT procedures or communicate the reasons why. The COM missed an opportunity to explore the incident on the bridge with Mr L six months before he took his life. The case handover between that COM and the subsequent COM was not sufficiently thorough and the COMs were not offered support after Mr L's death.

Ms M, 43, had a significant history of substance misuse and her recent sentences reflected a cycle of offending linked to her substance misuse, short prison sentences and community supervision. She arrived at prison withdrawing from heroin and alcohol. She was prescribed methadone (an opiate substitute) and completed an alcohol detoxification programme.

Ms M was eligible for early release from prison. She stopped taking methadone. She was to be prescribed naltrexone (a drug that reduces drug cravings) before her release but this did not happen as she was released at short notice and the process for prescribing naltrexone took a week.

Ms M was referred to Nacro BASS, a bail and accommodation support service, as she had nowhere to live on release. The Offender Management Unit informed Nacro BASS that she had no substance misuse needs. Ms M accepted the offer of a room in a hostel.

The prison resettlement team and substance misuse team only found out that Ms M was to be released the day before her release. She was left to make her own appointment with the local drug recovery service as she was no longer taking methadone. She was advised about the risks of mixing drugs and overdosing.

After her release, Ms M breached her licence a number of times: she was late to return to the hostel twice (the first time because she was drunk),

she drank alcohol in her room with an unknown male visitor, she behaved inappropriately and admitted to drinking alcohol and smoking cannabis. Her offender manager issued a warning.

Ms M was found dead in the hostel, three days after she was released from prison. She died from cocaine toxicity.

There were gaps in information sharing about Ms M's substance misuse. Some relevant information about this was not shared effectively between the prison and probation services, and the hostel where she lived. This meant that key information that may have informed decision-making was not available. Ms M was given conflicting advice about the substance misuse service she was required to engage with. Her licence condition required her to attend a service not local to her while her offender manager advised her to attend a local one. There is no evidence that Ms M was referred to her local Integrated Offender Management Unit following her release.

Approved premises

We began investigations into the deaths of 13 residents of probation approved premises (APs) in 2021/22, two fewer than last year. Of these deaths, four were self-inflicted deaths, three were from natural causes and six were from other non-natural causes such as drug-related deaths.

Although we continue to see drug-related deaths, there were three fewer than last year. In previous years, we have persisted in recommending that the Probation Service should update its drug strategy to include the provision of naloxone and testing for psychoactive substances in APs. We are pleased that naloxone has now been rolled out to all APs across England and Wales, and the Probation Service's drug strategy widens the range of drugs that can be tested for in APs and includes testing for psychoactive substances, cocaine, cannabis, pregabalin and some other prescription drugs.

Naloxone has been administered by AP staff on 26 occasions and contributed positively to saving lives.[8] APs have now set the blueprint for rolling out naloxone in the community, and work has begun for this to be replicated across frontline services such as ambulance services and the Salvation Army. This is a good example of how our recommendations can effect positive change.

Although good work continues to be done in APs, we know that the demands on staff working in them are considerable. The following cases illustrate the nature and complexities they face to support residents and keep them safe.

8 Data provided by National AP team who hold data on centrally reported use of Naloxone in all APs as part of Serious Incident Notifications – reporting from June 2020 to July 2022.

Ms N, who was 44 years old, was diagnosed with Unstable Emotional Personality Disorder, Borderline Personality Disorder and Anti-Social Personality Disorder. Her offence and her previous offending history were associated with drug and alcohol abuse. She engaged with therapy while in prison.

After serving her sentence, Ms N was released on parole to a Psychologically Informed Planned Environments AP which is designed to support and manage individuals with complex needs.

Ms N arrived at the AP with a significant amount of medication, including amitriptyline (an antidepressant), nefopam (a painkiller) and pregabalin (to treat nerve pain). Her medication was held by AP staff and dispensed from the staff office while a medication risk assessment was completed. The risk assessment was completed incorrectly which meant that Ms N was able to keep some of her medication, including pregabalin. Pregabalin is a controlled drug so staff should have stored it securely under supervision.

Ms N had been at the AP for 11 weeks and there had been no significant problems during that time. Although she had initially been very nervous about life outside prison, she seemed to have settled at the AP and kept herself very busy. There were problems arranging her mental health support in the community, but she received support from other sources.

A few days before her death there appears to have been a downturn in her mood and Ms N told her keyworker that she was struggling and felt worthless. However, she denied any thoughts of suicide or self-harm.

On the afternoon of her death, Ms N returned to the AP drunk. At some point she took large amounts of her prescribed antidepressants and painkillers. After AP staff breathalysed her, Ms N became aggressive and then collapsed on the floor outside her room. Staff observed her on CCTV from their office but left her lying there for around 45 minutes before another resident told them she was not breathing. They called an ambulance and began CPR, but the ambulance staff confirmed that she had died.

We were concerned that staff did not realise there was a possibility that Ms N had taken some of her medication on the day of her death; that they did not call the police when she became aggressive; and, most importantly, that they left her lying on the floor for 45 minutes unresponsive or semi-conscious without properly observing her.

Ms N took a substantial amount of pregabalin on the day she died. We do not know how she collected this amount. She may have obtained it illicitly or she may have stockpiled it when it was dispensed to her by staff each day. We were concerned that AP staff did not know that pregabalin was

a controlled drug a year after it was made one and that as a result Ms N had the drug in her possession for at least a week.

Mr O, who was 51, was monitored under ACCT on several occasions in prison between 2006 and 2019.

Towards the end of 2019, Mr O transferred to an open prison. Although it had been intended that he would be released to an AP in his home area, he wanted to make a fresh start in a different area where he said he thought there would be more employment opportunities. Prison staff therefore explored the possibility of release to an AP in his chosen area.

In February 2021, Mr O was released on licence to an AP in his preferred area. AP staff completed his induction and recorded in his 'risk to self' assessment that suicide and self-harm had not previously been identified as an area of concern for him, but that he had "had thoughts over 30 years ago". They also recorded that he had been subject to ACCT procedures back in 2006 and assessed his overall risk to himself as low. They did not record that he had had thoughts of self-harm in 2018/19.

Mr O's stay at the AP was only temporary. He started looking for private rented accommodation but was aware that finding somewhere to live in his chosen area would be difficult. His offender manager met with him and told him that the local council might not house him as he had no local links to the area. He told her that he did not want to go back to his home area as he wanted a new start.

Mr O began to feel stressed about his housing situation but continued proactively looking for somewhere to live. Over the next few weeks, AP staff did not raise any concerns about him. Staff continued to meet him regularly and helped him with several issues including accessing benefits and attempting to secure suitable accommodation. He was due to leave the AP at the end of May.

At the beginning of May, staff advised Mr O that he needed to start looking at supported accommodation and hostels for those at risk of homelessness, as his due date to leave the AP was fast approaching. He told them that he did not want to live in supported housing. They talked through the options available to him and tried to manage his expectations and he appeared to accept what they advised him.

Later that afternoon, Mr O asked a member of AP staff if he could help him find an email from the council about his housing situation. The member of staff told him that he was busy but would be free in a couple of hours and suggested that he ask one of the other members of staff instead, and Mr O said that he would.

Half an hour later, Mr O went for a walk. He killed himself by jumping from a bridge.

We were not able to say what led Mr O to kill himself. He was due to leave the AP three weeks after his death and there is evidence that he was worried about having somewhere to live after that. He was also in a relationship, but he did not speak about this to staff and we have no way of knowing if this was also an issue for him at the time of his death.

Despite good evidence of collaborative working with Mr O's offender managers, we were concerned that AP staff did not know that Mr O had had thoughts of self-harm in 2018/19. We recommended that offender managers should obtain all relevant risk information and share it with AP staff to inform 'risk to self' assessments for new residents.

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In previous years, we have persisted in recommending that the Probation Service should update its drug strategy to include the provision of naloxone and testing for psychoactive substances in APs.

We also investigated the case of Mr P, a young person who died 12 days after being released from prison, while he was a resident at an AP.

Mr P was released from prison to an AP. Mr P was 19 years old and had a long history of offending, substance misuse and mental health issues. His engagement with support services was mixed. When Mr P arrived at the AP, he told staff that he had no thoughts of suicide or self-harm.

Mr P had to attend a court hearing for the application of a Sexual Harm Prevention Order against him. He did not discuss the outcome with AP staff when he returned. Two days later, Mr P did not return to the AP by his curfew. Police informed staff he had died after jumping or falling from a bridge in the city. Mr P had been living at the AP for 12 days when he died.

We could not be sure whether Mr P had meant to take his own life, or whether it was an accident (he had also been drinking alcohol before he died). At the inquest, the cause of death was neck, chest and pelvic injuries. We found that AP staff were focused on the risk Mr P posed to others, rather than the risk he posed to himself or that others posed to him. We were concerned that the assessment of his risk to himself was limited and based primarily on Mr P's denial of suicidal thoughts rather than a holistic consideration of the risk factors he presented. We also considered that it would have been good practice for

staff to have asked Mr P about his court hearing, given the impact it might have had on his wellbeing.

Babies

We were asked by the Secretary of State for Justice to investigate the deaths of two babies, one of which was a stillborn baby in prison. At that time, the investigations were outside our Terms of Reference. We have, subsequently, expanded our remit so that any future deaths of babies in prison, or children in Mother and Baby Units, will be investigated within our Terms of Reference. We have used the learning and findings from these investigations to influence changes to relevant prison service policies.

Baby A

Ms A was pregnant when she was remanded to prison in August 2019. She had refused all antenatal treatment in the community and there was conflicting information about when her baby was due. A pregnancy test in February indicated a delivery date between 6 September and 6 October but a visual assessment in hospital in July estimated her baby was not due until November.

Shortly after her arrival in prison, a visiting midwife measured the unborn baby and the result indicated the baby was due between 24 September and 14 October. The midwife did not recalculate the due date and prison staff continued to believe the baby was due at the end of November. At about the same time, Ms A was told by social services that her baby was likely to be taken from her after birth. Ms A refused all other antenatal care at the prison and gave birth alone in her cell during the night of 26/27 September. The pathologist was unable to conclude whether the baby was born alive or stillborn.

We concluded that the healthcare offered to Ms A was not equivalent to that she could have expected in the community. Information sharing within the prison and health agencies was poor and the approach to managing Ms A was uncoordinated. No one responsible for Ms A's care had a full history of her pregnancy.

Ms A was a vulnerable young woman with a complex history who found it difficult to trust people in authority. She was afraid (with reason) that her baby would be taken away from her immediately after birth and she refused to engage with maternity services. She was a challenging person to manage but we found that the midwives' approach to her care was inflexible and insufficiently trauma-informed and that there was no plan for dealing with a pregnant woman who refused to accept the usual procedures.

Prison healthcare staff were not sufficiently involved in maternity care in general and in Ms A's maternity care specifically. Maternity services at the prison were outdated and inadequate. There was insufficient oversight of the

midwifery team by the local hospital that employed them. The midwife-centric model of maternity care in the community is not appropriate in a custodial setting.

There was a lack of clarity about Ms A's estimated delivery date. It should have been calculated using the only clinical information available, which was the measurement of the unborn baby taken by the midwife and which indicated the birth would occur between 24 September and 14 October.

In the days leading up to Baby A's birth there were several missed opportunities to increase observations on Ms A that might have led to her labour being discovered. A nurse and officer who spoke to Ms A on 25 September should have started ACCT after she said she would kill herself or someone else if her baby was taken away.

Staff working on Ms A's house block on 26 and 27 September did not know that Ms A might give birth imminently. The response to Ms A's request for a nurse on 26 September was completely inadequate. An ambulance was not called promptly in response to two medical emergency codes on 27 September.

Baby B

It was Ms B's first time in prison. At an initial health assessment, a nurse asked Ms B whether she was pregnant and offered her a pregnancy test. Ms B declined the pregnancy test and said it was not possible she was pregnant because she did not have sexual relationships with men.

Over the next few months, Ms B did not report any obvious symptoms of pregnancy. None of the staff or prisoners we interviewed, including her cellmate, thought Ms B looked pregnant or considered she might be.

One afternoon three months into her sentence, Ms B began bleeding from her vagina. She continued to pass a lot of blood and in the early evening, she began complaining of pain. That evening, a supervising officer contacted the duty nurse three times and told her that Ms B was in a lot of pain and her stomach was swollen. The nurse did not assess Ms B. Almost an hour later, an officer responded to Ms B's emergency cell bell and found her on all fours in great pain.

The officer rang the duty nurse, who arrived within 30 seconds. While the nurse was talking to Ms B, she began to give birth sitting on the toilet. The nurse radioed for an ambulance, but the prison's radio system had failed a few minutes earlier and, although staff with radios could hear each other, the communications officer in the control room could not hear them. The nurse delivered the baby, who was stillborn.

Ms B did not know she was pregnant until her baby was delivered, and she did not report any symptoms that might reasonably have led staff to suspect

that she was. Several officers thought Ms B was pregnant when they saw her during that evening, but they all rightly accepted Ms B's conviction that she could not be. The supervising officer on Ms B's houseblock acted appropriately to alert the duty nurse to Ms B's condition and update her when the situation changed.

The duty nurse did not review Ms B's record sufficiently or go to see Ms B as she should have done. She failed to fully assess Ms B's clinical situation, and this was a serious error of judgement. There was a communications failure during the emergency response that led to a delay in calling an ambulance and in providing the ambulance service with enough information to triage the emergency properly.

We made recommendations about the initial and secondary health assessments used across the prison estate, which do not reflect the gender-specific standards introduced by Public Health England (PHE) and do not readily facilitate the discovery of denied pregnancy (the clinical term for when a woman is unaware of, or unable to acknowledge, the existence of her pregnancy).

We also recommended that there should be guidance to staff on what to do in the event of an unexpected birth, and training for nurses in women's prisons in reproductive health, long-acting reversible contraception and recognising early labour.

Appendices

Recommendations

Our vision is that the PPO's independent investigations contribute to making custody and offender supervision safer and fairer. A vital part of fulfilling this ambition involves making effective recommendations for improvement in both complaint and fatal incident investigations. Our recommendations must be specific, measurable, realistic and time-bound and must focus on outcomes to deliver the required changes needed to reduce the likelihood of repeat failings.

When we make recommendations in a fatal incident investigation, the service in remit must confirm where a recommendation is accepted and produce an action plan outlining what action will be taken and when, and who will be responsible for the action.

For complaints, the organisation must confirm whether they accept any recommendations and must provide evidence of implementation. Where the service in remit does not accept a recommendation, the Director General of Prisons must notify the PPO for public sector prisons. For other services in remit, and for privately managed prisons, a designated senior manager must respond.

The PPO has agreed a feedback loop with HM Inspectorate of Prisons (HMI Prisons) to support independent assessment about what prisons have done to implement our recommendations. As part of their inspections, HMI Prisons follow up the recommendations we make following fatal incident investigations. They also invite PPO complaint investigators to identify any particular issues they wish to raise about a prison prior to the inspection.

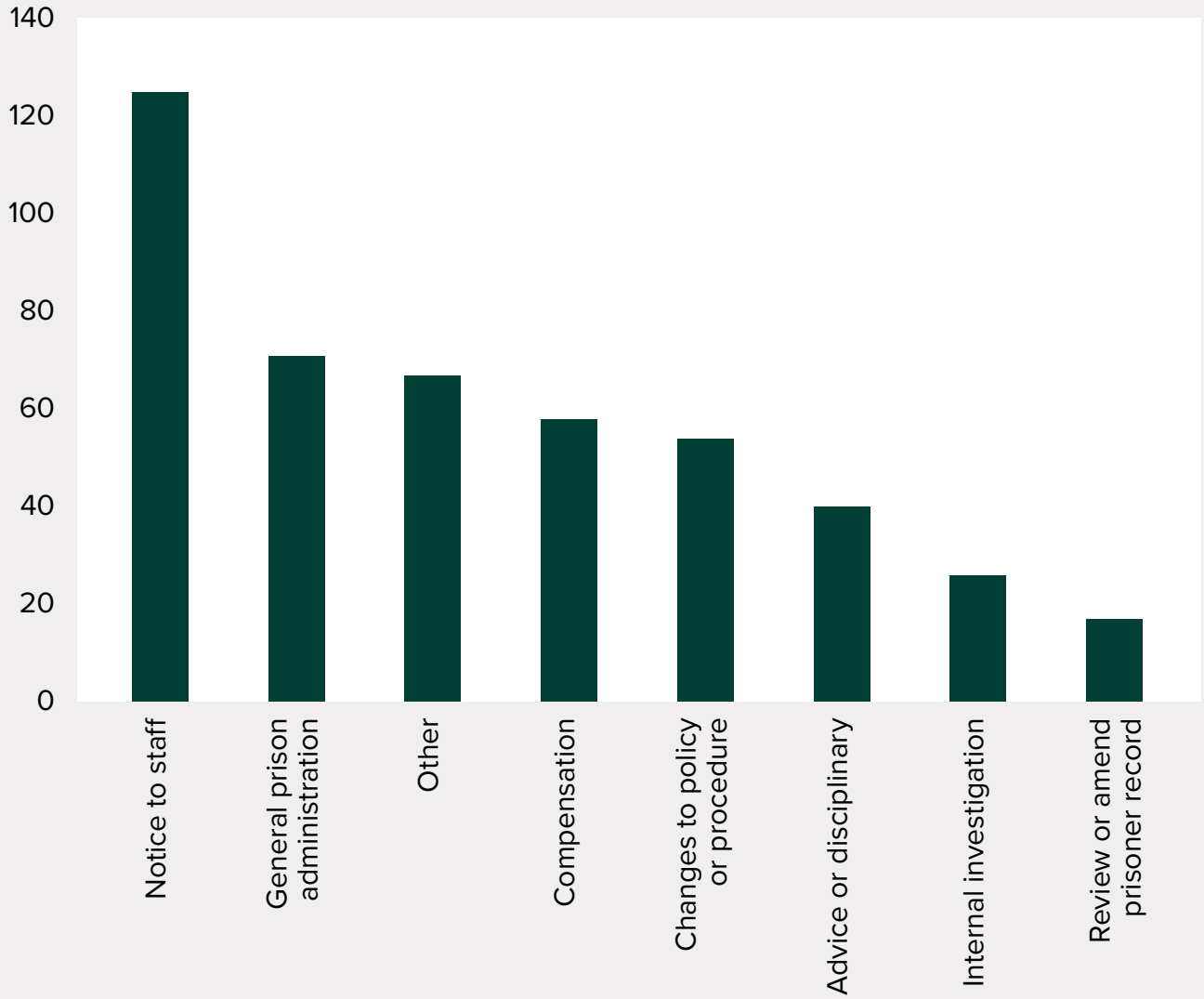
Our investigations provide an opportunity to understand what has happened and to correct injustices. Recommendations also enable us to identify learning for organisations, including sometimes at national level. Disappointingly, we continue to identify repeat concerns and failings as we make the same recommendations, sometimes in the same establishments, and sometimes after the recommendations have been accepted and action plans agreed to implement them.

Complaints

We count recommendations about complaints in cases where we have issued the final report within the financial year. Please see the 'About the data' section for more details.

In 2021/22, we made 458 recommendations across 186 cases, with an average of 2.5 recommendations per case. We are awaiting a response for 83 of these recommendations. We have had one recommendation rejected and in a further two, the situation had changed. The remaining 372 have been accepted, and we have received evidence of implementation of 84% of these. This is an increase from 76% in the previous year.

Complaints recommendations, by action (2021/22)



Fatal incidents

We count recommendations about fatal incidents investigations in cases where the final report was issued in the financial year. Please see the 'About the data' section for more details.

In 2021/22, we issued 378 final investigation reports following deaths in custody and made recommendations in 308 of these cases.

We made 1,125 recommendations, with an average of 3.7 per case.

At the time of writing, most of our recommendations had been accepted (1,010) and we were awaiting the service response to 114 recommendations. One of our recommendations was rejected by HMPPS.

Health provision recommendations covered a wide range of issues such as the need for robust record-keeping, following NICE guidance, timely referrals for health appointments and prescription medications.

Emergency response recommendations covered staff understanding their responsibilities in emergency incidents. This included the correct use of the emergency code system, administering CPR in line with best practice, entering cells without delay, carrying the correct equipment and calling ambulances.

Our recommendations relating to suicide and self-harm prevention included:

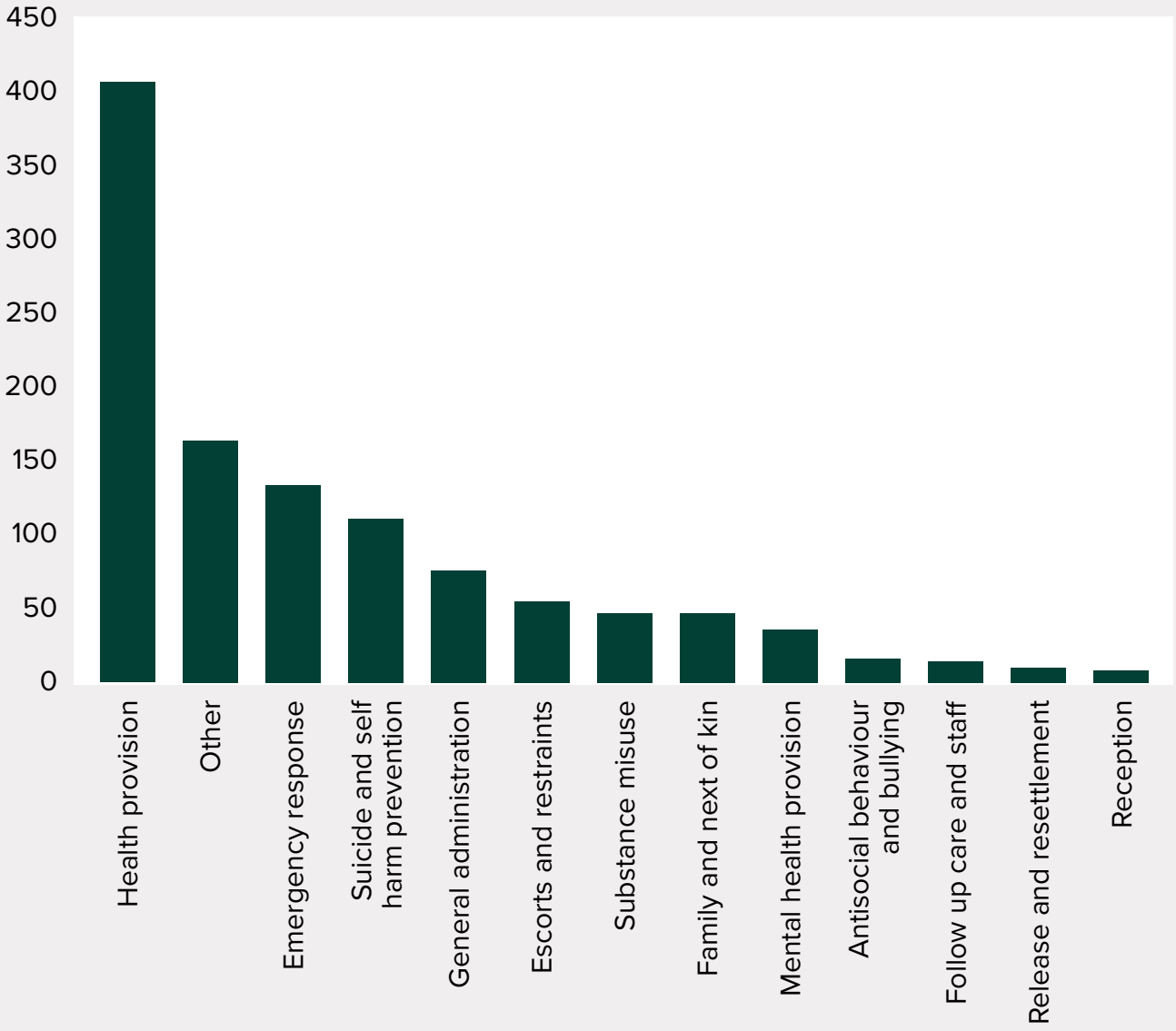
- assessing prisoners based on their risk factors
- accurate record keeping and care plans
- carrying out meaningful welfare checks – including after court appearances and family/friend deaths
- following ACCT procedures

Some of the recommendations we made related to COVID-19.[9] These included:

- identifying those at risk and advising them to shield
- accurate record keeping
- appropriate care plans put in place
- staff being aware of who is positive for COVID-19
- appropriate use of the NEWS2 scoring system

9 Please see the 'About the data' section for details on COVID-19 recommendations.

Recommendations following deaths, by category (2021/22)



Stakeholder feedback – emerging findings

We collect feedback from our stakeholders to understand how they engage with our work, their level of satisfaction and to seek suggestions on how we can improve. To that end, the PPO runs four rolling stakeholder surveys to obtain feedback from:

- those with whom we engage (by way of our general stakeholder survey)
- those involved in deaths in custody investigations (by way of our fatal incidents post-investigation survey)
- the next of kin of deceased prisoners (by way of our bereaved families' survey)
- those who complain to us (by way of our complainants' survey)

General stakeholder survey

We ask a broad range of stakeholders for feedback on our performance over the previous year. This includes feedback on our investigations into fatal incidents and complaints.

We received 96 responses in 2021/22, compared to 490 responses in 2020/21. We have included partial survey responses this year, as we did in 2020/21. The survey ran throughout March 2022 and responses came from prisons (including operational staff, non-operational staff, business staff and other services such as chaplaincy) probation, healthcare services, MoJ, HMPPS HQ and others.

Overall satisfaction

- 58 of the 67 respondents who had some experience of the PPO in the past year rated the overall quality of their experience as satisfactory or better.

Reports

- Of the 32 respondents who had read PPO reports (complaints, fatal incidents, or both), 23 found these reports to be quite or very clear.
- 41 out of the 63 respondents who answered the question found anonymised fatal incident reports very useful or quite useful.

Our website

- 48 of the 58 respondents who answered the question said they had visited the PPO website in the last 12 months.

Impressions of the PPO

- Of the 56 respondents who answered the question, 38 agreed we were impartial, 45 agreed we were respectful, 39 agreed we were inclusive, 38 agreed we were dedicated and 39 agreed we were fair.[10]

10 Includes those who agreed and strongly agreed.

Post-investigation survey

Following each fatal incident investigation, we send our post-investigation survey to prison liaison officers, establishment heads and healthcare leads within the establishment. We ask that these stakeholders respond to the survey about specific investigations. We also survey coroners at the end of the year about their overall experiences with fatal incident investigations.

We received 243 responses (from 610 surveys sent) in 2021/22. This is a 17% increase from last year, when we received 208 responses (from 464 surveys sent). This includes partial survey responses. We received responses from liaison officers, establishment heads, healthcare leads and coroners.

Overall satisfaction

- 96% of respondents (of the 119 who answered the question) rated the quality of the investigation as satisfactory or better.
- 87% of respondents (of the 240 who answered the question) rated the quality of the communication with the PPO as satisfactory or better.

Reports and recommendations

- 95% of respondents (of the 110 who answered the question) stated the report we issued met their expectations.
- 95% of respondents (of the 107 who answered the question) stated that the PPO report contained about the right amount of detail.
- 67 respondents (of the 74 who answered the question) said they found the recommendations fair or very fair.
- We asked coroners how worthwhile they found the recommendations. 14 (of the 15 who completed the survey) stated they were quite or very worthwhile.

Impressions of the PPO

- Of the 228 respondents who answered the question, 89% agreed we were impartial, 93% agreed we were respectful, 86% agreed we were inclusive, 90% agreed we were dedicated and 91% agreed we were fair.[11]

Bereaved families' survey

We also send surveys to families or the next of kin of the deceased following our investigations of deaths in custody. A questionnaire is usually sent to bereaved families three months after the final investigation report is issued. Due to COVID-19 restrictions, the surveys were sent out later than that in some cases. (Please see the 'About the data' section for further details.)

We have received 34 responses (from 251 surveys sent) during this data collection period, compared with 11 responses (from 104 surveys sent) in 2020/21.

11 Includes those who agreed and strongly agreed.

Overall satisfaction

- 17 out of 29 respondents who answered the question felt that the overall quality of the PPO's investigations was very good or good; 8 deemed it poor or very poor.
- 16 out of 34 respondents who answered the question felt satisfied or very satisfied with the PPO's communication; 11 felt dissatisfied or very dissatisfied.

Reports

- 17 out of 32 respondents who answered the question felt the initial (draft) report met their expectations.
- Of the 27 respondents who answered the question, 18 thought there was the right amount of detail, with 8 respondents thinking there was not enough.

Impressions of the PPO

- Of the respondents who answered the question, 17 agreed we were impartial, 23 agreed we were respectful, 14 agreed we were inclusive, 15 agreed we were dedicated and 18 agreed we were fair.[12]

Complainants' survey

We send surveys to a sample of those whose complaints we have investigated in the past year – both to those whose complaints were upheld, and those whose were not upheld. We also sample those who have contacted us, but whose complaints were ineligible. A questionnaire is usually sent to complainants two months after the case has been closed, to allow for a rest period where any potential final changes may be made. Due to COVID-19 restrictions, the surveys were sent out later than two months in some cases. (Please see the 'About the data' section for further details.)

We received 407 responses (from 933 surveys sent) in 2021/22, in comparison with 169 (from 613 surveys sent) in 2020/21:

- 156 responses came from those whose complaints were ineligible. These complaints were not investigated, and the complainants received letters explaining why.
- 251 respondents had eligible complaints. 122 had their complaints upheld or partially upheld and 129 had their complaints not upheld.[13]

12 Includes those who agreed and strongly agreed. There were different numbers of respondents who answered each question: 31 for impartial, 31 for respectful, 30 for inclusive, 29 for dedicated and 31 for fair.

13 Please see the 'About the data' section for what is an eligible, upheld and not upheld case.

Complaint handling

- 39% of respondents (of the 113 who answered the question) whose complaints were upheld said COVID-19 had affected the way their complaint was handled by us.
- Of those whose complaints were not upheld, 52% of respondents (of the 115 who answered the question) said COVID-19 had affected the way their complaint was handled by us.
- For those whose complaints were ineligible, of the 133 who answered the question, 40% of respondents said COVID-19 had affected the way their complaint was handled by us.
- During the pandemic, HMPPS agreed with the PPO that complainants in prisons could get free photocopies of their complaint forms.
  - 45% of respondents whose complaints were upheld (of the 112 who answered the question) said they were able to get free photocopies of their complaint form.
  - 47% of respondents said they could not, and 8% said they did not know.
  - 38% of respondents whose complaints we did not uphold (of the 112 who answered the question) said they were able to get free photocopies of their complaint form.
  - 27% of respondents whose complaints were ineligible (of the 132 who answered the question) said they were able to get free photocopies of their complaint form.

Quality of investigation and service

- 68% of respondents (of the 111 who answered the question) whose complaints were upheld rated the quality of investigation as either satisfactory or better.
- Of those whose complaints were not upheld, 29% of respondents (of the 110 who answered the question) rated the quality of investigation as either satisfactory or better.
- For those whose complaints were ineligible, we asked their opinion about the overall quality of the service they received. Of the 135 who answered the question, 39% of respondents rated the service they received as either satisfactory or better.

Reports and letters

- 91% of respondents whose complaints were upheld (of the 112 who answered the question) said they understood the report or letter they received. 6% of respondents stated they had not received a report or letter.
- 88% of respondents whose complaints we did not uphold (of the 116 who answered the question) said they understood the report or letter they received. 9% of respondents stated they had not received a report or letter.
- 50% of respondents whose complaints were ineligible (of the 136 who answered the question) said that our letter explaining why their complaint wasn't eligible was clear. 20% of respondents stated they had not received this letter.

Outcome

- 64% of respondents whose complaints were upheld (of the 111 that answered the question) agreed that the PPO helped them reach a satisfactory outcome to their complaint.
- In contrast, 18% of respondents whose complaints we did not uphold (of the 114 that answered the question) agreed that we helped them achieve a satisfactory outcome.
- For those whose complaints were ineligible, we asked if they had done anything differently after contacting us, 44% respondents stated they had (of the 133 that answered the question).
    - Respondents were asked what they were planning to do with their ineligible complaint. Of the 156 that answered the question, 26% said they would send it to a different body. 17% stated they would send it back to the Ombudsman and 8% stated they would complete the internal complaints procedure.

Impressions of the PPO

- Of the respondents who answered the question, 35% agreed we were impartial, 60% agreed we were respectful, 43% agreed we were inclusive, 37% agreed we were dedicated and 36% agreed we were fair.[14]

14 Includes those who agreed and strongly agreed. There were different numbers of respondents who answered each question: 355 for impartial, 347 for respectful, 342 for inclusive, 345 for dedicated and 351 for fair.

About the data

Statistical data tables can be found on our website: **www.ppo.gov.uk/about/latest-statistics**. These tables are available for those without internet access by request.

Some totals may not add up to 100% due to rounding.

Some figures have been updated and corrected, and therefore do not match what was published in the previous annual report.

Complaints

Complaint categorisation is based on the substantive element of the complaint. Categorisation is carried out by the assessment team and may be edited by the investigator through the course of the investigation. This can lead to similar complaints being categorised differently.

In 2020, the PPO added a tick box to the case management system we use, so we could highlight COVID-19 related cases. The following guidance is used to help guide what should be classified as a COVID-19 complaint:

- The COVID-19 category is applied as soon as a COVID-19 related element becomes apparent, from the initial assessment stage to the finalisation of the case. The COVID-19 element is removed if it subsequently becomes apparent that the complaint is not COVID-19 related.
- The COVID-19 category is applied, if relevant, to all complaints, even if the complaint is not eligible or is subsequently dealt with in line with Paragraph 20, set out in our Terms of Reference.[15]

The COVID-19 flag is added to cases where the complaint:

- mentions COVID, COVID-19, coronavirus, pandemic and/or epidemic in the complaint forms
- relates to any temporary measure or policy put in place by the prison because of the pandemic – for example social distancing, self-isolation, restricted prison visits, education, reverse cohorting units, protective isolation units, shielding units
- relates to access to cleaning products, PPE or access to laundry facilities because of the complainant's concerns about COVID-19
- relates to a lack of staff (includes operational, non-operational staff) where COVID-19 is the cause of the staffing shortage including healthcare, religious ministers, meetings or education provision

A complaint is eligible if it is from a person who has been through the relevant internal complaints process (the two-stage prison process, or the immigration or probation process) and the complainant brings it to us within three months of receiving the final stage reply from the service in remit. The complaint also has to be about something which is within our remit.

A complaint is upheld if, after investigation, we find in favour of the complainant – i.e. we find the service in remit has acted contrary to their local and/or national policy, or otherwise inappropriately or unreasonably. Upheld cases comprise of cases which are upheld and partially upheld. A complaint is

15 **https://www.ppo.gov.uk/about/vision-and-values/terms-of-reference/**

not upheld if we find that the service in remit has acted in keeping with policy, if there is no specific relevant policy, or if they have not acted unreasonably or inappropriately.

Complaints data contained in this report is frozen. Data for 2020/21 was frozen in April 2021, data for 2021/22 was frozen in April and May 2022. Data for each section was frozen on different days, so represents different cohorts of cases.

A small number of cases received and completed will be counted in multiple years. This only happens when a previously closed case is subsequently reopened after we have received new information over different financial years.

Each case that is ineligible for investigation will be categorised with a reason for its ineligibility. This can happen several times if the complainant continues to send correspondence that would still render their case ineligible, but the reasoning for the ineligibility can update and change.

The number of eligibility letters sent in 2021/22 refers to letters of eligibility that the PPO sent to complainants in both eligible and ineligible cases. In some cases, the PPO sent multiple eligibility letters about the same case. This happens when a case does not initially meet the eligibility criteria but is later deemed to be eligible when we receive further information. This includes the number of eligibility letters prepared and not sent. This only happens in a small number of cases when we receive a complaint and we are unable to send the eligibility letter – for example, if we do not have access to the complainant's release address.

A completed case in 2021/22 is defined as one where the draft outcome has been approved. This excludes withdrawn and Paragraph 20 cases. We have not been able to calculate how many cases were completed on time as our move to a new case management system resulted in a change in definition. We are continuing to explore ways to collect this data in the future.

A 'backlog' is defined by the PPO as any complaints case that is eligible for investigation but has not been allocated to an investigator within 12 weeks of the date it became eligible.

Prison population data is taken from the March 2022 population bulletin published on GOV.UK: **https://www.gov.uk/government/publications/prison-population-figures-2022**.

HMPPS complaints data

The HMPPS data used does not represent national statistics, as it comes from an information management tool. The data is 'live' and remains subject to change.

It may not tally with other official statistics and is not 100% accurate as it is not always subject to full checks. We gained prior approval for use and publication of this data.

The HMPPS data reflects the number of prisoner complaints, and those at Morton Hall IRC / Prison. The data reflects the number of prisoner complaints raised at the establishment in the period. Complaints where the individual is residing in a different establishment to the establishment they are complaining about are counted in the establishment for which the complaint is about.

The following categories of complaints are included within this data:

- Stage 1/COMP1 forms – where these are to be answered by the establishment the complainant resides in
- Stage 2/COMP1a forms – where these are to be answered by the establishment the complainant resides in
- Confidential Access complaints/COMP2 forms – where these are to be answered by the establishment the complainant resides in or where they are being passed to the IMB or Prison Group Director
- Discrimination Incident Reporting Forms (DIRFs) – where these have been submitted by a prisoner to be answered by the establishment the complainant resides in
- Reserved subject complaints – for example, where an allegation is made against the governor

Fatal incidents investigations

Data is based on when the PPO were notified of the death.

The PPO does not determine the cause of death. This is determined by a coroner following an inquest. Cases are separated into administrative categories, but these categories may differ from a coroner's conclusions. Classifications may change during an investigation. However, they are not altered following the conclusion of the inquest. A small number of classifications for previous years have been updated for this publication, so may not match what has previously been published.

Self-inflicted deaths: The death of a person who has apparently taken their own life and the circumstances suggest this was deliberate, irrespective of whether this would meet the legal definition of intent (i.e. suicide).

Homicide: Where one person has killed another, irrespective of their level of intent.

Natural causes: Any death of a person as a result of a naturally occurring disease process that is organic and not triggered by something non-natural.

Other non-natural: These deaths have not happened organically; they are non-natural but cannot be readily classified as self-inflicted or homicide. They include accidents and cases where the post-mortem has not ascertained a cause of death. This category also includes drug-related deaths where there is not enough evidence to classify them as a self-inflicted death.

Awaiting classification: These are deaths where there is currently no indication of the cause of death.

COVID-19 related fatal incident investigation: A death of a person where COVID-19 is mentioned on the death certificate or post-mortem report. Deaths are recorded as COVID-19 from the outset of the investigation if there appears to have a COVID-19 element. If information provided later shows the death does not fit our definition, it will be re-categorised. It is important to note, death certificates are not always consistently filled in.

Fatal incident data was frozen in mid-May 2022.

The PPO and HMPPS have different defining criteria for classifying cases. For this reason, the totals in each category may differ from what is published by HMPPS.

Initial reports are counted as having been completed 'in time' when the report is issued within 20 weeks of the date of notification for natural cause deaths which were originally classed as natural causes, and 26 weeks for all others (including those that are unclassified at the time of notification). However, we must sometimes suspend our investigations while we wait for key information, such as the cause of death, toxicology tests or a clinical review.

Timeliness calculations exclude the times when a case is suspended for reasons that are outside the PPO's control.

Final reports are counted as having been completed 'in time' when the report is issued 12 weeks following the initial report.

Timeliness is calculated based on working days and excludes bank holidays.

Some totals may not add up to 100% due to rounding.

Some figures have been updated and corrected, and therefore do not match what was published in the previous annual report.

Post-release deaths: On 6 September 2021, the PPO launched a year-long pilot to investigate the deaths of individuals who die within 14 days of release from custody from natural, self-inflicted, or other non-natural causes. Deaths where the cause of death was homicide are not included in the pilot. The PPO may exercise its discretion to investigate deaths of individuals who die beyond the 14-day threshold, such investigations will still be categorised as post-release cases. However, we refer to our investigations of deaths, where an individual is released directly to hospital or where an individual was released into the community but died before 6 September 2021, the beginning of our pilot, as a discretionary case rather than a post-release case.

Surveys

Throughout the surveys, some respondents did not answer all the questions, and depending on certain question responses, some respondents were not asked all questions. This year, like last year, we included partial survey responses in the data. In previous years, we have excluded partial survey responses.

General stakeholder survey (GSS):

The GSS is an online survey that was promoted on Twitter, our website and sent to our stakeholders. This means that we can only reflect the number of responses received. It was sent out at the beginning of March 2022, with a reminder which was shared later in the month. The survey was then closed at the end of March 2022.

Bereaved families' survey:

The survey is sent monthly to family members/next of kin who have been sent a final report three months previously. Survey results presented in this Annual Report are reflective of cases where a final report was issued in October 2020 to November 2021. This, in part, was due to COVID-19 and being unable to post surveys due to lockdown restrictions.

Surveys which were due to be sent out in March 2022 were sent out in April 2022, and therefore will be included in the 2022/23 analysis.

Complainants' survey:

The survey is sent monthly to a sample of complainants who have had their complaints closed. This includes:

- a sample of eligible cases
- a sample of ineligible cases
- a sample of ineligible probation cases
- all eligible probation cases
- all eligible and ineligible cases from women
- all eligible and ineligible cases from those in immigration removal centres
- all eligible and ineligible cases from those aged 21 and under

We send our surveys two months after the case has been closed, to allow for a rest period where any potential final changes may be made.

Survey results presented in this Annual Report are reflective of cases closed between November 2020 and December 2021. This, in part, was due to COVID-19 and being unable to post surveys due to lockdown restrictions.

Surveys which were due to be sent out in March 2022 were sent out in April 2022 and will be included in the 2022/23 analysis.

Ineligibility reasons are updated and overwritten every time a new eligibility assessment has been completed when new information is provided. Therefore, the outcome of the cases included in the sample may have changed after sampling.

Post-investigation survey:

The post-investigation survey is sent to PPO liaison officers (the prison officer who has been the main point of contact for the PPO investigator) once the initial report has been issued, and to establishment heads and healthcare leads after the final report has been issued. It is sent out at the beginning of each month, for the previous month.

The results presented include cases which had their reports issued between March 2021 and February 2022. Cases where reports were issued in March 2022 will be included in the 2022/23 survey results. It is also sent to coroners at the end of the financial year (March 2022) who have been involved in fatal incident investigations that had a fatal incident final report issued in 2021/22, with a two-week allowance for completion. These results are then combined.

Recommendations

Complaints' recommendations

Recommendations about complaints are those where we have issued the final report within the financial year.

Recommendations can be amended or removed at any point until the case is closed. This means that, until the case is closed, the data is changeable.

The data provided was frozen in April 2022.

Recommendations are categorised by investigators which can lead to similar recommendations being categorised differently.

Accepted recommendations include partially accepted recommendations. Sometimes when the recommendation is due to be implemented, the situation changes which means the recommendation is no longer applicable.

Fatal incidents recommendations

Recommendation data provided covers recommendations which were made in cases where the final report was issued in the financial year.

The data provided was frozen in May 2022.

Recommendations are categorised by investigators which can lead to similar recommendations being categorised differently.

There is no separate category for COVID-19 related recommendations. Included in this section are any recommendations where COVID-19 was mentioned in the recommendation.

Financial data

	2020/21		2021/22		Change 2020/21 to 2021/22	% change year on year
Budget allocation	£5,627,000		£5,883,000		£256,000	5%

Actuals	2020/21	% of total 2020/21	2021/22	% of total 2021/22	Change 2020/21 to 2021/22	% change year on year
Staffing costs	£5,079,267	94%	£5,206,655	92%	£127,388	2%
Non-staff costs	£338,224	6%	£469,976	8%	£131,752	2%
Total spend	**£5,417,491**	**100%**	**£5,676,631**	**100%**	**£259,140**	**5%**
Underspend	**£209,509**		**£206,369**		**-£3,140**	**0%**

Terms of Reference

Please visit our website for our full Terms of Reference:

https://www.ppo.gov.uk/about/vision-and-values/terms-of-reference/

If you do not have access to the internet, please write to us to request a printed copy:

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