Prisons & Probation Ombudsman
Independent Investigations

Annual Report

2022/23

CP 928

Prisons and Probation Ombudsman

Annual Report 2022/23

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

September 2023

CP 928

This publication is available at: www.gov.uk/official-documents

Any enquiries regarding this publication should be sent to the Prisons and Probation Ombudsman at:

Third Floor,
10 South Colonnade,
Canary Wharf,
London E14 4PU

020 7633 4100
mail@ppo.gov.uk

ISBN 978-1-5286-4370-2

E 02948425 09/23

Printed on paper containing 40% recycled fibre content minimum

Printed in the UK by HH Associates Ltd. on behalf of the Controller of His Majesty's Stationery Office

Designed by Design102.co.uk

Contents


Employment Hub

The role and function of the Prisons and Probation Ombudsman

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 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).

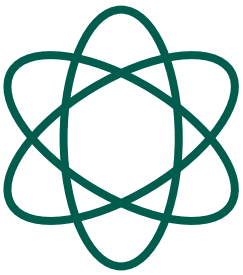
The roles and responsibilities of the PPO are set out in the Terms of Reference, the latest version of which can be found in the appendices.

The PPO has three main investigative duties:

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

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

I am writing this foreword as I was asked to stand in as the Acting Ombudsman when Sue McAllister retired in June 2022. Sue was the Ombudsman from October 2018 and led the organisation through the difficult times of the COVID-19 pandemic. Sue's focus on impact and outcomes has paved the way for the PPO to look at how we can best effect change and help the services within our remit learn from past actions.

I am pleased to have welcomed Adrian Usher who became the Ombudsman in April 2023:

"I am delighted to have taken up the role of Ombudsman on 24 April this year. As this Annual Report covers a period before I was appointed, it felt more appropriate for Kimberley Bingham as the Acting Ombudsman to take the credit for her hard work and to contextualise it by providing the foreword.

I should also like to thank Kimberley for her determination and innovation during a challenging year as HMPPS emerged from COVID-19 restrictions. The PPO had to rapidly and regularly adapt their investigative practices and I am very grateful for the leadership shown by Kimberley. This has made taking over the role infinitely easier and I look forward to the year ahead with great optimism."

Adrian Usher, Ombudsman,
April 2023 to present

The PPO's role in investigating complaints is crucial to our aim of making custody safer and fairer. Our complaint investigations can provide a resolution for prisoners, detained individuals and those under probation supervision. These investigations also provide learning that we share with services in our remit to help improve their policies and practices.

In 2022/23 we received 4,472 complaints, 1% more than in the previous year. We started investigations into 2,094 complaints this year, an increase of 8% on 2021/22. We also completed 2,165 investigations, an increase of 13%.

Our complaint investigators spent part of the year trying to understand more about complaint handling in women's prisons and raising awareness of the PPO across the women's prison estate. We receive fewer complaints from women than we would expect, and this was an important exercise to find out why. Last year, investigators visited all of the prisons in the women's estate to speak to groups of women about their experiences. This provided valuable learning about how we can improve our handling of complaints for women and for other groups. As part of this work, investigators fed back key themes to HMPPS to help them consider what they might do differently.

Complaint investigators also started to look in depth at complaint handling for young people. As with the women's estate, investigators spoke to young people in custody to explore their perceptions of the complaints process, identify barriers and raise awareness of the role of the PPO. This work continues but it is already evident that young people find the internal complaints processes too long. They also had little awareness of the PPO, which we will work to rectify.

The lack of awareness of the PPO among HMPPS staff was an issue we highlighted in our 2022/23 Strategic Plan.[1] During the year, we developed a training package for HMPPS frontline staff that I am pleased to say will be rolled out during 2023/24. The digital e-learning package includes practical information drawn from our investigations that should contribute to positive outcomes.

This awareness project builds on a new approach we trialled in 2022/23 to summarise our learning into brief, focused information for HMPPS frontline staff. The PPO feeds into HMPPS and Home Office policy consultations, using learning from our investigations to influence and shape prison policy. While securing changes to policies is important, we know it does not always mean that practices actually change. For this reason, in September 2022 I published the first Policy into Practice publication, which is a blend of our Learning Lessons Bulletins and the work we do to influence changes to prison policies. Our Policy into Practice publication on the use of restraints on escort was published in 2022 and highlighted a recurring issue we saw during the year in relation to the risk assessment process.[2]

1 Prisons and Probation Ombudsman (2022), 2022/23 Strategic Plan. Available online at: **https://s3-eu-west-2.amazonaws.com/ppo-prod-storage-1g9rkhjhkjmgw/uploads/2022/06/PPO-Strategic-Plan-22-23-FINAL-JUNE-22.pdf**

2 Prisons and Probation Ombudsman (2022), Policy into Practice: Use of restraints on escort. Available online at: **https://s3-eu-west-2.amazonaws.com/ppo-prod-storage-1g9rkhjhkjmgw/uploads/2022/09/Policy-into-Practice-Use-of-restraints-on-escort-1.pdf**

2022/23 was the year we emerged from the COVID-19 pandemic. It was a significant challenge for all of us and like many organisations, we are still dealing with its effects. However, I am pleased to say that in 2022/23, we saw a sharp reduction in the number of COVID-19 pandemic-related deaths in prisons. Since March 2020, the PPO has investigated 175 deaths from COVID-19, far fewer than had been predicted at the start of the pandemic.

In 2022/23 we saw the impact that staff shortages in prisons have on prison regimes and the ability of prison staff to complete all their duties. In some investigations carried out in 2022/23, we have been able to link the care the prisoners received to the reduced staff levels.

In September 2022 we completed a 12-month pilot to investigate the deaths of people who had recently been released from prison, and we continue to investigate these deaths now the pilot has concluded. We evaluated the pilot and found common themes across our post-release investigations, particularly in relation to a lack of support for people with substance misuse issues and a lack of provision of accommodation.

> “
>
> While securing changes to policies is important, we know it does not always mean that practices actually change.

Following this evaluation, we shared the thematic learning through the publication of a research evaluation report and a Learning Lessons Bulletin.[3,4] The evaluation report was the first of its kind for the PPO, and allowed us to examine a new aspect of our remit in depth. The Learning Lessons Bulletin enabled us to highlight learning in an area that has previously had very little focus and attention. The acute vulnerability of those being released from prison became apparent during our investigations and we have made it clear that more needs to be done to support prison leavers through the process. We will continue to do our part in evaluating, learning and sharing findings on this important issue.

3 Prisons and Probation Ombudsman (2023), Investigating deaths after release from prison – a pilot evaluation. Available online at: **https://s3-eu-west-2.amazonaws.com/ppo-prod-storage-1g9rkhjhkjmgw/uploads/2023/01/Investigating-deaths-after-release-from-prison-Final-report.pdf**

4 Prisons and Probation Ombudsman (2023), Learning Lessons Bulletin: Post-release death investigations. Available online at: **https://s3-eu-west-2.amazonaws.com/ppo-prod-storage-1g9rkhjhkjmgw/uploads/2023/01/14.202_PPO_LL_Bulletin_Issue17_FINAL_WEB_V2-3.pdf**

The inclusion within our remit of post-release death investigations has increased the number of fatal incident investigations we started during the year. In 2022/23, we started to investigate 404 deaths, an increase of 23% on the previous year. I was concerned that 322 of those deaths were in prisons, 34 more than last year. The number of self-inflicted deaths within prisons rose to 92, which is 5 more than last year. Deaths from natural causes also increased, with investigations starting into 224 cases, 24 more than in 2021/22.

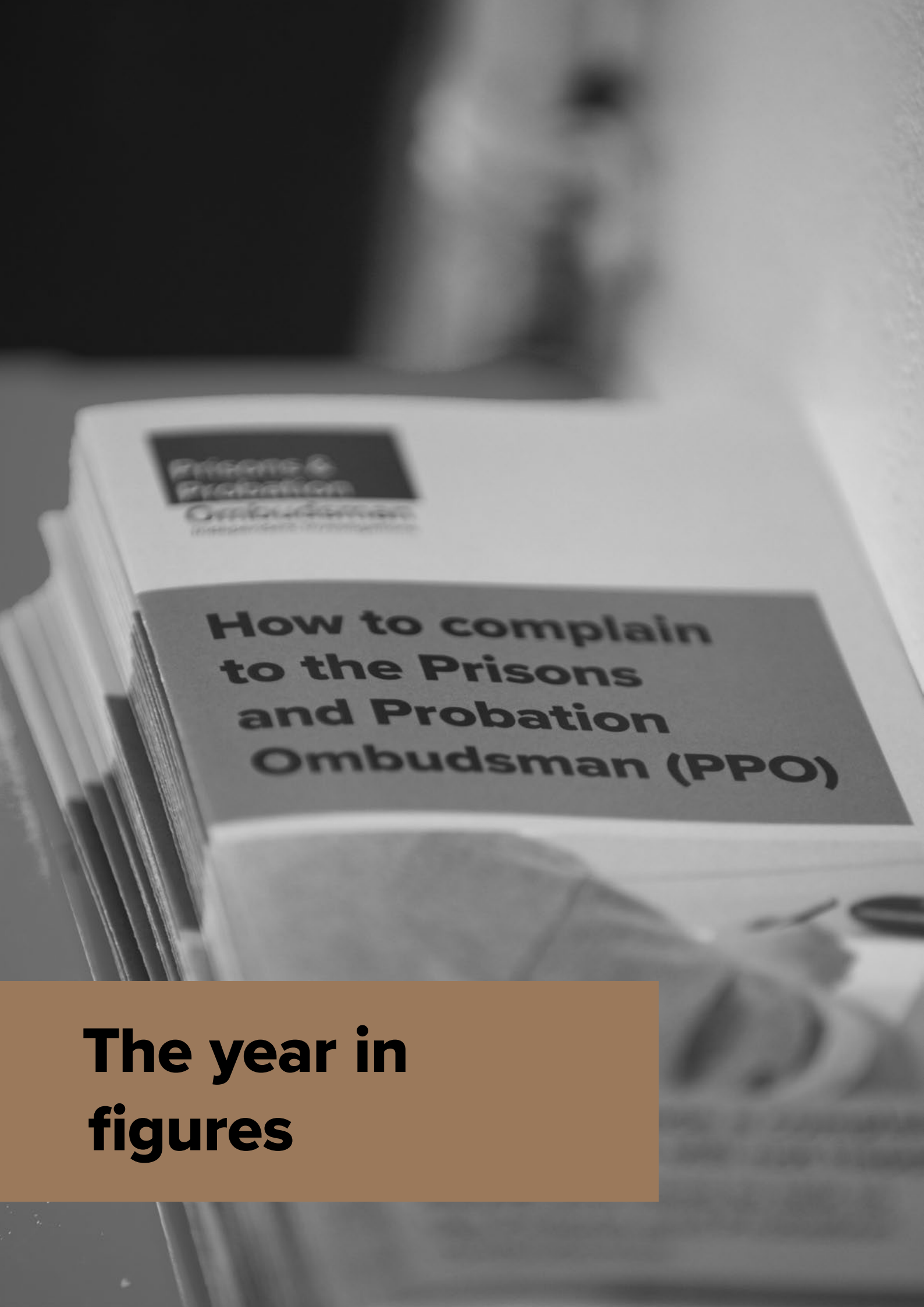
We saw deaths occur in a number of prison cluster sites this year, where multiple deaths happen in one prison over a specified period. I am concerned that this included two self-inflicted deaths in a women's prison occurring within days of each other, with a third self-inflicted death in the same prison a few months later. Three self-inflicted deaths occurred in another prison within the space of a few weeks. At the time of writing, the findings from these investigations have not yet been published, and a key question in our investigations is whether there were underlying systemic issues that need to be brought to light.

We also investigated a number of fatal incidents during the year that involved prisoners' self-neglect. These were particularly distressing cases, and we recommended that HMPPS should develop a self-neglect strategy and guidance to be used in the prison environment.

Deaths in immigration removal centres also come within the PPO's remit. There are very few deaths in these establishments but during 2022/23 we started investigations into two deaths, including one of a man at Manston Short-Term Holding Facility.

In closing, I want to say that it has been a privilege to lead this organisation. I want to thank all the staff at the PPO who have continued to work so hard for the fairness and safety of people in custody and under community supervision.

Kimberley Bingham, Acting Ombudsman (July 2022 to April 2023)



The year in figures

Complaints

Complaints received

In 2022/23 we received **4,472 complaints,** an increase of **1%** compared to last year.

Of these:

4,211
were about prisons, **69** more than last year

252
were about probation services, **35** fewer than last year

8
were about immigration removal centres, **1** fewer than last year

0
were about secure training centres, **2** fewer than last year

Eligible complaints and complaints started

We sent out **5,230** eligibility letters to complainants in 2022/23,* a **3%** increase compared to last year

In **2022/23** we started investigations into **2,094** cases compared to **1,936** cases in the previous year, an increase of **8%**

* Timeliness data for these letters is unavailable due to ongoing work with the case management system. Refer to the 'About the data' section for definitions of eligibility, upheld cases and not upheld cases.

Complaints completed

In 2022/23 we completed **2,165** investigations compared to **1,924** in the previous year, an increase of **13%. 1,292** (60%) were completed on time.[5]

Of these:

Property
29%
the most common complaint category

Staff behaviour
10%

Administration
7%

27%
of all completed cases were found in favour of the complainant, similar to the rate of **28%** 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 2022/23:

124 declined

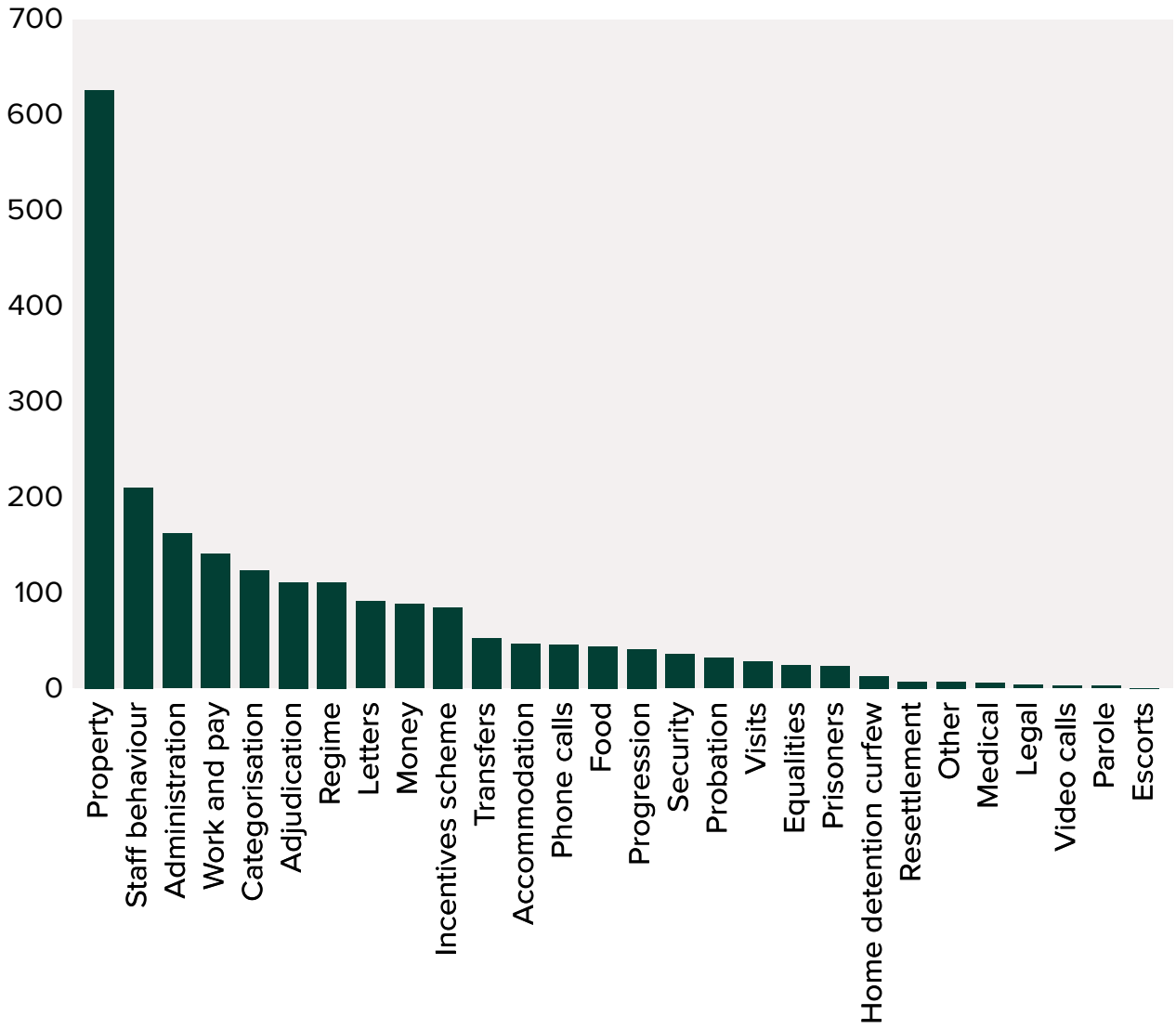
124 complaints were declined for investigation, **3** fewer than last year

27 withdrawn

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

5 There were 29 suspended cases that have been excluded from this calculation. This is due to complications in how suspensions are recorded.

Complaints completed in 2022/23 by category:



Fatal incidents

Investigations started

In 2022/23, we started investigations into **404 deaths,** a **23% increase** compared to the previous year. We began investigations into:

224

deaths from natural causes, 24 more than last year

65

other non-natural deaths, 28 more than last year. It is important to note that, at the time of writing, there are **20 deaths** awaiting classification (which tend to be classified as other non-natural)

3

apparent homicides, 2 more than last year

92

self-inflicted deaths, 5 more than last year

Of the **404 deaths** in 2022/23, the location of investigations started consisted of:

322

prisoner deaths, 34 more than last year

63

post-release deaths

15

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

2

deaths of residents of the immigration removal estate, 2 more than last year

2

discretionary cases

- the death of an individual who was released into a care home and died shortly after
- the death of an individual who had been in a hospital and was moved to a hospice

Fortunately, this year we began **no investigations of fatal incidents in secure children's homes,** the same as last year.

Reports issued

This year we issued **317 initial reports** and **314 final reports** compared to **391** initial reports and **379** final reports last year:

60%

of initial reports were on time, compared to **46%** last year

55%

of final reports were on time, compared to **50%** last year

22 weeks

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

31 weeks

for all other deaths

765

fatal incident investigations not yet published on our website (as of 31 March 2023)

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

881

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

318

healthcare provision

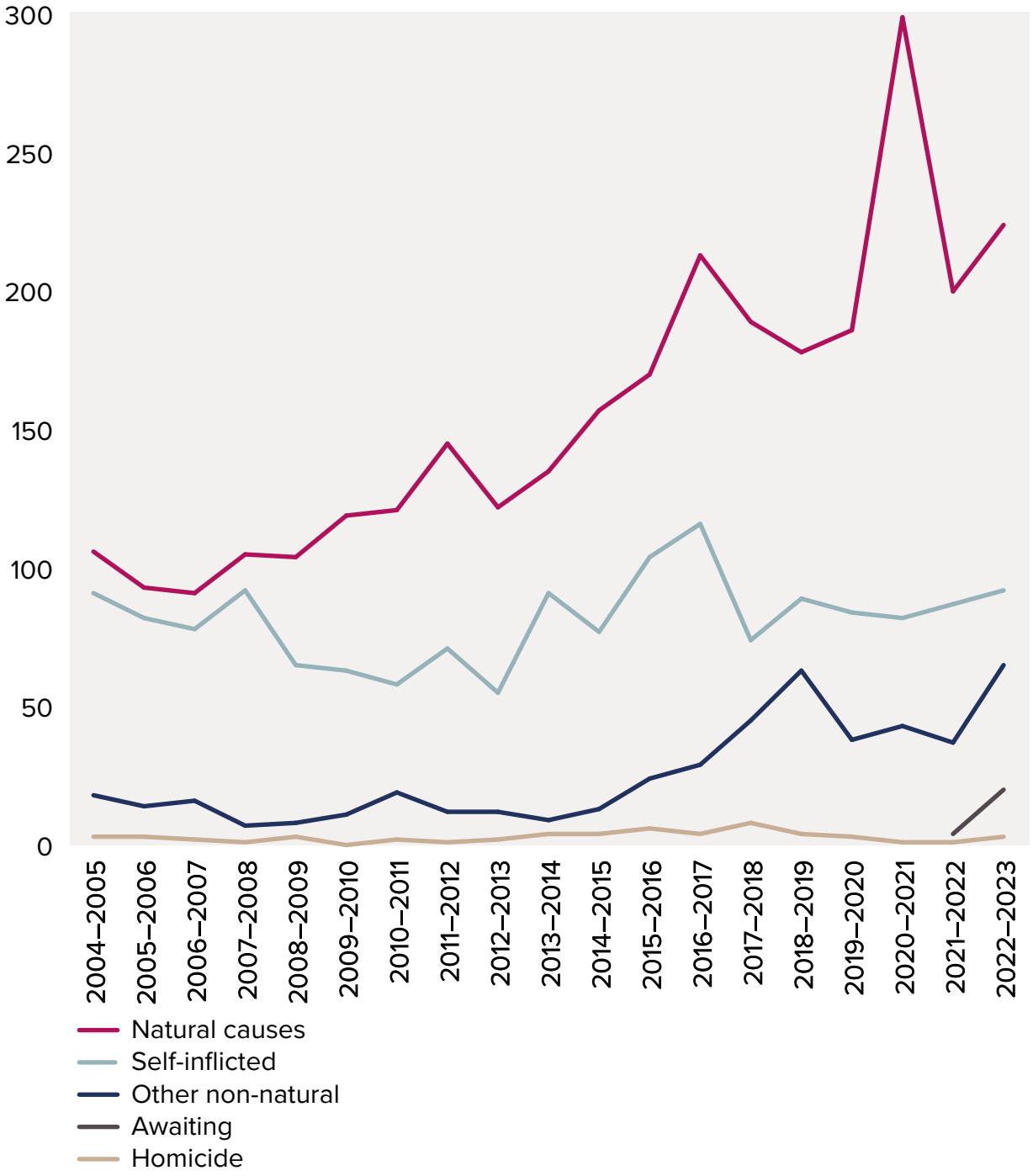
107

emergency response

97

suicide and self-harm prevention

Fatal incidents investigated:



Investigating complaints

“

The number and type of complaints we receive continues to reflect the resourcing pressures being experienced across the prison estate.

In 2022/23 we received 4,472 complaints, an increase of 1% from last year. The consistently high number of complaints we receive year-on-year is a testament to the importance of the PPO's service.

It also suggests that those who use our service recognise the quality of our work, trusting that as an independent organisation we will look into matters thoroughly and fairly. In our annual complainants' survey, 74% of respondents whose complaints were upheld rated the quality of investigation as either satisfactory or better.

The eligibility rate of the complaints we receive is also consistent. This year we sent out 5,230 eligibility letters to complainants, which was an increase of 3% on last year. However, one in two complaints are still being assessed as ineligible, and of these, 79% are as a result of complainants not following the correct complaints process.

On that basis, we still have work to do to communicate more effectively to those who might contact us, when and how they can use our service and what we need from them to enable us to progress their complaint.

A deep dive we undertook into eligibility last year has provided insights into where the complaints process may be more likely to fall down. These insights will help us target our communications and simplify our processes wherever possible.

We will continue to use channels such as National Prisoner Radio, Inside Time, Women in Prison and other targeted media campaigns to promote our work and to let people know when and how we can assist. But we can and will do more about increasing eligibility in the coming year.

The number and type of complaints we receive continues to reflect the resourcing pressures being experienced across the prison estate.

Where these pressures impact on a prison's ability to deliver a full regime for prisoners, we often see a consequent increase in complaints about access to open air, weekly worship, progression, transfers and a myriad of property complaints.

On some occasions, these resourcing pressures directly impact on our ability to get the information we need to carry out our investigations, delaying and sometimes impeding our ability to get a full picture of what has happened and why.

Where prison staffing resources are stretched, or not at full complement, it can exacerbate some of the tensions of life in prison.

Impact of implementing security measures

We regularly investigate complaints about the impact of prison security measures on day-to-day life for prisoners. We recognise the importance of creating a safe and secure environment for prisoners and prison staff, particularly at a time when prisoner numbers are increasing, and there is an increasingly sophisticated approach to smuggling drugs and weapons into the estate. However, a balance needs to be struck between implementing security policies that reduce risk and maintain safety, and ensuring that the impact on individuals is fair and proportionate.

The PPO's role is to consider if HMPPS policy has been applied fairly and correctly, as well as to consider the circumstances at play relating to the incident(s) brought to our attention.

Mr A complained to us about the use of restraints during a hospital visit. He had been cuffed to escort officers during previous medical examinations, and as a result had asked that his security status be reduced on this occasion when attending hospital for an intimate examination (because he did not want any prison officers to be present in the treatment room).

When at the hospital, Mr A asked if staff would be removed from the medical room during future intimate examinations, pointing out that an escort chain (a longer chain) had not been provided as an option. On the basis that his request was not agreed to, he refused the important examination.

In our investigation, we considered the Prison Service Instruction on the Prevention of Escape: External Escorts Policy Framework, Mr A's previous security risk assessment and the prison's response.

We found that it was the policy of the prison to undertake a risk assessment of every prisoner ahead of them leaving the prison for medical treatment at hospital. We also found that when completing the risk assessment for Mr A's previous appointment, the healthcare team did not highlight that Mr A would undergo treatment of a sensitive nature. When this did become apparent (at the hospital), the officers present should have called the duty director to get authorisation for an escort chain to be applied. It appeared that they did not do that on this occasion.

We did not uphold Mr A's complaint as we determined that the security department at the prison had responded to Mr A's complaint appropriately. They had confirmed to him in their response that they would agree to the use of an escort chain on future visits, and that privacy screens could be used which officers could remain behind.

We were satisfied that Mr A had received an assurance that in future, steps would be taken to ensure he was able to maintain decency and dignity during treatment, balanced with the necessary security requirements.

“

We regularly investigate complaints about the impact of prison security measures on day-to-day life for prisoners.

Technological advances have led to a number of positive developments across the criminal justice system. However, sometimes there are unintended consequences when new technology is introduced and particularly when it is applied indiscriminately.

The use of X-ray body scanners in prisons is a key strand in the fight against illicit smuggling, and the PPO supports measures designed to ensure prisoners remain safe.

We have investigated cases where X-ray body scanners were being used excessively. In some prisons, all prisoners were being scanned on entry rather than selectively to combat an identified threat. Body scanners emit small doses of radiation and staff need to be confident about following the correct practices, supported by operational guidance.

Mr B contacted us to complain about being put through an X-ray body scanner automatically upon his arrival at prison. He was asked to sign paperwork without being given time to read through its contents and was told he would be X-rayed. He said he did not consent to this. He reported that at the prison, every prisoner appeared to be X-rayed on arrival.

As part of our investigation, we spoke to operational policy leads and discussed the area of the prison policy framework that specifies that prisoners should only be scanned if part of an identified threat.

Policy holders agreed that the blanket use of scanners was not reasonable. This was helpful in setting out what could be expected from prisons when defining ‘threat’ to determine the appropriate use of X-ray body scanners.

We upheld the complaint and recommended actions the prison should adopt to bring their practice in line with the framework, which the prison accepted and implemented.

The PPO is one of a number of organisations that are able to engage in confidential correspondence with prisoners. This is important for maintaining a prisoner's trust.

One of the cases we investigated in 2022/23 highlighted a key error that was made when policies on confidential access correspondence were updated. This led to at least one prisoner having his confidential mail opened, despite the prison technically following policy guidance. Our work to identify what happened in this case has resulted in remedial action to correct the error.

Mr C complained to the PPO that a letter addressed to him from the Parliamentary and Health Service Ombudsman (PHSO) had been opened, contrary to confidential access correspondence procedures.

Mr C said the letter from the PHSO was open and in a plain envelope with the PHSO address partially covered by a sticker. He was concerned that the prison had stated that PHSO was not covered by Rule 39. Rule 39 means that any correspondence a prisoner has with the courts or their legal advisors can only be opened, read or stopped in specific circumstances. A number of people and organisations are covered by Rule 39. There are also several organisations, such as the PPO, that come under confidential access arrangements. This means that, as with Rule 39 letters, the prison can only examine and open letters from those organisations under specific circumstances.

The prison said that the letter, despite being marked 'strictly confidential rule applies', was dealt with as normal mail as PHSO was not on the confidential access list.

Mr C appealed as he was unhappy to be told that PHSO was not listed under Rule 39. He believed it was included, and that if there was any doubt, his letter should have been opened in front of him. The governor's response confirmed that following his review, the complaint would not be upheld as the prison had acted in accordance with policy: PHSO was not one of the organisations listed in the relevant Prison Service Instruction.

Mr C was unhappy with this response and complained to the PPO. We upheld Mr C's complaint. Our investigation identified that an error had been made when the original policy instruction was revised, with PHSO being omitted when they had originally been on the list of confidential access organisations.

Following our involvement, HMPPS acknowledged the error and confirmed that the list would be amended to once again include PHSO.

Use of force

We received 35 complaints about the use of force in 2022/23, of which 25 were eligible for investigation. This is slightly more than in 2021/22, when we received 30 complaints, of which 16 were eligible.

2022/23 also saw the introduction of a new sub-category of use of force complaints, which was about the use of PAVA (an incapacitant spray similar to pepper spray, dispensed from a handheld canister in a liquid stream). We completed one PAVA case in 2022/23.

We recognise the use of force is often the last resort for staff dealing with a difficult operational environment. However, when it is used, it is important that staff act in line with lawful principles, are proportionate and make every attempt to de-escalate the situation.

Mr D complained about the manner in which staff carried out a full search of him following a use of force incident.

As part of his complaint, he maintained that he had been 'thrown' into a cell in the segregation unit, where he was placed in the prone position, which made him fear for his life. When he was in that position, an officer pulled down his boxer shorts. Mr D said that this action was not warranted and constituted a sexual assault which should be referred to the police.

In response, the prison said that a full relocation was required due to Mr D's non-compliance and the seriousness of the incident. Among the evidence that we reviewed were the prison's local security and segregation policies, Prison Service policy, use of force forms and a report from the police intelligence officer.

The prison informed the investigator that while body worn video camera footage was available for the relocation incident, it did not include footage of the full search inside the segregation unit cell, and so could not be reviewed as part of this investigation.

The use of force forms indicated that Mr D had refused to get behind his cell door, violently resisted, and assaulted five members of staff.

Both the police and the prison's investigations found that a full search in the circumstances was justifiable and

proportionate, and concluded that Mr D had not been sexually assaulted.

In our consideration of the complaint, we accepted that there was no CCTV or body worn video camera evidence of the full relocation, given that it involved a strip search. Although Mr D maintained that having his boxer shorts pulled down constituted a sexual assault, our investigation concluded that Prison Service policy allows for a prisoner's underwear to be removed as part of a full search, and we were therefore satisfied that this was not unreasonable.

However, by considering the Searching Policy Framework, we recognised that arrangements must be in place for keeping records of searches and finds, and that records must detail why, when and where the full search was conducted and by whom. Regrettably, the prison was unable to supply us with any records of the search and said that they were not available. This was not only disappointing but in complete contrast to the guidance.

As a result, we partially upheld Mr D's complaint, and recommended to the prison's director that they issue a notice to staff reminding them to keep records of whenever full searches were carried out.

> "

It is important that staff act in line with lawful principles, are proportionate and make every attempt to de-escalate the situation.

Property

Once again, the issue that we received the most complaints about during 2022/23 was property, which formed 25% of all our complaints. This is at a similar level to 2021/22, where it formed 27% of the complaints we received.

- Property complaints make up 26% of men's complaints received, and 10% of women's complaints received.
- Property complaints make up 39% of complaints from those aged 16 to 25, compared to 26% for those aged 26 to 49, and 20% for those aged over 50.

The typical rate of ineligibility of all the complaints we receive is 50%. Property complaints are less likely to be ineligible, with 45% being ineligible in 2022/23.

Across all of the complaints we receive, we generally uphold about 27% of the cases we look into. However, this number is considerably higher for property complaint cases, where 40% are upheld.

23% of property complaints have the outcome 'upheld mediated', compared to 4% of other complaints.

Mediation

Mediation is an important strategy in securing mutually acceptable outcomes where cases have become stuck. In using this approach, our investigators need to gather as much information as possible about the items of property which are subject to dispute. We know that prisoners are unlikely to keep receipts for items they have brought with them to prison. They can attach sentimental value to items, and being offered an amount of compensation that does not recognise the value can increase their unhappiness with the loss.

Mr E complained that following a transfer to another prison, the prison he transferred from had lost 27 items of his property that were incorrectly confiscated during a cell clearance. The prison had used old property cards when completing the cell clearance certificate and they sought to rectify the situation by sending the confiscated property to Mr E's current establishment.

There was evidence that the current establishment had received the parcels as they were signed for by a member of prison staff. However, after this, there is no record of what happened to Mr E's belongings, and they remained unaccounted for. As a result, we upheld Mr E's complaint.

Mr E did not provide any values for the lost property, so we had to determine what we considered a reasonable value and took that to the prison to mediate the settlement. The PPO asked the prison to compensate Mr E £497 for 22 of the items (five of the items were not listed on the cell clearance certificate so there was no evidence that they were in his cell when it was cleared).

The prison agreed and we notified Mr E of the offer.

Money matters

Over the last year, we have investigated a number of complaints which have been disputes about money, both in relation to money unfairly charged and where compensation offered does not reflect the value of goods lost or destroyed.

Mr F asked the PPO to investigate his complaint about the unauthorised destruction of his property. He had received a birthday parcel (with new clothing items) which an officer brought to him, in turn taking clothes he now didn't need to his stored property. When the officer returned, he told Mr F that the exchanged property would be destroyed. Mr F said he would pay for the property to be posted out but was told this was not possible. He also reminded staff that he was a remand prisoner and they agreed that under no circumstances would his property be destroyed.

On learning later that his property had indeed been destroyed, Mr F asked for £1,500 compensation for a Dolce and Gabbana jacket, £350 for a Gucci t-shirt, and approximately £300 for non-designer clothes.

The officer who replied to Mr F's complaint said his property card stated that the items had been destroyed with his permission and showed him the card with what appeared to be his signature. Mr F then alleged that someone in the prison had forged his signature. Mr F was reminded by the prison that he had signed a disclaimer which included the line: "I have been advised not to bring valuable and sentimental items into prison". The prison confirmed designer items had been destroyed, and he was offered compensation of £100.

The PPO investigator determined from the Prison Service Instruction on prisoners' property that a prisoner may be temporarily deprived of their possessions but that there is no power to permanently deprive them of ownership. There is an option for a prisoner to request that the stored property "be sold or destroyed as appropriate". In relation to compensation, the Prison Service Instruction states that all claims for compensation should be adequately investigated before an establishment accepts responsibility for lost or damaged property.

When the PPO investigator reviewed the property card, they were unable to find evidence that Mr F had authorised the destruction of his property. Staff acknowledged that they had destroyed Mr F's property. While Mr F had signed a disclaimer, it did not absolve the prison of their responsibility for their actions. We noted that public funds would be used to pay compensation and consequently, we would expect to see receipt evidence of the actual cost of the high value items recorded on the property card.

During our investigation, the head of operations at the prison reviewed the level of compensation and increased it

to £187, confirming that if Mr F produced proof of purchase for the designer and high value items, further compensation would be considered. We were satisfied that this was a reasonable conclusion.

Sometimes our investigation of an individual complaint uncovers a concern which affects many more prisoners.

Mr G and Mr H separately complained that the prison had overcharged them for phone calls. When the two prisoners asked for a refund of the overcharge, they were told that the money had been given to the prison's own Prisoners' Amenities Fund, which was set up to help provide prisoner activities and projects.

On investigation, it became clear that the phone system, supplied by an external provider, had been overcharging everyone for approximately six months. It was established that the total overcharge amounted to around £209,000.

When the PPO asked for copies of complaints that had been made by prisoners about the overcharging, we were told that numerous informal complaints had been made. As complaints had been made verbally to staff, the prison said it was unable to identify all of the people who had complained.

The prison could not provide evidence that the decision to allocate the overcharge to the Prisoners' Amenities Fund had been discussed with any prisoner forum groups, or that prisoners had been informed of the decision.

Both Mr G and Mr H's complaints were upheld. The prison said it would be an enormous task to track every prisoner who had been overcharged and refund them. However, we felt it was important that those prisoners who asked for a refund should be given one, and set a time limit of six months from the issue of our final report for prisoners to approach the prison to make a claim. The prison issued notices to prisoners, advising them of how to submit a claim.

At the time of writing this Annual Report, three prisoners had been refunded a total of £545.

The right to read

Prisoners' access to books and magazines has been a subject of debate in recent years. The blanket ban on sending material to prisoners has been reversed and people are currently allowed to send or hand in books to prisoners. There is no numerical limit on the number of books a prisoner can have in their cell, subject to overarching volumetric control limits on property.

The following case studies provide insights into the challenges that some prisoners still face in being able to take up the right to access books and reading materials.

Mr I was unhappy that the prison refused to allow him to have two items sent in by his family. The items were a 'bookazine' (described as a cross between a book and a magazine) and a diary. The prison refused to allow these items on the basis that they were not books, and so needed to be purchased from an approved prison supplier.

When investigating this complaint, we checked national Prison Service policy which confirms that only books are usually allowed to be sent in by friends or family. Diaries were available to order through the approved prison supplier and the prison therefore acted reasonably by not issuing it to the complainant.

We then carried out research into 'bookazines' to establish if they should be considered books or magazines. ISBN numbers are used to identify editions of books. ISSN numbers are used for serial publications (such as magazines). We asked the prison for a copy of the complainant's bookazine which showed it had an ISBN number.

On that basis, we asked the prison to issue the bookazine as it should have been treated as a book. We also asked the prison to issue a notice to staff notifying them that items with ISBN codes should be considered books in accordance with the Incentives Policy Framework (and may therefore be sent in by friends or family).

The prison agreed to issue the complainant with the bookazine and issued the notice to staff we had requested.

Mr J complained to the PPO about being unable to receive a book sent to him by a friend in the post. Mr J's friend had sent the book after consulting the official website for the prison which said: "Family and friends of prisoners are permitted to send books directly to their loved ones".

The prison responded to his initial complaint saying they could not adhere to the relevant policy because of an unprecedented level of illicit items being sent to prisoners that were not from approved suppliers. The prison acknowledged that itemiser technology could be used, which detects whether any book or letter contains synthetic cannabinoids, but the resource required to undertake this process wasn't always available.

Mr J appealed saying it was not for the prison to decide whether it would adhere to national policy. The response to the appeal reiterated the reply given at stage 1 of the complaint.

To investigate this complaint, we reviewed the Incentives Policy Framework and the Prisoner Complaints Framework, which said that from September 2015, families and friends will be allowed to send in or hand in books to prisoners.

We checked the official government website for the prison in question, which confirmed that families and friends could send books directly to "loved ones". We also sought further information from staff and received exactly the same response as Mr J had received at both stages of his complaint.

We recognise the pressures prisons face in terms of contraband, and accept that one of the methods of entry may be via books sent in. But we concluded that a prisoner being able to have a book sent in by a friend is an important entitlement, particularly if confined to their cell for long periods of time.

We also addressed the repetitive nature of the replies given to Mr J and the PPO, and found that this did not demonstrate that the complaint had been fairly considered by staff on its merits. We also did not believe that staff had adopted the problem solving approach or provided the meaningful reply required by the Complaints Policy Framework.

We upheld the complaint and asked that Mr J receive an apology for the poor handling of his complaint and an offer of financial reimbursement to cover the costs of postage.

Our thematic complaints work

In last year's Annual Report, we committed to understanding why so few women and young people complain to us, to identify the barriers and to ensure those groups feel empowered and supported to use our services.

Women

In 2022/23 we received 145 complaints from women, which is a 51% increase from the year before. We started investigations into 53 cases compared to 35 cases in the previous year. 27% of all completed cases found in favour of the complainant.

Year on year, the PPO historically received a relatively small number of complaints from women. When we started to examine this issue in summer 2021, women made up 4% of the total prison population in England and Wales but complaints from women accounted for only 1% of total complaints submitted to the Ombudsman.[6] Following conversations with partners and stakeholders, it was clear there were assumptions about why women complain less than men, including that they might have better dispute resolution skills or be better able to form constructive relationships.

6 Offender management statistics quarterly: October to December 2021 – GOV.UK. Available online at: **www.gov.uk/government/statistics/offender-management-statistics-quarterly-october-to-december-2021**

“

Since our work was completed in 2022/23, we have seen an increase in the number of complaints received from women and in their eligibility.

With the support of the director of HMPPS women's team, we set out to test these assumptions and see if there were tangible actions that could remove the barriers preventing women from complaining to HMPPS and the PPO.

Between May and November 2022, PPO investigators held outreach events with women prisoners in all of the women's prisons in England. Our findings fell into three main themes: awareness, perceptions and processes.

Awareness

Many women and some staff had not heard of the PPO. There was a lack of PPO publicity materials in all of the establishments we visited.

Many women serve relatively short sentences. This reduces institutional memory, so word-of-mouth referrals to the PPO between women are less likely to occur. Women told us they would be reluctant to engage with an organisation that they, or the people they knew, had never contacted.

Some women recalled mention of the PPO at induction stage, but all spoke of the trauma associated with arrival at prison and the impact this had on their ability to process and retain information.

Perceptions

In every prison we visited, women spoke of their fear of reprisals when making a complaint. None of the women we spoke to provided examples of when this had actually happened, but it is a deeply held perception across the estate.

There were concerns about confidentiality in the complaints process. Officers resolving complaints will need input from others. Women viewed this as a breach of trust, which exposes a lack of understanding of HMPPS complaint policy.

Many women said that governors resolved their complaints effectively, but it was often hard to get their complaint heard by a governor. In all prisons, women confirmed that there was at least one member of staff they could turn to. In all of the discussions, we heard examples of staff and governors going above and beyond to deliver positive outcomes for prisoners.

Processes

Some women said they were unwilling to escalate their complaint to the PPO because of the length of time it took HMPPS to reply to their initial complaint.

Women also mentioned lack of access to complaint forms, broken photocopiers, irregular emptying of complaint boxes, no independent oversight of complaint boxes and meaningless replies to complaints from prison staff as reasons why they don't go on to complain to the PPO.

Next steps

We have shared our findings with HMPPS, which has welcomed them. We will continue to work with the women's estate director while they consider how they want to address the concerns raised about internal complaints processes in prisons.

The PPO is taking steps to address the issues raised too. This includes:

- a targeted programme of activities raising awareness of the PPO across the women's estate
- workshops for HMPPS staff
- a rolling programme of outreach visits to establishments in the women's estate
- a pilot to fast-track eligible complaints from women who have shorter sentences

Since our work was completed in 2022/23, we have seen an increase in the number of complaints received from women and in their eligibility.

Young people

In 2022/23 we received 87 complaints from people aged under 21, an increase of 13% compared to the 77 received last year.

Of these, the most common complaint category received was property (40%), followed by staff behaviour (16%) and adjudication (7%).

We started investigations into 43 cases compared to 27 cases in the previous year, an increase of 59%. We completed 49 investigations compared to 26 in the previous year, an increase of 88%.

The most common complaint category completed was property (29%), followed by staff behaviour (24%) and adjudication (10%). 22% of all completed cases found in favour of the complainant.

As with complaints received from women, the PPO receives fewer complaints from young people than we would expect. Over recent years, we have built more effective relationships with stakeholders within the Youth Custody Service to raise our profile, and we will continue this important work.

In autumn 2021, following the issue of an Urgent Notification by HM Inspectorate of Prisons into practice at a secure training centre, the PPO visited the centre to review the complaints process and identify any barriers to complaints.

A team of PPO staff went to the centre four times during spring 2022, with the following aims:

- to explain and raise awareness of the independent role of the PPO in the complaints process
- to explore the children's perceptions of the complaints process and understand any barriers to them making complaints

The PPO held focused conversations with 20 of the 36 children in residence at the centre. Participation in the conversations was voluntary but all 36 of the children were invited.

We also reviewed the complaints processes and spoke to senior members of staff.

Findings

There was little evidence of PPO publicity materials, signposting the role of the independent Ombudsman. The internal complaints process did not explain when or how the young people could complain to the PPO. The young people we spoke to had little confidence in the complaints process and said they would like the opportunity to complain to someone outside the establishment.

Senior staff at the centre welcomed our involvement, although the views of the young people did not reflect the findings of their own review of internal complaints.

Follow up

We received regular updates from the centre reporting that issues we brought to their attention were being addressed. At a follow-up site visit, we were pleased to see significant improvements had been made across each of our recommendations. For example, complaint boxes on wings were more secure, and complaint forms were more readily available. We saw posters advertising the PPO as a route of appeal. The local complaints processes were considerably more streamlined and included the appeal route to the independent Ombudsman.

We were also pleased by the engagement of the staff at the centre in improving local complaints processes and hope to work with them to share examples of these improvements as we roll out our work across the youth estate during 2023/24.

Next steps

The PPO is committed to visiting all establishments within the youth custodial estate during 2023/24 to undertake similar exercises. We will report our findings in the next Annual Report.

Going forward

In the coming year, we will continue to consider how accessible our complaints service is for those who need to use it. We will continue our vital work with women and those in the youth estate to reduce barriers and increase awareness of our service.

We will widen this work to consider how accessible our service is for prisoners from ethnic minority backgrounds, and for those with physical or learning disabilities.

We will continue to review our processes and our responses to prisoners, making sure they are written in plain English and are accessible to those whose first language is not English or who have differing levels of literacy.

Alongside raising awareness of the PPO among prisoners, we want to raise awareness among frontline staff. During 2022/23, the PPO developed an e-learning module. It provides easily accessible information to frontline staff about what the PPO does, where staff might encounter us in their work and how they can ensure our service is used by those who need it.

Complaints recommendations

Our investigations provide an opportunity to understand what has happened and to correct injustices. We produce recommendations to identify learning for organisations, including sometimes at national level.

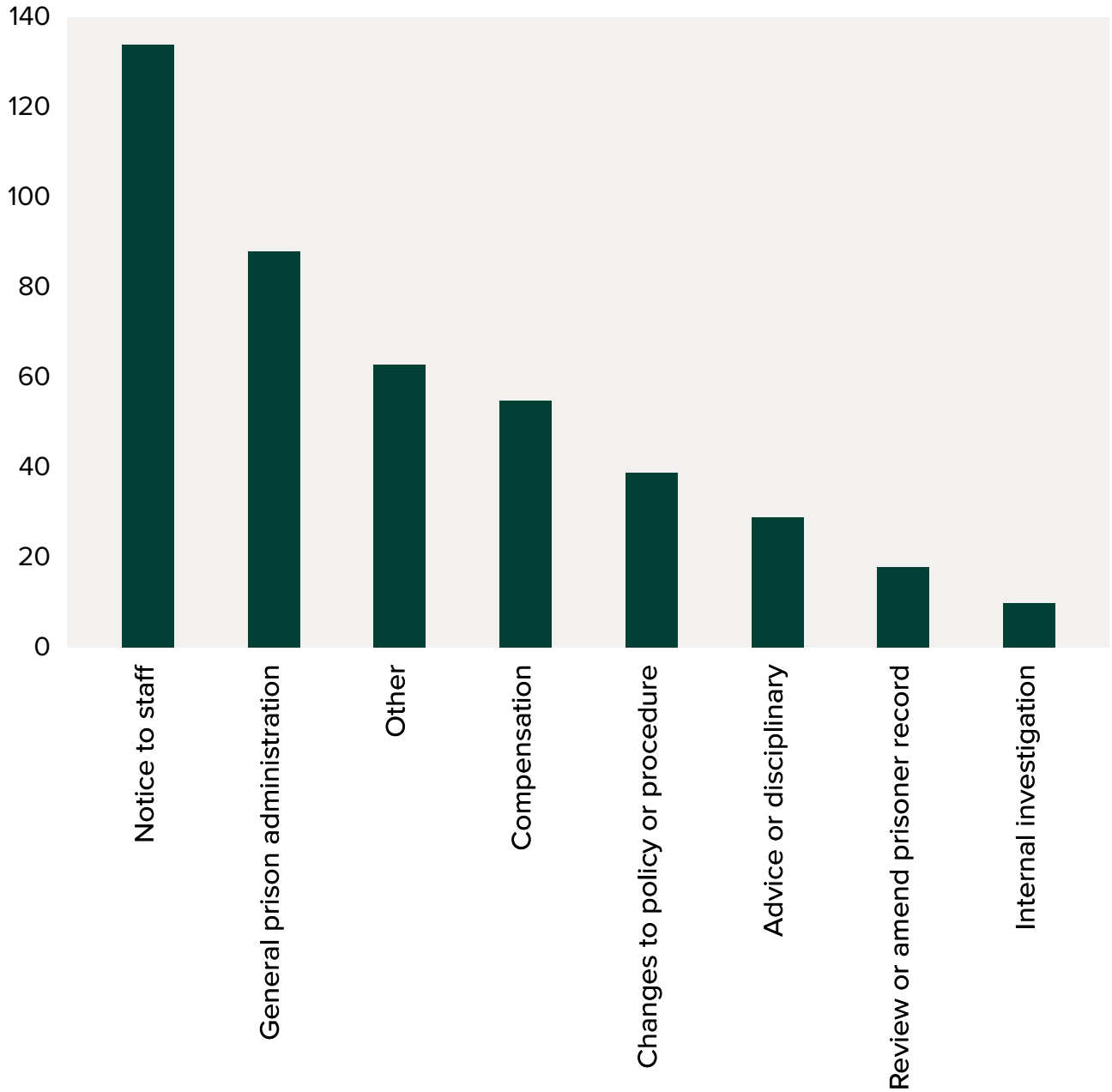
When we make a recommendation after a complaint investigation, the organisation must confirm whether they accept any recommendations and must provide evidence of implementation. Where the service in remit does not accept a recommendation, the director general operations at HMPPS must notify the PPO for public sector prisons. For other services in remit, and for privately managed prisons, a designated senior manager must respond.

Disappointingly, we continue to identify repeat concerns and failings in our complaint investigations. We make the same recommendations, sometimes in the same establishments, and sometimes after the recommendations have been accepted and courses of action agreed to implement them.

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 2022/23, we made 436 recommendations across 177 cases, with an average of 2.5 recommendations per case. At the time of writing, we are awaiting a response to 49 of these recommendations. We have had one recommendation rejected. The remaining 386 have been accepted, and we have received evidence that 91% of these have been implemented.

Complaints recommendations, by action (2022/23):



Investigating fatal incidents

In 2022/23 we began investigations into 404 deaths, a 23% increase on the previous year.

We started 224 investigations into deaths from natural causes, 24 more than in 2021/22, and 92 investigations into self-inflicted deaths, five more than last year.

322 of the investigations related to deaths in prisons and 313 (77%) related to male prisoners aged over 21.

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

Adult safeguarding

Prisons have a duty to keep prisoners safe and protect them from abuse and neglect. In our 2021/22 Annual Report, we highlighted investigations which raised adult safeguarding issues.[7] This continues to be an area of concern, particularly given the evident risks of an ageing prison population. This reporting year, we have investigated cases raising safeguarding issues in both self-inflicted and natural cause deaths.

In prison, the overall responsibility for safeguarding adults falls to prison staff, but healthcare staff also have a responsibility to report safeguarding concerns to the prison. In some cases, the prisoner's needs will also require input from local authority social services, involving effective multidisciplinary working.

"

Prisons have a duty to keep prisoners safe and protect them from abuse and neglect.

Self-neglect is an extreme lack of self-care and is a category of neglect which falls under the adult safeguarding procedures in the Care Act 2014. It can be challenging for prison and healthcare staff to work with someone who self-neglects, and it requires a complex and multifaceted approach.

While there are a number of guidance materials available to prison and healthcare staff, including HMPPS' policy on safeguarding adults and children (2020), Prison Service Instruction 16/2015 on adult safeguarding in prison, and Practice Plus Group's safeguarding policy (October 2020), they lack details about how to support people who neglect themselves.

In the case of Mr K, we identified that there was no national self-neglect strategy to help embed a robust, multidisciplinary, person-centred approach.

7 Prisons and Probation Ombudsman (2022), Annual Report 2021/22. Available online at: **https://s3-eu-west-2.amazonaws.com/ppo-prod-storage-1g9rkhjhkjmgw/uploads/2022/10/15.32_PPO_ARA_2021-22_FINAL_WEB.pdf**

Mr K was found hanged in his cell six weeks after arriving at the prison. He had a history of self-harm, emotionally unstable personality disorder and drug-induced psychosis, and was prescribed antipsychotic medication.

He was a challenging prisoner who refused to engage with staff and spent much of his time living in a dirty cell that smelt of faeces. Mr K said that he heard voices and refused to flush his toilet because he believed that his family would be made to eat the contents. He spent long periods of time in his cell, neglected his self-care and did not always collect his medication. He was under the care of the mental health team and was managed under suicide and self-harm prevention procedures (known as ACCT) throughout the six weeks.

Mr K needed additional support, but staff did not consistently address his risk factors holistically, and his complex issues warranted better case management. Although staff identified and discussed Mr K's issues, they did not identify specific action to address or resolve them. His self-neglect was not identified as a safeguarding concern.

We identified a lack of effective care planning to help address Mr K's risk. When he was deemed not to have the mental capacity to make decisions, we found insufficient staff action, including to improve his living conditions. We found that HMPPS had no self-neglect guidance in place to help staff to support prisoners like Mr K.

Ten days before his death, Mr K was assaulted by a prisoner as a direct result of his dirty living conditions. Staff did not properly assess the risk or impact this might have had on him.

Staff underestimated Mr K's level of risk, placed too much emphasis on his behaviour and did not give sufficient weight to his underlying risk factors, including recognising that his self-neglect was a form of self-harm. The investigation concluded that there was a lack of safeguarding oversight in managing Mr K's risk. At the time of writing, we are waiting for HMPPS's response to our recommendations.

Mr L was 58 years old when he died in hospital from an infection at the site of his pacemaker. He had been in prison for around six weeks and was described as a very quiet person who kept to himself.

Four days before he went to hospital, Mr L left his cell to collect his evening meal. After that, he did not leave his cell again and did not collect his meals, shower or mix with other prisoners. Staff talked to him in his cell but had no concerns about him. The day before he died, Mr L told staff that he did not feel like eating. A member of staff brought his evening meal to his cell.

On the day he went to hospital, staff unlocked his cell for lunch and found Mr L slumped in his chair. He said he had not moved from his chair since the day before, could not move and had not eaten for two days. Nurses took his clinical observations, which were concerning, and requested an ambulance. Paramedics took Mr L to hospital where he was diagnosed with sepsis. He died a fortnight later.

We were critical that staff did not notice Mr L had not left his cell for four days, which should have triggered concern as a possible sign of self-neglect.

Restraints

When prisoners have to travel outside prison, for example to attend hospital, a risk assessment is conducted to decide the level of security arrangements required, including restraints. The Prison Service has a duty to protect the public, but this has to be balanced with a responsibility to treat prisoners with humanity. Case law on this issue is clear following a judgement in the High Court: the use of handcuffs on a prisoner who is receiving medical treatment or care must be necessary and proportionate, taking into account factors such as the prisoner's current health and mobility. The risk assessment process must consider the views of healthcare staff.

We have expressed our frustration with the inappropriate and overly risk-averse use of restraints in previous Annual Reports. In 2022/23 we made 59 recommendations about the use of restraints or the risk assessment process to 36 different prisons. We made repeat recommendations (across more than one investigation) about the use of restraints to seven prisons. These investigations highlighted poor and policy-non-compliant decision making (both with and without healthcare input).

However, there have been positive developments too. In September 2022, HMPPS released a new national External Escorts Policy Framework, drawing on the learning from PPO investigations. To complement the framework, we published our first Policy into Practice publication, designed to emphasise the key learning for frontline staff. We used the publication to reiterate the need for close, collaborative

working between HMPPS and healthcare colleagues. Healthcare staff play a pivotal role in the risk assessment and their medical opinion must be sought and respected to improve outcomes for prisoners.

During the reporting year, we collaborated with colleagues in HMPPS' safer custody casework team to deliver a series of learning workshops on restraints for prison managers and healthcare professionals in the South East region. The workshops reviewed case law and policy, and provided practical guidance on the risk assessment process.

We were pleased to be engaged in this important work to drive change, but our investigations tell us there is more to be done.

> "The Prison Service has a duty to protect the public, but this has to be balanced with a responsibility to treat prisoners with humanity.

Mr M died in hospital from bleeding from blood vessels in the gastrointestinal tract. He was 60 years old and had alcohol liver disease and type 2 diabetes.

Prison staff alerted healthcare when they discovered Mr M clearly unwell in his cell, having vomited a large amount of blood. Nurses assessed him and found he had low blood pressure, a high pulse rate and complained of feeling dizzy. He moved to a wheelchair outside his cell and then again vomited a large amount of dark red blood. Paramedics arrived to take him to hospital and prison managers concluded he should be restrained by an escort chain (a length of chain with a handcuff at each end, one attached to the prisoner and the other to an officer).

Mr M remained restrained during an anaesthetic and endoscopy. Restraints were only removed when hospital staff told prison officers that his condition was life threatening. Mr M was placed in an induced coma and died the following day.

We were critical of the decision to restrain Mr M when it was clearly inappropriate and disproportionate to the risk.

> We collaborated with colleagues in HMPPS' safer custody casework team to deliver a series of learning workshops on restraints for prison managers and healthcare professionals.

Cluster sites

HMPPS monitors clusters of self-inflicted deaths, to ensure prisons have additional support where it is needed. A cluster is identified when two self-inflicted deaths occur at the same prison within an eight-week period or when three self-inflicted deaths occur at the same prison within 12 months. We monitor the findings from our investigations at individual prisons to identify any recurring themes. Deaths that occur within a cluster do not necessarily present the same issues, but a cluster might be indicative of a wider, systemic issue. We discuss learning from cluster sites both within our reports and in our routine engagement with prison group directors and senior leaders in HMPPS, to inform the support provided to the prisons.

We investigated two self-inflicted deaths, of Ms N and Mr O, who died on the same wing at the same prison, three days apart. Both prisoners were being monitored under ACCT procedures and, in both investigations, we identified issues in the management of these procedures.

It was Ms N's first time in prison. She had self-harmed in the escort vehicle and arrived at the prison highly distressed. Staff rightly started ACCT procedures to manage the risk of suicide and self-harm. Ms N's distress continued and she regularly self-harmed, including by banging her head against the wall, cutting her arms and tying ligatures.

Ms N, who was autistic, struggled to cope on the busy, noisy wing. A few weeks into her time in prison, Ms N was found hiding under a table in the association room and told staff she was being bullied. She refused to return to her cell and staff used force to move her. Shortly after, staff found Ms N hanging in her cell. She was taken to hospital but died three days later. We found that ACCT processes were poorly managed. No care plan was created for Ms N and there was little evidence that her risks had been explored and assessed effectively.

Mr O, a transgender man, had poor mental health and a long history of self-harm, which he used as a coping mechanism when he felt emotionally overwhelmed. Mr O's self-harm risks were managed using ACCT procedures on several occasions, including at the time of his death. However, Mr O's ACCT was poorly managed.

Among other issues, no care plan was developed for Mr O and opportunities to review his risks were missed. Staff also failed to follow the correct process for closing and re-opening Mr O's ACCT when the level of risk changed. We had significant concerns about the lack of risk assessment in the period leading up to Mr O's death, despite signs that constant supervision was necessary. Mr O was found in his cell with self-inflicted cuts to his neck and his death was confirmed shortly after.

We escalated our concerns about the weaknesses in ACCT management to the prison group director (the regional manager responsible for the prison). We asked the director to assure us of the action taken in response to our findings, to prevent future deaths.

Meaningful contact and key work

In 2022/23, we found issues with the delivery of key work. Key work is part of HMPPS' Offender Management in Custody model published in 2018. The aim is to co-ordinate prisoners' journeys through prison and back into the community, improving outcomes including safety. The learning from deaths and self-harm incidents in prisons, including PPO investigation findings, informed the development of the model.

Rollout began in the men's prison estate in April 2018, followed by an adapted scheme for the women's estate. Each prisoner is allocated a key worker (a prison officer) who they have regular contact with. The amount of time allocated to key work sessions depends on the individual, their risks and circumstances. The intention of the model is that key workers act as a first port of call for any issues the individual is experiencing and coaches them through their sentence.

During the COVID-19 pandemic, HMPPS paused key work, except for those prisoners assessed as the most vulnerable. Since the end of the pandemic, HMPPS has experienced severe staffing shortages (leading, among other things, to an inquiry by the Justice Committee) which have affected the delivery of aspects of prison regimes.[8] According to HMPPS, there has been a 6% increase in the prison population between 31 March 2022 and 31 March 2023.[9]

8 Justice Committee call for evidence: The prison operational workforce. Available online at: **https://committees.parliament.uk/call-for-evidence/2979/**

9 Offender management statistics quarterly: October to December 2022 – GOV.UK. Available online at: **www.gov.uk/government/statistics/offender-management-statistics-quarterly-october-to-december-2022**

“

Unsurprisingly, we noticed that prisons with severe staffing shortages tend to lack meaningful contact between staff and prisoners.

Our investigations have found that some prisons have been unable to reintroduce key work fully. Unsurprisingly, we noticed that prisons with severe staffing shortages tend to lack meaningful contact between staff and prisoners. We found that meaningful contact might be critical for prisoners who are at risk of suicide and self-harm, those who isolate from the regime, and those who are struggling with sentence progression and the prospect of release. We have found that some prisons with severe staffing shortages have continued to prioritise the prisoners they assess as the most vulnerable. However, in some cases, the criteria used to assess who to prioritise has been unclear.

We recognise that staffing shortages affect a range of prisons across England and Wales. There are a number of factors which influence prisons' ability to recruit and retain staff. We have considered each case on an individual basis, taking into account the specific challenges we have identified and the impact on the care of the individual who has died. We have addressed our recommendations to governors, regional prison group directors or the HMPPS director general depending on the nature of our concerns.

Mr P was serving a life sentence for murder. He had anxiety and depression and a history of self-harm. Mr P found it difficult to cope in the community and had been released and recalled to prison in 2017 and 2020, after breaking his licence conditions.

Mr P was engaged with planning for his parole hearing and applying for release but told his friends and family on the phone that he had suicidal thoughts and nothing to live for. He said he was spending long periods in his cell due to COVID-19 restrictions with no progression opportunities. He only had two key work sessions during his four months in the prison and one of the sessions was cut short because the key work officer had to attend other duties.

Mr P was found hanged in his cell.

The governor told us that staff shortages meant it was not possible to deliver key work in line with the model. The prison was still only delivering key work to prisoners assessed as most vulnerable. We recognised the challenges but were concerned that Mr P was missing out on three key elements of the regime: meaningful contact, activity and sentence progression. This had an impact on his wellbeing and, therefore, risk of harm. Mr P did not present as being in crisis and was engaged with some parts of the regime and forward planning, but was in fact struggling. Key work might have provided Mr P with an opportunity to build a trusting relationship and share his concerns.

We made a recommendation to the HMPPS director general and the Ministry of Justice People Group (responsible for recruitment) to consider what additional support could be put in place to address staffing shortages at the prison. They should also consider how staff could reasonably deliver a meaningful regime and key work in such circumstances.

Segregation

Segregation is a process by which a prisoner is removed from association with other prisoners. Sometimes a prisoner is segregated when prison managers consider that keeping them on a standard prison wing would be disruptive, difficult to manage or unsafe for others. A prisoner might also be segregated for their own protection and safety, when there is reason to believe that they might be under threat from other prisoners. Additionally, a prisoner can spend time in a segregation unit when serving a punishment of cellular confinement after being found guilty of a disciplinary offence, or in the period between an alleged offence and an initial hearing.

Segregation is an extreme and isolating form of custody. It inherently reduces protective factors against suicide and self-harm, such as activity and interaction with others, and should only be used in exceptional circumstances for those known to be at risk of taking their own life.

In 2022/23, we completed a number of investigations into deaths of prisoners in segregation units. In a few other investigations, we found that while the prisoner did not die in the segregation unit, there were concerns about how a recent period in segregation was managed. We made 11 recommendations, including one national recommendation calling for wider-scale change.

In the case of Mr Q, who was found hanging while in the segregation unit, we had multiple concerns about how his segregation was managed.

Mr Q had schizophrenia and a history of self-harm. After Mr Q refused to move wings, staff used force to take him to the segregation unit. He was left there for around two hours for a 'period of reflection'. The next day, staff again used force to take Mr Q to the segregation unit after he barricaded his cell door and refused to comply with staff instructions. He was subsequently sentenced to seven days' cellular confinement for disobeying a lawful order. Three days after being segregated, Mr Q was found hanging in his cell. He was taken to hospital but died three days later.

We are concerned that there were no legitimate grounds to keep Mr Q in segregation when he was taken there for a 'period of reflection'. No segregation paperwork was completed so there was no record to explain why he was held in that location or under which prison rule he was held.

There was little evidence that staff tried to engage with Mr Q after he was formally segregated the next day. He was not assigned a personal officer and staff made very few entries in his segregation records.

Mr Q had no access to any of his basic personal property such as his toiletries and prayer mat. There was also no evidence that Mr Q was offered any distraction materials, such as a radio or reading material, during his time in the segregation unit, despite him repeatedly asking for his newspaper.

Segregation health screens, an important tool used to assess whether a prisoner is fit to be segregated, did not consider Mr Q's medical history.

Mr Q received an extremely poor level of care while he was segregated. Staff failed to consider the impact that segregation might have on Mr Q given his history of schizophrenia and self-harm. At no point did anyone recognise that he might be at increased risk of suicide and self-harm. If staff had interacted with Mr Q in a more meaningful way, they might have identified his increased risks.

Drug deaths

In 2022/23, we began investigations into 65 other non-natural deaths (most of which are drug-related deaths), which is 28 more than last year. However, there are still 20 deaths awaiting classification, and we know from experience that most of these will turn out to be drug-related deaths.

Despite the introduction of various measures to tackle drug supply in prisons, including X-ray body scanners (to detect drugs secreted internally) and rapiscan technology (used to detect drugs in mail), we continue to see deaths involving all kinds of drugs, including heroin, cocaine, psychoactive substances and prescription drugs. While all prisons have drug strategies in place, they need to review these frequently to identify and address key weaknesses.

It is important that staff are vigilant for signs of substance misuse and that they respond quickly if they suspect that a prisoner is under the influence of drugs, as the following case study highlights.

Mr R had a long history of substance misuse. He engaged with the prison's substance misuse service but despite their best efforts, he continued to use drugs, including psychoactive substances.

Around two hours before Mr R died, staff smelled burning coming from Mr R's cell and saw him sitting on his bed slumped to one side. They thought he was under the influence of drugs. However, they did not ask healthcare staff to check on him for another half an hour and he was left alone in the meantime. By the time staff went back to check on Mr R, he was unresponsive. Healthcare staff and ambulance paramedics tried to resuscitate him but were unsuccessful. He died from the toxic effects of psychoactive substances and prescription medication.

The prison's substance misuse strategy says that staff should call healthcare staff immediately if they suspect that a prisoner is under the influence of drugs. Staff should then monitor the prisoner until healthcare staff arrive. This did not happen, and it was around an hour before staff checked on Mr R again and found him unresponsive. The emergency response was poor. There was a delay in staff calling a medical emergency code and no one started CPR until nurses arrived.

Approved premises

We began investigations into 15 deaths in probation approved premises in 2022/23, two more than last year. Of these deaths, 9 were recorded as other non-natural deaths, and most likely to be drug-related, while a further two were awaiting the cause of death.

As we noted last year, we are pleased that drug testing in approved premises has been expanded and that naloxone (a medication that rapidly reverses an opioid overdose) is now offered in all approved premises. However, we continue to see drug-related deaths in approved premises. Much like in prisons, staff at approved premises need to be vigilant for signs of substance misuse among residents and take the appropriate action when they suspect that a resident has taken drugs.

Mr S had been an approved premises resident for six weeks when he died of a heroin overdose. He had a history of substance misuse. A week before Mr S died, staff suspected that he had taken drugs, but they took no action other than recording it in the daily log. The evening before Mr S died, staff had no concerns about him. The next morning, they found him collapsed on his bathroom floor. They called for an ambulance but when paramedics arrived, they assessed that Mr S was dead.

Staff failed to take the appropriate action when they suspected that Mr S had taken drugs. They did not carry out a drug test or conduct a room search.

They did not record their suspicions on the probation case management system either. Therefore, his probation practitioner, who was responsible for his supervision in the community, was not aware that Mr S might have used drugs.

We also found that there was some confusion about how frequently Mr S was being drug tested. His probation practitioner thought he was being routinely tested at the approved premises but staff there told us that he was only tested on arrival and further tests would only be carried out if he was suspected of taking drugs. Mr S's probation practitioner should have picked up that Mr S was not being regularly drug tested as she had assumed.

Post-release deaths

In September 2022, we completed a 12-month pilot investigating the deaths (except homicides) of individuals who have died within 14 days of their release from prison into the community. In January 2023, we published an initial evaluation research report which provided data from the pilot, and a Learning Lessons Bulletin which summarised the key themes from the pilot. We continue to investigate post-release deaths and expect to publish more data about these cases in future.

> "Our investigations over the year have consistently highlighted the importance of strong partnership working to support those leaving prison, including detailed handovers, information sharing and timely referrals.

Between 1 April 2022 and 31 March 2023, we began 64 investigations into deaths of those who died within 14 days of release from prison. 59 of the 64 were male, and five female. 38 of the deaths were recorded as other non-natural causes, and therefore likely to be drug-related, with a further five awaiting the cause of death.

Our investigations into these deaths continue to highlight the acute vulnerability of those being released from prison, many of whom have a multitude of risk factors, from mental health issues to a history of substance misuse. Our investigations over the year have consistently highlighted the importance of strong partnership working to support those leaving prison, including detailed handovers, information sharing and timely referrals.

Recommendations from investigations into drug-related deaths covered the lack of naloxone provision on release (sometimes because the prison leaver refused it) and the lack of support for individuals at risk of substance misuse after release.

Homelessness on release is a significant and complex challenge and unfortunately, accommodation is not always found for individuals released from prison. We have seen that this is often due to the complex needs and resulting behaviours that prison leavers have, which makes it even harder for local authorities or community accommodation services to house them. We are working to share our learning from our post-release investigations with relevant organisations outside our normal Terms of Reference to influence the progress of work in this important area.

Mr T died after being hit by a train two days after his release from prison. Toxicology tests identified a high level of alcohol in his blood and CCTV footage showed that he was unsteady on his feet and appeared to fall from the train platform accidentally.

Mr T had a history of alcohol dependence and told prison staff that he usually drank all day. Mr T completed alcohol detoxification in prison but declined to engage with the prison's substance misuse psychosocial team. This meant that he could not be referred to similar community services on release.

Mr T also had a history of homelessness. Probation practitioners worked with local housing officers and arranged temporary release accommodation in a bed and breakfast. Mr T chose not to check in to the bed and breakfast on his first night of release and stayed with his mother instead. He travelled to the bed and breakfast the following day.

While Mr T was not released homeless, the emergency accommodation he was provided with was not in the area where he lived. Therefore, it did not meet his needs as it was far from his home area, family and support network. This is an issue that extends beyond the remit of prison and probation services.


FIRE EXIT
FIRE EXIT

Fatal incident recommendations

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.

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

In 2022/23 we issued 314 final investigation reports following deaths in custody and made recommendations in 252 of these cases.

We made 881 recommendations, with an average of 3.5 per case.

At the time of writing, most of our recommendations had been accepted (789) and we were awaiting the service response to 87 recommendations. Five of our recommendations were rejected by HMPPS.

Health provision

Our recommendations about health provision highlighted the following issues:

- robust record keeping
- following up on health tests, timely referrals and hospital appointments
- appropriate use of the NEWS2 scoring system
- following NICE guidance to manage health conditions, including thorough care plans and multidisciplinary case reviews
- accurate prescribing of medications, including conducting reviews of prescriptions and in cell holds
- reception and secondary health screenings taking place in line with national guidance
- information sharing between prison, healthcare and hospital staff
- following guidelines for the management of prisoners with COVID-19, including testing, record keeping and offering shielding to those at increased risk of health complications

Emergency response

Staff should understand their responsibilities during a medical emergency. These include:

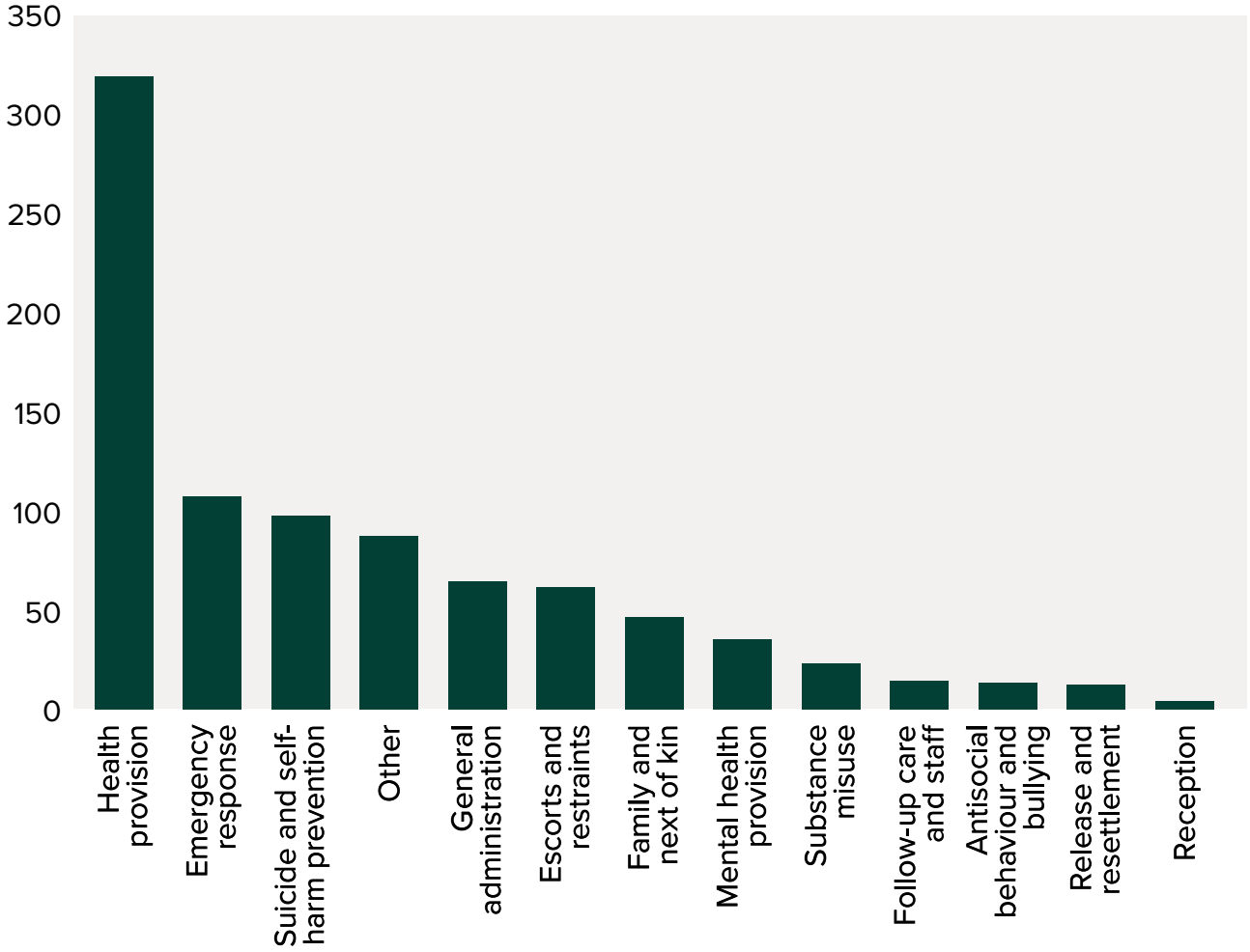
- radioing the correct emergency code immediately
- ensuring the control room calls an ambulance immediately, including communicating all relevant information to the paramedics
- carrying and having access to the correct equipment, including sealed pouches and radios
- entering cells without delay and unlocking cell doors in potentially life-threatening situations
- being aware of the circumstances in which resuscitation is inappropriate
- satisfying themselves of the wellbeing of all prisoners during roll checks

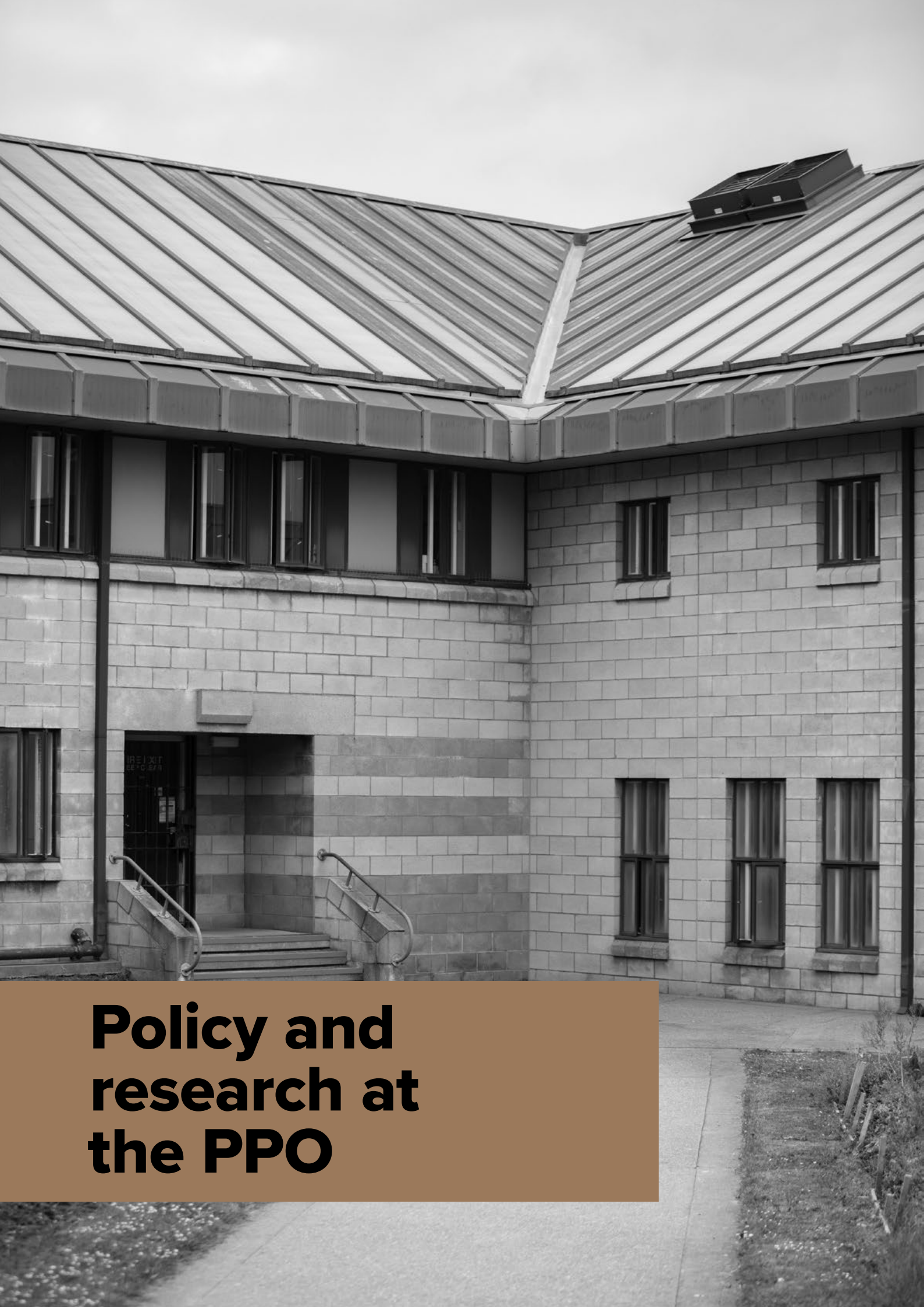
Suicide and self-harm prevention

Recommendations about suicide and self-harm prevention include following ACCT procedures and national guidelines. These include:

- assessing the level of a prisoner's risk of suicide and self-harm based on all known risk factors and not only on a prisoner's presentation
- accurate record keeping and care plans
- opening an ACCT where there are risk factors, including if an ACCT is not open, and documenting the risk information considered and the reasons for not starting ACCT procedures
- attending case reviews, which should be thorough and multidisciplinary where needed
- carrying out meaningful welfare checks, including after court appearances, and observations at the agreed frequency
- ensuring information is shared across prison and healthcare staff

Recommendations following deaths, by category (2022/23):





Policy and research at the PPO

Alongside our complaints and fatal incident investigation functions, the PPO also has a research, strategy and corporate services function. The research and strategy teams use the findings from the PPO's individual investigations to highlight thematic issues and learning to stakeholders and services in remit, including policy teams and frontline staff.

Influencing national policy (use of restraints on escort)

During 2022/23 we used learning from our investigations to influence changes to a number of national HMPPS and Home Office policies. For this reason, we published our first Policy into Practice publication in September 2022.[10] The first publication focused on HMPPS' External Escorts Policy Framework, looking at the use of restraints on escort. As highlighted in previous Annual Reports, we have continued to see far too many cases in which handcuffs were used on frail and/or very unwell prisoners to escort them to hospital. The Policy into Practice publication uses case studies to explain to frontline staff why the policy is important and why we recommended the policy changes we did.

During the consultation stage of the External Escorts Policy Framework, the PPO's recommended changes to the policy included:

- providing more detail to prisons about how often approval needs to be obtained for the use of restraints on tetraplegic and paraplegic prisoners – as a result, the new framework specified that "approval must be sought for each time the prisoner is to undergo an escort unless the HMPPS Chief Executive Officer … states otherwise for an individual prisoner"
- clarifying the position on the use of escort chains – the new framework explained that "escort chains are not to be used as a less secure form of restraint … If no restraints are to be used, then this includes the use of an escort chain"

The Policy into Practice publication also highlighted the importance of prison managers working collaboratively with healthcare colleagues when completing escort risk assessments.

10 Prisons and Probation Ombudsman (2022), Policy into Practice: Use of restraints on escort. Available online at: **https://s3-eu-west-2.amazonaws.com/ppo-prod-storage-1g9rkhjhkjmgw/uploads/2022/09/Policy-into-Practice-Use-of-restraints-on-escort-1.pdf**

Providing expertise to stakeholders (segregation)

Another means for the PPO to have an impact and influence changes to policies and practices is through membership of advisory panels and groups. During 2022/23 the PPO participated in a number of advisory groups, covering topics such as use of force, segregation and pregnancy in prisons.

As members of an advisory group on segregation in adult prisons, the PPO's research and strategy teams provided learning about segregation in prisons. We looked at our investigations between 1 April 2019 and 31 October 2022 and shared the following findings.

- A common complaint from prisoners relating to segregation is about the lack of regime while segregated, and we have identified cases where prisons should have done more to enable daily exercise and time in open air.
- We found repeated examples where a prison's decision making was poorly recorded when authorising initial and continued segregation.
- We have often found that there has been inadequate mental health input when making the decision to segregate a prisoner.
- We also highlighted the importance of having a designated officer, meaningful conversations and sufficient distraction material.

Publishing thematic learning from PPO investigations

Remand

In March 2023 the PPO published research into fatal incidents within the remand population.[11] We were aware of the increasing remand population and of the MOJ's data which identified in 2022 that 35% of all self-inflicted deaths were of prisoners on remand. We felt that it was important to look into whether our investigations had identified any common themes or learning for HMPPS.

Our research identified common findings, such as the importance of:

- examining all documentation that arrives with a prisoner and ensuring it transfers with them
- considering risk factors over how a prisoner presents
- identifying triggers for potential self-harm and suicide (such as court dates for trials and hearings) and re-assessing risk following such triggers

Post-release deaths

As already mentioned, in September 2022 we completed a 12-month pilot to investigate the deaths of those who die within 14 days of release from prison. Following this pilot, our research team carried out and published an

11 Prisons and Probation Ombudsman (2023), The Investigator Issue 12. Available online at: **https://s3-eu-west-2.amazonaws.com/ppo-prod-storage-1g9rkhjhkjmgw/uploads/2023/03/The-Investigator-Issue-12-2023-Final.pdf**

evaluation of the pilot and the findings.[12] We also published a Learning Lessons Bulletin in January 2023 to share our initial findings with HMPPS and other stakeholders.[13]

The PPO's Learning Lessons Bulletins summarise the thematic learning from our investigations. The learning identified by our post-release investigations and summarised in the bulletin included findings about homelessness, accommodation, substance misuse and mental health. The bulletin also highlighted findings in relation to handovers, referrals and information sharing between agencies. The range of insights identified has meant that the PPO are now working with agencies beyond HMPPS to share learning about homelessness and accommodation.

Providing evidence to parliamentary committees (prison operational workforce)

In December 2022, the Justice Committee put out a call for evidence relating to the prison operational workforce. This included evidence relating to the implications for prisons that struggled to recruit or retain staff, particularly in being able to provide effective regimes.

While investigating deaths in prisons, we will consider and set out the context prison staff work in and, in specific cases, we have touched on staffing levels. In some investigations carried out during 2022/23, we have taken this a step further because we were able to link the treatment prisoners received to the reduced staffing levels.

In our evidence, we highlighted recent concerns about the impact of prisons' inability to provide meaningful activity and sentence progression opportunities due to staff shortages.[14] We raised the importance of staff at a receiving prison alerting a sending prison of any limitations on progression activities at that prison. This would enable staff at the sending prison to consider the suitability of the transfer and manage prisoners' expectations, as it may affect their wellbeing and risk of self-harm.

We also said that due to staff shortages, staff are unable to complete all their duties such as key work, accurate record keeping, prison inductions and escorts to hospital appointments. It has become clear that during 2022/23, we saw more cases where staff shortages were impacting on the interaction and support that a prisoner could receive from staff.

12 Prisons and Probation Ombudsman (2023), Investigating deaths after release from prison – a pilot evaluation. Available online at: **https://s3-eu-west-2.amazonaws.com/ppo-prod-storage-1g9rkhjhkjmgw/uploads/2023/01/Investigating-deaths-after-release-from-prison-Final-report.pdf**

13 Prisons and Probation Ombudsman (2023), Learning Lessons Bulletin: Post-release death investigations. Available online at: **https://s3-eu-west-2.amazonaws.com/ppo-prod-storage-1g9rkhjhkjmgw/uploads/2023/01/14.202_PPO_LL_Bulletin_Issue17_FINAL_WEB_V2-3.pdf**

14 Prisons and Probation Ombudsman email to the Justice Committee. Available online at: **https://s3-eu-west-2.amazonaws.com/ppo-prod-storage-1g9rkhjhkjmgw/uploads/2023/01/Justice-Committee-Inquiry-into-the-prison-operational-workforce-final.pdf**

Appendices

Stakeholder feedback – emerging findings

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

- those we engage with (by way of our general stakeholder survey)
- those involved in deaths in custody and post-release death 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 80 responses in 2022/23, compared to 96 responses in 2020/21. This year we have included partial survey responses only where sufficient information has been provided. Please see the 'About the data' section for more detail.

The survey ran throughout March 2023 and responses came from prisons (including operational staff, non-operational staff, business staff and other services such as chaplaincy), probation, healthcare services, MOJ, HMPPS, academics and the third sector.

Overall satisfaction

- 65 of the 70 respondents who had some experience of the PPO's investigations in the past year rated the overall quality of their experience as satisfactory or better.

Reports

- Of the 36 respondents who had read PPO reports (complaints, fatal incidents or both), 32 found these reports to be quite or very clear.
- 33 out of the 67 respondents who answered the question found anonymised fatal incident reports very useful or quite useful.
- Regarding the research and policy publications the PPO released this year, 40 out of the 67 respondents who answered the question found the Learning Lessons Bulletin on post-release deaths very useful or quite useful.
- 26 out of the 67 respondents who answered the question found the Policy into Practice publication on restraints very useful or quite useful.

Our website

- 49 of the 66 respondents who answered the question said they had visited the PPO website in the last 12 months.
- 45 of the 48 respondents who answered the question said they found it quite easy or very easy to find what they were looking for on the website.

Impressions of the PPO

- Of the 65 respondents who answered the question, 50 agreed we were impartial, 55 agreed we were respectful, 47 agreed we were inclusive, 54 agreed we were dedicated and 52 agreed we were fair.[15]

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 178 responses (from 604 surveys sent) in 2022/23. This is a 27% decrease from last year, when we received 243 responses (from 610 surveys sent). This year, we included substantial partial survey responses (please see the 'About the data' section for more details). We received responses from liaison officers, establishment heads, healthcare leads and coroners.

Overall satisfaction

- 88% of respondents (of the 178 who answered the question) rated the quality of the investigation as satisfactory or better.
- 83% of respondents (of the 178 who answered the question) rated the quality of communication with the PPO as satisfactory or better.
- 77% of respondents (of the 178 who answered the question) rated the time it took the PPO to complete its investigation as satisfactory or better.

Reports and recommendations

- 93% of respondents (of the 162 who answered the question) stated the report we issued met their expectations.
- 94% of respondents (of the 155 who answered the question) stated that the PPO report contained about the right amount of detail.
- 78% respondents (of the 175 who answered the question) said they found the recommendations made by the PPO quite worthwhile or very worthwhile.

Impressions of the PPO

- Of the 178 respondents who answered the question, 85% agreed we were impartial, 93% agreed we were respectful, 86% agreed we were inclusive, 87% agreed we were dedicated and 90% agreed we were fair.[16]

15 This includes those who agreed and strongly agreed.

16 This includes those who agreed and strongly agreed.

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. Please see the 'About the data' section for further details.

We have received 26 responses (from 211 surveys sent) during this data collection period, compared to 34 responses (from 251 surveys sent) in 2021/22. This includes substantial partial responses.

Overall satisfaction

- 10 out of 22 respondents who answered the question felt that the overall quality of the PPO's investigations was good or very good. 10 deemed it poor or very poor.
- 10 out of 26 respondents who answered the question felt satisfied or very satisfied with the PPO's communication. 10 felt dissatisfied or very dissatisfied.

Reports

- 11 out of 23 respondents who answered the question felt the initial report met their expectations.
- Of the 21 respondents who answered the question, 9 thought there was the right amount of detail, with 11 respondents thinking there was not enough.

Impressions of the PPO

- Of the 22 respondents who answered the question, 11 agreed we were impartial, 14 agreed we were respectful, 11 agreed we were inclusive, 12 agreed we were dedicated and 12 agreed we were fair.[17]

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 complaints 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.

We received 348 responses (from 957 surveys sent) in 2022/23, in comparison with 407 (from 933 surveys sent) in 2021/22.

- 135 responses came from those whose complaints were ineligible. These complaints were not investigated, and the complainants received letters explaining why.
- 213 respondents had eligible complaints. 109 had their complaints upheld or partially upheld and 104 had their complaints not upheld.[18]

17 This includes those who agreed and strongly agreed.

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

Complaint handling

Previously during the COVID-19 pandemic, the PPO agreed with HMPPS that complainants could get free photocopies of their complaint forms.

- 49% of respondents whose complaints were upheld (of the 108 who answered the question) said they were able to get free photocopies of their complaint form. 44% of respondents said they could not, and 6% said they did not know.
- 45% of respondents whose complaints were not upheld (of the 101 who answered the question) said they were able to get free photocopies of their complaint form.
- 36% 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

- 74% of respondents (of the 108 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, 19% of respondents (of the 101 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 42 who answered the question, 38% of respondents rated the service they received as either satisfactory or better.

Reports and letters

- 95% of respondents whose complaints were upheld (of the 108 who answered the question) said they understood the report or letter they received. 3% of respondents stated they had not received a report or letter.
- 86% of respondents whose complaints we did not uphold (of the 102 who answered the question) said they understood the report or letter they received. 7% of respondents stated they had not received a report or letter.
- 49% of respondents whose complaints were ineligible (of the 43 who answered the question) said that our letter explaining why their complaint wasn't eligible was clear. 19% of respondents stated they had not received this letter.

Outcome

- 69% of respondents whose complaints were upheld (of the 108 who answered the question) stated that the PPO helped them with their complaint.

- In contrast, 13% of respondents whose complaints we did not uphold (of the 100 who answered the question) stated that the PPO helped them with their complaint.
- In addition, 50% of respondents whose complaints were upheld (of the 108 who answered the question) said they were satisfied with the time it took the PPO to complete their investigation.
- For those respondents whose complaints were not upheld, 25% (of the 102 who answered the question) stated they were satisfied with the time it took the PPO to complete their investigation.
- For those whose complaints were ineligible, we asked if they had done anything differently after contacting us. 47% respondents stated they had (of the 43 who answered the question). Respondents were also asked what they were planning to do with their ineligible complaint. Of the 43 who answered the question, 30% said they would send it to a different body. 14% stated they would send it back to the Ombudsman and 35% stated they would do nothing further.

Impressions of the PPO

- Of the respondents who answered the question, 36% agreed we were impartial, 62% agreed we were respectful, 46% agreed we were inclusive, 38% agreed we were dedicated and 37% agreed we were fair.[19]

19 This includes those who agreed and strongly agreed. There were different numbers of respondents who answered each question: 321 for impartial, 321 for respectful, 310 for inclusive, 312 for dedicated and 317 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 throughout the investigation. This can lead to similar complaints being categorised differently.

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 within our remit.

A complaint is upheld if, after investigation, we find in favour of the complainant. This means that 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 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 2021/22 was frozen in April 2022, and data for 2022/23 was frozen in May 2023. 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 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 and 2022/23 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, which 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. It 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 and 2022/23 is defined as one where the draft outcome has been approved. This excludes withdrawn cases and Paragraph 20 cases.

For standard complaints, initial reports are counted as having been completed 'in time' when submitted within 12 weeks (60 working days) of accepting the complaint as eligible. For complex complaints, initial reports are counted as having been completed 'in time' when the investigation is completed and the report is submitted within 26 weeks (130 working days) of accepting the complaint as eligible. However, we must sometimes suspend our investigations while we wait for key information, such as cell clearance certificates and property cards.

Timeliness calculations exclude the times when a case is suspended for reasons that are outside the PPO's control. We are continuing to explore ways to collect this data in the future.

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

Prison population data is taken from the March 2023 population bulletin published on GOV.UK.[20]

Fatal incident investigations

Data is based on when the PPO was 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, which 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 year's Annual Report, 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 it was deliberate, irrespective of whether it would meet the legal definition of intent (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 in 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 be a COVID-19 element. If information provided later shows the

20 Prison population figures: 2023 – GOV.UK. Available online at: **www.gov.uk/government/publications/prison-population-figures-2023**

death does not fit our definition, it will be re-categorised. Death certificates are not always consistently filled in.

Fatal incident data was frozen in mid-May 2023.

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

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 being 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. These 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. Comparisons of post-release deaths across financial years have not been made due to the pilot starting on 6 September 2021.

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, we included partial survey responses, only where sufficient information had been provided – where respondents had completed a minimum of five questions. In the previous two years, we included all partial survey responses in the data.

General stakeholder survey

The general stakeholder survey is an online survey that was promoted on Twitter and our website, and sent to those on our stakeholder mailing lists. This means that we can only reflect the number of responses received. It was sent out at the beginning of March 2023, with a reminder email two weeks later. The survey was then closed at the end of March 2023.

Bereaved families' survey

The survey is sent monthly to family members and next of kin who have been sent a final report three months previously. Survey results presented in this Annual Report reflect cases where a final report was issued in December 2021 to December 2022.

As mentioned in last year's Annual Report, surveys due to be sent out in March 2022 were sent out in April 2022, and therefore have been included in the 2022/23 analysis.

Complainants' survey

The survey is sent monthly to a sample of complainants whose complaints are 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 up to 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 reflect cases closed between January 2022 and January 2023.

As mentioned in last year's Annual Report, surveys due to be sent out in March 2022 were sent out in April 2022, and therefore have been included in the 2022/23 analysis.

Ineligibility reasons are updated and overwritten every time a new eligibility assessment is completed when there is new information 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 draft report has been issued, and to establishment heads and healthcare leads once the final report has been issued. It is sent out at the beginning of each month, for the previous month.

The results include cases with reports issued between March 2022 and February 2023. It is also sent to coroners at the end of the financial year (March 2023) who have been involved in fatal incident investigations with a fatal incident final report issued in 2022/23. There is a four-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 May 2023.

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

Fatal incident recommendations

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

The data provided was frozen in May 2023.

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

Performance against the 2022/23 business plan

Objective 1: Confidence

Improve the confidence of our stakeholders in our role as an independent, impartial and fair investigative body and complaints resolution service.

Key deliverable	End-year update
Continue to campaign for the PPO to be given statutory footing.	**Not achieved** A legislative slot was not available during 2022/23. During 2022/23 the PPO supplied the MOJ with further evidence as to why statutory footing would have a positive impact on the PPO.
Raise awareness of the PPO's work with our external stakeholders and those in custody.	**Achieved** The PPO has used communications channels such as National Prison Radio, Inside Time and Women in Prison's magazine, as well as rebranding and reissuing posters and leaflets for prisoners. The PPO has published two The Investigator newsletters in 2022/23 that highlighted the work of the PPO to external stakeholders. The investigation teams have run prisoner focus groups with young people and women in prison to raise awareness of the PPO.
Regularly review our recommendations to services in remit to ensure they are proportionate, targeted and appropriate.	**Ongoing** Work has taken place to review outstanding complaints recommendations and escalate where appropriate to ensure compliance.

Key deliverable	End-year update
Effectively seek and take account of our key stakeholders' opinions, including feedback from our general stakeholder and bereaved families' surveys.	**Ongoing** The PPO continued to meet a wide range of stakeholders throughout the year. Stakeholder and bereaved families' surveys were conducted in 2022/23 and the feedback will inform plans for continuous improvement. The PPO held a stakeholder event to share and discuss the findings from the post-release deaths pilot.
Ensure our updated publicity materials are available in all establishments so those in custody and under offender supervision have up-to-date knowledge about our services and how to contact us.	**Achieved** Updated publicity materials were provided to all establishments. PPO staff continue to monitor whether the publicity materials are visible in the establishments during their visits.

Objective 2: Effectiveness

Empower staff to further improve the quality and timeliness of our investigations and resulting reports, ensuring a robust and proportionate approach.

Key deliverable	End-year update
Meet the timeliness targets for all complaints investigations. Determine the eligibility of complaints within 10 working days of receipt. Standard complaints: submit the initial report within 12 weeks (60 working days) of accepting the complaint as eligible. Complex complaints: complete the investigation and submit the initial report within 26 weeks (130 working days) of accepting the complaint as eligible.	**Ongoing** The PPO submitted 2,119 initial reports for standard complaints, of which 60% were submitted on time. The PPO also submitted 17 complex cases, of which 65% were submitted on time. There were 29 suspended cases that have been excluded from these calculations. Improvements were made throughout 2022/23 to enable us to calculate and measure complaints timeliness. Now that our case management system is able to calculate the timeliness of complaints investigations, we will introduce a defined measure of success in our 2023/24 business plan. **Not measured** This year 4,441 cases were assessed for eligibility. Reporting issues mean our case management system is unable to calculate the timeliness of assessments, but work is underway to change this.

Key deliverable	End-year update
Meet the timeliness targets for all fatal incident investigations. Natural cause deaths: submit the initial report within 20 weeks (100 working days) of initial notification. Self-inflicted and other non-natural, drug-related deaths and homicides: submit the initial report within 26 weeks (130 working days) of initial notification. Finalise the investigation report within 12 weeks (60 working days) of the initial report. We will consider these targets to have been met if at least 70% of reports are delivered to time and quality. Publish anonymised reports for fatal incident investigations within one week (five working days) of being notified that the inquest has concluded, and our investigation report has been finalised.	**Not achieved** This year the PPO issued 317 initial reports, of which 60% were on time. The PPO also issued 314 final reports, of which 55% were on time. **Not measured** This year the PPO published 327 anonymised reports. Due to the process of notification we are currently unable to assess the timeliness of these publications, but work is underway to change this.

Key deliverable	End-year update
The senior leadership team will conduct regular reviews of our cases and investigation reports to ensure we have confidence and consistency in our decision making and to assure ourselves that we are contributing to a safer, fairer custody and offender supervision.	**Achieved** Regular case reviews and validation (for fatal incident investigations) and quality assurance audits (in complaints) have taken place throughout the year.
Consider trialling the use of external bodies or another Ombudsman to conduct reviews of our cases and investigation reports to further ensure we have confidence and consistency in our decision making.	**Not achieved** This was explored but the PPO encountered data protection issues that prevented it happening during the year.
Work with staff to identify areas where our productivity is blocked and reduce activities that do not add value to our organisations.	**Ongoing** Continuous improvement forums have been established and work has started to use continuous improvement methods to identify where productivity may be blocked and reduce activities that do not add value.

Objective 3: Impact

Focus on the outcomes of investigations and increase the impact of our work on the actions of services in remit and the day-to-day lives of those in custody.

Key deliverable	End-year update
Continue with the pilot to investigate the deaths of recently released prisoners. We will work to the timeliness targets defined above and evaluate the impact of these investigations.	**Achieved** The PPO completed 63 investigations into post-release deaths in 2022/23. The PPO published a research evaluation report and a Learning Lessons Bulletin about post-release death investigations in January 2023. The PPO also held a stakeholder event where we shared the learning from our investigations with services in remit and other stakeholders.
Produce our Annual Report for publication in autumn 2022.	**Achieved** The 2021/22 Annual Report was published in October 2022.
Continue to refine our data collection and data management to uncover themes and trends in our casework.	**Ongoing** In 2022/23 we started work on developing a new data dashboard which will put accessible visual data into the hands of investigators and managers, empowering them to interrogate our data quickly and uncover trends in exploratory ways. We have also been refining and developing our definitions of key indicators such as 'timeliness' and 'repeat recommendations' to make them more useful. New functionality is being added in the case management system to allow us to analyse assessment timeliness data.
Continue our efforts to develop an effective means of tracking repeat recommendations and holding services in remit to account for not implementing recommendations.	**Ongoing** The PPO has appointed an implementation officer who is working with the PPO's stakeholders and staff to track progress of recommendations and share learning.

Key deliverable	End-year update
Ensure we have impact by producing regular news and publications, including Learning Lesson Bulletins and The Investigator (our newsletter) to engage external stakeholders.	**Achieved** During 2022/23 the PPO published the following articles and bulletins: ■ Learning Lessons Bulletin: Post-release death investigations ■ Policy into Practice: Use of restraints on escort ■ an article on research into fatal incidents within the remand prison population (The Investigator issue 12, March 2023) ■ The Investigator issue 12, March 2023, and The Investigator issue 11, August 2022 ■ PPO submission to the Justice Committee on the impact of prison workforce on prisons ■ news articles helping prisoners complain to us, highlighting our independence and women's complaints ■ 2021/22 Annual Report
Respond to all Freedom of Information Requests and Subject Access Requests within the prescribed timescales.	**Partially achieved** During 2022/23, the PPO received 77 Freedom of Information Requests and responded to them all within the prescribed timeframe. We received 70 Subject Access Requests and responded to 40 within the prescribed timescales.

Key deliverable	End-year update
Develop our relationships with HM Inspectorate of Prisons, Independent Monitoring Boards, HM Inspectorate of Probation and the Independent Advisory Panel for Deaths in Custody, and work together where our aims align.	**Ongoing** We had regular engagement with HM Inspectorate of Prisons, Independent Monitoring Boards, HM Inspectorate of Probation and the Independent Advisory Panel for Deaths in Custody. At the time of writing, we have been working on updating our memorandum of understanding with the Independent Monitoring Boards and with HM Inspectorate of Prisons to reflect our current working arrangements.
Continue to work closely with universities and academics to support our work and ensure it has impact.	**Achieved** We have worked closely with universities and academics throughout 2022/23. During that time, two university students joined the PPO on a placement. We have worked with academics on projects such as the post-release deaths project to use their research and knowledge in their specialist areas.
Update the PPO's corporate branding so it is accessible and allows us to have a stronger impact.	**Achieved** The PPO's rebrand was completed and launched in May 2022.

Objective 4: Efficiency

Use our resources efficiently and effectively.

Key deliverable	End-year update
Support staff wellbeing through our staff support team and through introducing a trauma-informed approach to investigations.	**Achieved** The staff support team have continued to support staff throughout 2022/23. The PPO has also introduced one-to-one reflective sessions for PPO staff carrying out or involved in fatal incident investigations as part of the PPO's commitment to introducing a trauma-informed approach.
Championing diversity and inclusion through our five equality and diversity groups. We will take action to make the PPO a great place to work and ensure that all colleagues are well supported.	**Achieved** The equality and diversity group: ■ published the PPO's Race Action Plan ■ obtained registration for the PPO as a Disability Confident Committed Employer (level 1) ■ hosted multiple events throughout the year, including for Black History Month, International Women's Day and LGBTQ+ History Month

Key deliverable	End-year update
Produce a Race Action Plan and begin actioning the previous plan.	**Achieved** We developed an action plan and have completed actions from the previous plan. This includes developing internal guidance for managers and staff on dealing with discrimination, victimisation, harassment and bullying. We also created a zero-tolerance policy which is included on relevant PPO letters, stating our approach to discrimination and harassment.
Review our recruitment processes with all the PPO's equality, diversity and inclusion staff groups to make the PPO even more inclusive.	**Achieved** The recruitment processes were reviewed following every large-scale campaign. All equality, diversity and inclusion groups were consulted on any proposed changes to the process and had the opportunity to feed back.
Maintain a case management system, which supports an efficient and effective investigation process.	**Achieved** The PPO continues to use its case management system to support investigators with their investigation processes. Throughout 2022/23 a number of changes were made to the case management system to improve efficiency.

Key deliverable	End-year update
Support our staff with a learning and development strategy and signpost colleagues to opportunities to build their skills and capability.	**Ongoing** The PPO promoted leadership development during the year. This included support for staff participating in cross-government leadership programmes and formal training courses for senior leaders.
Support our staff by holding regular full-staff meetings and development events across the year.	**Achieved** The PPO held full-staff meetings throughout the year.
Keep staff up to date on important information through regular internal communications.	**Achieved** The communications and media manager issued the PPO's regular internal newsletter to staff and issued ad-hoc communications to all staff when required.
Respond to the findings from the People Survey and implement actions to support colleagues across the office.	**Ongoing** Learning and development emerged as a key theme and the PPO will focus on this ahead of the next survey.
Develop a PPO green policy which will include being less reliant on paper and embracing digital working.	**Partially achieved** The PPO now has digital case files and no longer uses paper files for investigations. This has resulted in a substantial decrease in reliance on paper.

Financial data

	2021/22		2022/23		Change 2021/22 to 2022/23	% change year on year
Budget allocation	£5,883,000		£6,179,000		£296,000	5%

Actuals	2021/22	% of total 2021/22	2022/23	% of total 2022/23	Change 2021/22 to 2022/23	% change year on year
Staffing costs	£5,206,655	92%	£5,564,651	93%	£357,996	6%
Non-staff costs	£469,976	8%	£435,178	7%	-£34,798	-1%
Total spend	**£5,676,631**	**100%**	**£5,999,829**	**100%**	**£323,198**	**6%**
Underspend	**£206,369**		**£179,171**		**-£27,198**	**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:

Prisons and Probation Ombudsman
10 South Colonnade
Canary Wharf
London
E14 4PU

ISBN 978-1-5286-4370-2
E02948425