Prisons & Probation Ombudsman
Independent Investigations

Annual Report 2023/24

CP 1107

Prisons & Probation Ombudsman

Annual Report 2023/24

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

July 2024

CP 1107

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 978-1-5286-4677-2

E03062894 07/24

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

The role and function of the PPO

The Prisons and Probation Ombudsman (PPO) is appointed by and reports directly to the Secretary of State for Justice. The Ombudsman's office is wholly independent of the services in remit, which include those provided by HM Prison and Probation Service (HMPPS), the 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:

Complaints from prisoners and young people[1] in custody are investigated by Independent Prisoner Complaint Investigations (IPCI). IPCI is part of the PPO.

1 IPCI 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 deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO

Resolve complaints

Investigate deaths

Special investigations

Identify and disseminate learning

Ensure trust and confidence in the criminal justice system

WHAT WE VALUE

Ambitious thinking

Professional curiosity

Diversity & inclusion

Transparency

Teamwork

Foreword

Adrian Usher
Prisons and Probation Ombudsman

I was very proud to be selected to lead the Prisons and Probation Ombudsman from April 2023. Having spent just over a year witnessing first-hand the hard work and dedication of my staff, that pride has only increased. As might be expected upon the appointment of a new Ombudsman, this year has seen some significant changes taking place within our working practices and more will follow in the months ahead. These changes have been informed by consultation with my staff, the services in our remit, key stakeholders and third sector organisations, alongside my previous experience of investigation and community engagement.

> “
>
> I was very proud to be selected to lead the Prisons and Probation Ombudsman from April 2023.

One of the most important aspects of the consultative change process this year was the refresh of our vision and values. When I first joined the PPO, I met individually with every single one of our staff and those conversations informed the new vision and values. I wanted to be able to set out clearly what we do, how we will achieve it and the core values that guide our work. Those values are there for when I, or my staff, have a difficult decision to make as solid principles that can guide our thinking and practice. They were launched on 29 September 2023, and you will see them on page 3 of this report.

The focus and content of this Annual Report has been amongst some of the other changes I have made. This is not change for the sake of it but to reflect the belief that, though being proud of our independence, we are nevertheless funded by the taxpayer, and therefore I believe the focus of the report should be on what we have delivered this year and the tangible differences we have made to operational delivery and safety for those services in our remit.

In a further change to this report, I have asked for each of the main functions of our work on complaints, fatal incidents and corporate learning for the relevant Deputy Ombudsman to personally write a section. This is to recognise and directly share the individual insights and expertise that each of them brings to their role and their teams. I am grateful for the enthusiasm with which they have responded to this development. It remains the case that ultimately, I am responsible for all the strategic decisions taken at the PPO, and so I will touch on some of the other important changes we have made in 2023/24.

> “

...by being more succinct in our reports and without losing any investigative rigour, we can focus resources on higher risk work.

In our fatal incident investigations function, we have streamlined the way we report on our natural cause death investigations. We still focus on the standard of healthcare provided as well as whether appropriate compassionate release was actioned, and the far too frequent issue of inappropriate restraints when care is being provided beyond the prison walls. However, by being more succinct in our reports and without losing any investigative rigour, we can focus resources on higher risk work.

We have also made changes to the volume and type of recommendations that we make. If, during the course of an investigation, we uncover that a process or procedure was not followed correctly, we will always state this publicly and highlight this to the relevant head of the institution. In my opinion, making a recommendation should be reserved for those occasions where we have evidence of systemic or endemic fault and in those occasions, our recommendations should be based on the highest quality evidence and therefore lead to lasting, tangible change. I believe this optimises the chances of the services in our remit becoming safer.

In our complaints investigations function, 2023/24 was dominated by the creation, launch and promotion of Independent Prisoner Complaint Investigations (IPCI). This new name for our complaints investigation work was driven out of the consistent evidence that the PPO had relatively low recognition amongst those who need to complain to us. The word ‘Ombudsman’ was perceived as obscure and a barrier to accessing a service and so the establishment of IPCI was intended to raise the number of eligible complaints we receive, whilst reducing the near 50% of complaints that are ineligible.

In terms of holding to our value of transparency, we now publish summaries of all complaints that we uphold on our website, as well as the names and establishments of the fatal incident investigations we are carrying out, as the deaths occur. This year we have also dedicated greater resources to our complaints Assessment Team to improve timeliness and allow for better and more consistent analysis of complaints that should have been dealt with more effectively by the primary service which initially addressed them. As a result of this, we now return complaints back to the service in remit if we feel they should have dealt with it more appropriately in the first place.

Lastly, our learning function is another area that I have significantly strengthened with more resource. This has allowed for more regular, strategic analysis of the masses of data produced by our investigations. Our **2023/24 Business Plan** is now far more ambitious in terms of the volume and quality of our thematic work that is fed back to the services in our remit.[2]

2 Prisons and Probation Ombudsman (2023), Strategic Plan 2023-26 Business Plan 2023/24. Available online at: **https://cloud-platform-e218f50a4812967ba1215eaecede923f.s3.amazonaws.com/uploads/sites/34/2023/11/Strategic-and-Business-Plan-November-2023-FINAL.pdf**

One of the first tasks I set in 2023/24 was to begin work on fully understanding common themes from our property complaints that account for over a quarter of all our complaints work. Ultimately the PPO should not be engaged solely in the practice of upholding or otherwise individual complaints, but also providing the services in our remit with well-evidenced learning on how to deal with prisoner's property more effectively and thus drive down demand. This work is ongoing, and we hope to publish this work in 2024/25.

We also published our second Policy into Practice publication on the use of force and started work on our second Learning Lessons Bulletin on post-release deaths. The aim is that these regular publications will strengthen frontline staff's working practices and make custody a safer and fairer place.

The following pages in this Annual Report provide a great deal of data from our work and data is extremely important. Without it, we are not best placed to provide the best evidence upon which to base our recommendations or drive policy changes. There are also many descriptions of tangible achievements resulting from our work. What is not explicit is the incredible hard work of individuals within the PPO that make all of that possible. Coping with increased demand whilst delivering a series of significant changes to all areas of the PPO's work is challenging on a corporate and individual level. My staff have excelled with the enthusiasm, innovation and professionalism they have brought to their work. I am incredibly grateful to them, and they allow me to look forward to the coming year with both optimism and pride.

"

...data is extremely important. Without it, we are not best placed to provide the best evidence upon which to base our recommendations or drive policy changes.

The year in figures

Complaints

In 2023/24 we received **4,575 complaints**, an increase of 2% compared to last year. Of these:

*Timeliness for these letters are unavailable due to ongoing work with a new case management system, however, a solution has been identified and will be implemented in the 2024/25 business year. Refer to the About the data section for definitions of eligibility, upheld and not upheld cases.

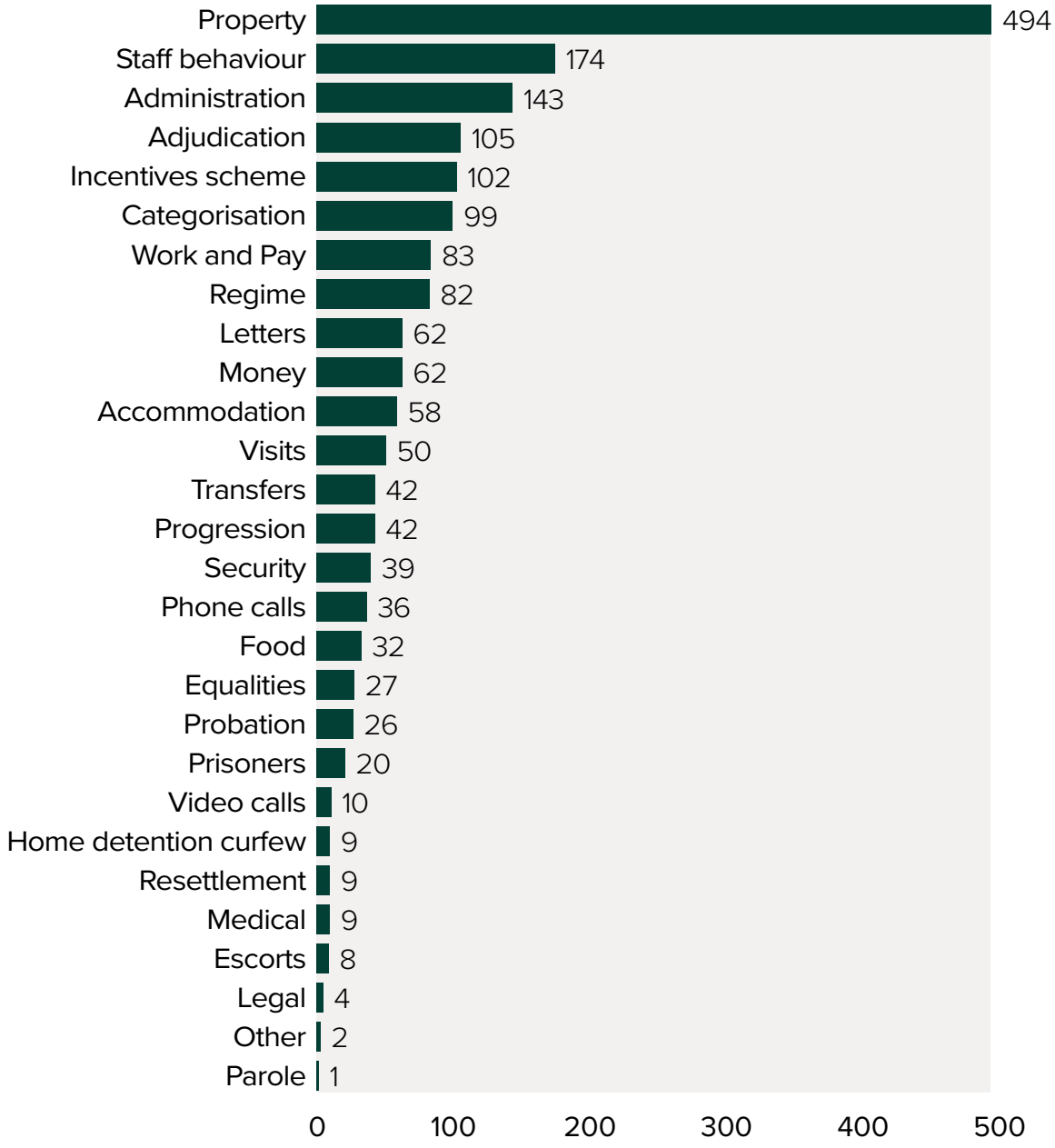
In 2023/24 we completed **1,830 investigations** compared to 2,165 in the previous year, a decrease of 15%. Of these:

†There were 15 suspended cases that have been excluded from this calculation. This is due to complications in how suspensions are recorded.

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.

Of the cases we closed in 2023/24:

Complaints completed in 2023/24 by category



Fatal incidents

In 2023/24, we started investigations into **360 deaths**, an 11% decrease compared to the previous year. We began investigations into:

188 deaths from natural causes, 34 fewer than last year

104 self-inflicted deaths, 13 more than last year

2 apparent homicides, 1 fewer than last year

45 other non-natural deaths, 42 fewer than last year

However, it is important to note that at the time of writing, there are 21 deaths awaiting classification (which tend to be classified as other non-natural)

Of the **360 deaths** in 2023/24, the locations of investigations started consisted of:

292 deaths in prisons, 28 fewer than last year
This included the death of a baby after their birth

53 post-release deaths, 14 fewer than last year

10 deaths of residents living in probation approved premises, 3 fewer than last year

1 death of a resident of the immigration removal estate, 1 fewer than last year

4 discretionary cases:

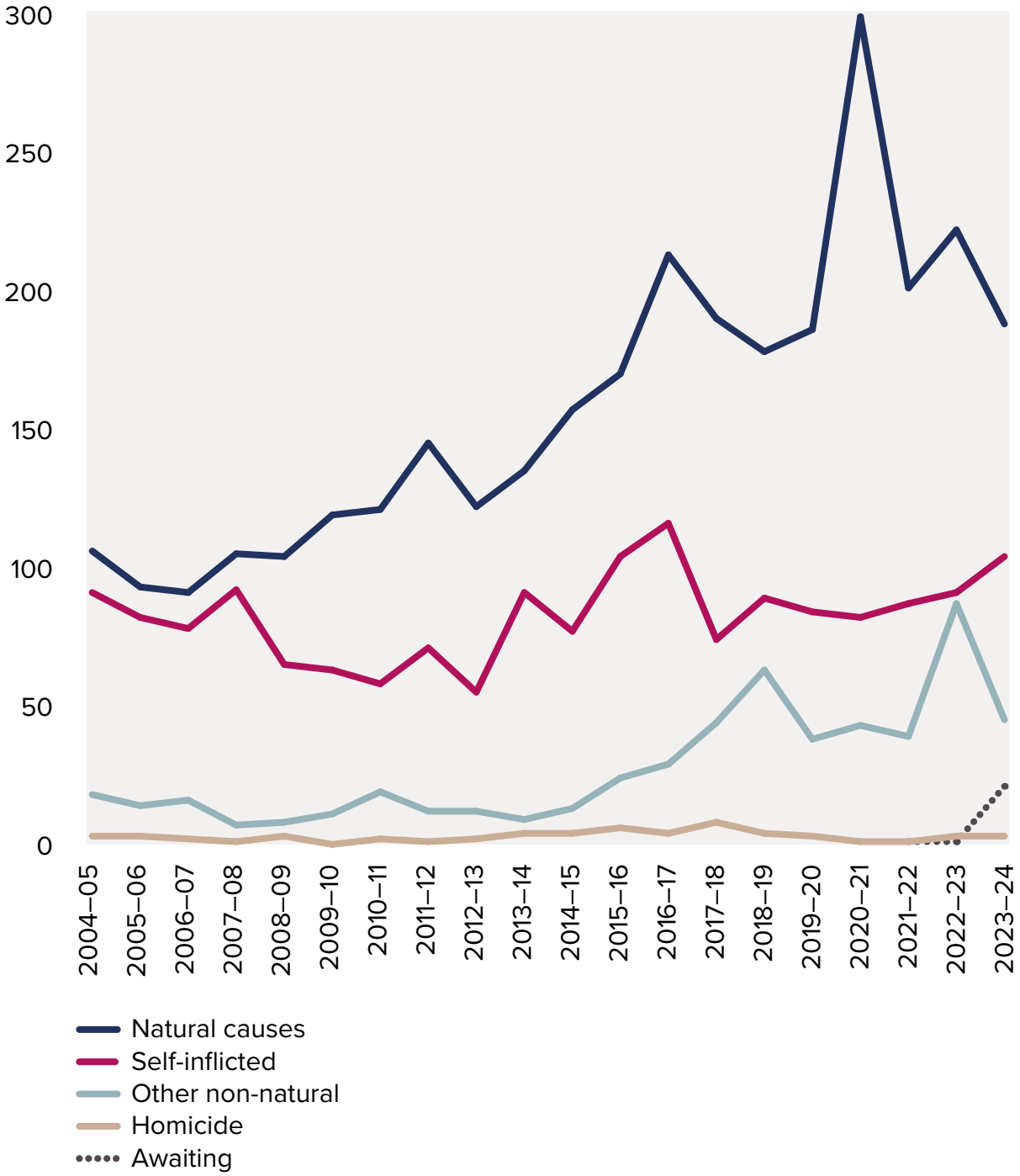
- The death of an individual that occurred in a court cell
- The death of an individual who suffered a seizure while in a vehicle being transported from Thames Magistrates' Court to HMP Thameside
- The deaths of individuals in the Isle of Man prison which is outside of our remit

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

This year we issued **441 initial** and **433 final reports** compared to 318 initial and 315 final reports last year.

In 2023/24:

Fatal incidents investigated



Investigating complaints

By Miriam Minty
Deputy Ombudsman, Complaints Director, Independent Prisoner Complaint Investigations

Independent Prisoner Complaint Investigations

The development of Independent Prisoner Complaint Investigations (IPCI) was a significant focus for complaints this year. We were concerned about how effectively we were reaching those who might need our service, and the high number of ineligible complaints we received. In 2022/23, one in every two complaints we received was ineligible for investigation. The majority of these (72%) were because the right processes were not being followed.

We also recognised the word 'Ombudsman' wasn't commonly used, and the name may have caused some confusion about whether we were part of the prison and probation service.

Therefore, in early Autumn of 2023, following early engagement with prisoners on awareness of the PPO and barriers to our use, we developed **Independent Prisoner Complaint Investigations (IPCI)** as the new name for our complaint investigations work for prisoners and those in the youth custodial estate.

IPCI materials:

We developed new IPCI materials to promote our new name and be clearer about the process of escalating a complaint to us. This included an **IPCI form** to help prisoners summarise why they are unhappy with the prison's response and to remind them to go through the prison's complaints process first. We also created a new **IPCI information card** to be given to new prisoners which can be kept and used later, if needed.

IPCI launch:

IPCI was launched in November 2023. To support the launch, we placed articles and adverts in prison newspapers, and we launched a campaign on National Prison Radio to share information about the changes with prisoners.

My team also carried out visits to all prisons in England and Wales to talk to prisoners and staff about IPCI to support the launch.

At the time of writing, the new name appears to be well received by prisoners who told us being clear about our independence was really important in raising their confidence in contacting us. They said a simpler and clearer name helps them better understand what we do and how we can help.

> "
>
> It's good, does what it says.
>
> **Prisoner at Bullingdon**

What difference has IPCI made?

It is still early days, however since the launch of IPCI and our subsequent visits we have seen an increase in the use of our complaints services.

In the three months after November 2023, we saw a 10% increase in the number of eligible complaints received and a 24% increase in the number of complaints received overall compared to the three months before.

Understanding the needs of d/Deaf prisoners

In last year's Annual Report, we described our work with women prisoners who complained less. We recognised that access to local complaints processes and our service can be impacted by several factors, including personal, local and systematic ones.

This year, we delivered a programme of engagement with d/Deaf prisoners. Ahead of our direct work with prisoners, we worked with Dr Kelly Corless, Senior Criminology Lecturer at the University of Central Lancashire to agree discussion points and how best to engage.

In summer 2023, we held five focus groups, engaging with 38 prisoners at HMP Whatton. Each session was structured differently to meet language preferences and included sign language and lip reading.

Findings:

It was clear there were additional challenges for d/Deaf prisoners, including:

- **long waiting times to get hearing aids** and difficulty in resolving problems with hearing equipment
- **problematic communication with prison staff.** Difficulty in hearing tannoy relayed information and staff not looking at prisoners when speaking to them
- **staff not appropriately trained on d/Deaf needs**. Few staff knew British Sign Language (BSL)
- **no support groups specifically for d/Deaf prisoners** meant limited information sharing and peer support
- **poorly understood local complaints processes.** Lack of awareness amongst prisoners and lack of promotion by staff

- **lack of confidence in the complaints process.** Fear of ramifications, and concerns about impartiality

Action at HMP Whatton:

Following this work, HMP Whatton agreed to:

- improve access to hearing loops and consideration of separate visiting rooms for d/Deaf prisoners
- use the findings to inform tender processes for hearing equipment and services
- include a deaf prisoner on the Equalities Group as a rep for others
- run awareness sessions for staff

Next steps:

We are committed to:

- ensuring our investigators confirm with prisoners what communication adjustments are needed and considering how d/Deaf prisoners can make us aware if they are struggling to use the local complaints process
- exploring options to have BSL translations of our promotional materials

We shared our findings with the HMPPS Expert Forum and Implementation Group and will share these more widely to promote the importance of d/Deaf awareness and address the challenges faced.

Youth engagement programme

In last year's Annual Report, we described our work with young prisoners under 21, who rarely raised complaints with us. This year, we rolled that work out across the entire youth custodial estate to identify local and estate wide challenges and barriers to young people wishing to raise complaints locally, and with us.

We visited all six youth custodial establishments:

- Oakhill
- Werrington
- Wetherby
- Cookham Wood
- Feltham
- YOI Parc

In each centre, we met with managers, Safeguarding and MMPR (Minimising and Managing Physical Restraint), Conflict Resolution, Education and Activities leads, and the Business Hub.

We discussed the barriers to the complaints process with young people and separately, with staff. We were impressed by the willingness of many staff to go the extra mile in creating a harmonious working environment, and their appreciation and understanding that, for many young people, this was 'home' for the foreseeable future.

Most importantly, we spoke to over 100 young people during these visits. We met them in education and on activities, in cells, on the wings, and individually. At times, staff or Barnardo's independent advocates were present, but we also took every opportunity to speak to young people on their own.

Proactive engagement with YCS:

YCS senior staff were instrumental in facilitating this engagement at a time when staffing resources presented a significant barrier to delivering effective regimes. The Executive Director and his team were committed to working with us, but it was clear that staff in the establishments were

stretched, and our visits did present some logistical difficulties. We would have liked to see more young people.

Collaborating with partners:

We worked closely with Barnardo's, who function as Independent Advocates within the youth estate and have been instrumental in increasing the number of complaints we receive, helping us identify themes in complaints, and how we may overcome barriers in the submission of complaints.

Our findings:

Our findings fell into the following themes:

- **safeguarding** – Staff struggled to reconcile national policy with local complaints
- **MMPR** – The need to separate MMPR issues from safeguarding issues
- **cultural considerations** – Many young people of colour struggled to find culturally appropriate items on facilities lists
- **access to regime** – In some establishments access to regime, particularly activities and education, was sporadic and limited
- **local complaints processes not adhering to national policy** and a lack of trust in them by young people

However, against this challenging backdrop, we identified areas of good practice where teams have worked hard, and creatively, to make improvements. We wanted to share these and explore the opportunity to do more both systematically and locally.

We arranged a youth symposium to share our learning in April 2024. This brought together senior leaders from the youth custodial estate, stakeholders including Barnardo's, the Howard League and HM Inspectorate of Prisons, as well as the Governors and Directors of the 6 establishments.

At the symposium we presented our findings and facilitated discussions on what good practice might look like if implemented more widely to improve regime delivery and ensure better outcomes for young people.

Adopting a healthy challenge on local complaints handling

We have found that where people feel they are treated in a procedurally fair and just way from their first contact, they will view those in authority as more legitimate and will respect them more.[3] They are more likely to cooperate and engage, even when the outcomes of the decisions or processes are not what they had hoped for.

This ethos underpins the work we are doing to make clear our expectation that organisations in our remit take their responsibility seriously to properly consider complaints in the first instance.

We let complainants know that we can normally only look at their complaints when they have completed the relevant organisation's internal complaints procedure first. This provides the important opportunity for organisations to address issues, where possible, earlier in the process to bring about locally agreed resolutions.

3 https://www.justiceinspectorates.gov.uk/hmiprobation/research/the-evidence-base-probation/models-and-principles/procedural-justice/

Unfortunately, during the course of our complaints investigation work, we regularly see cases that should never been escalated to us, and we are addressing this in a number of ways.

Publishing complaint summaries on our website:

In June 2023, we began publishing monthly summaries of complaints we upheld or partially upheld. The aim was to increase transparency of our work, share the recommendations we have made to the services in our remit and to inform learning and drive best practice.

Where we have investigated a complaint that should not have come to us, we say so on our website. We want those with oversight of the appeals process locally to consider, ahead of their final decisions, if everything has been done locally to resolve the matter.

The website summaries we published in 2023/24 were complaints from prisoners. In 2024/25, we will be including summaries of complaints from those under community supervision (probation) and in immigration removal centres (IRCs).

Pushbacks:

This year we restructured our Assessment Team, who receive the first communication from complainants. The team now has the capacity and capability to routinely consider whether cases coming to us have been given proper consideration, and a meaningful response, locally. If not, the complaint is returned to the organisation, accompanied by a letter from the Ombudsman, setting out our concerns and asking for swift remedial action. We let complainants know we are doing this, and should they remain dissatisfied with a subsequent response, we will reassess the complaint.

In 2023/24 we sent at least 45 complaints back to organisations within our remit.[4]

Our IPCI visits to prisons have been a great way to raise issues such as proper consideration of complaints with Governors and Business Hubs, as have our meetings with Prison Group Directors.

In 2024/25, we will be developing a video for staff considering complaints at the first and appeal stages, initially for use in prisons but with a view to developing similar materials for use in IRC's and for probation staff too.

Complaints going forward

In 2024/25, building on the early roll out of IPCI, we will continue our work to improve the accessibility of our complaints investigation work by identifying barriers for complainants and working with our partners to consider how we effectively address these. This will ensure those who need to use us, can do so more.

Towards the end of the 2023/24 business year, we started early work on a programme of deep dives that we will be completing in 2024/25 into awareness and confidence of both local complaints processes within IRCs and probation. This will include awareness and confidence in the service that PPO offers those wishing to escalate complaints for our attention. We look forward to sharing progress on this work with those organisations within our remit, users of the services and wider stakeholders during 2024/25.

4 Due to technical challenges recording this data, we have not included cases that resulted in further investigation here, however we are working on a new system to report on all of these cases in the next financial year.

Complaints recommendations

Our vision behind conducting independent investigations is to ensure making custody and offender supervision safer and fairer. Our investigations provide an opportunity to correct injustices, and help produce recommendations to improve learning within organisations, including sometimes at national level. Our recommendations must be specific, measurable, realistic and time-bound, with tangible outcomes to structure learning and deliver the required changes needed to reduce the likelihood of repeat failings.

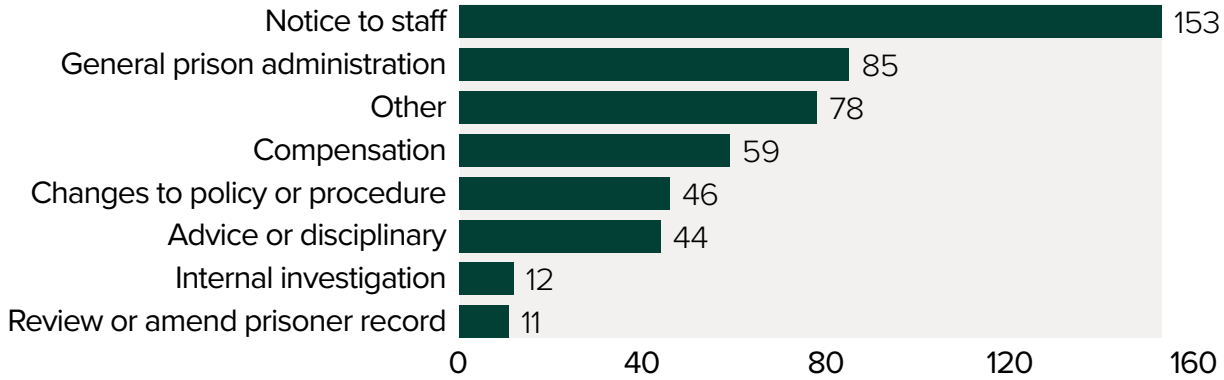
When a recommendation is made after a complaints investigation, the organisation must confirm whether they accept any recommendations and must provide evidence of implementation. In cases where the service in remit does not accept a recommendation, the director general operations at HMPPS must inform the PPO, for public sector prisons. For other services in remit, and for privately managed prisons, a designated senior manager must respond.

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

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 action plans agreed to implement them.

In 2023/24, we made 488 recommendations across 185 cases, with an average of 2.6 recommendations per case. At the time of writing, we are awaiting a response to 109 of these recommendations. The remaining 374 have been accepted. We have received evidence that 71% of these have been implemented.

Complaint recommendations, by action (2023/24)




Easy Read
CCRC Appli
The CCRC can look into
Prisons & Probation Ombudsman
Independent Investigations
How to complain to the Prisons and Probation Ombudsman (PPO)
Have you made a complaint and are you still not happy?
Maybe you need to talk to the Prisons and Probation Ombudsman.
CCRC
Wrongly convicted of a crime?
Lost your appeal?
You can apply for FREE to the CCRC

Investigating fatal incidents

By Susannah Eagle
Deputy Ombudsman,
Fatal Incident Investigations

As Adrian reflected in his foreword, it has been a busy year for the FII team and the wider PPO, welcoming a new Ombudsman. Adrian's vision for the organisation has provided opportunities to think about how we do what we do, what is important and to really focus on how we might best have an impact, drive learning in the services in our remit and ultimately, reduce preventable deaths.

Recommendations

One of the most important changes has been in our approach to making recommendations. The Year in figures section of this Annual Report shows that we have made 718 recommendations this year compared to 881 in 2022/23. But the number of recommendations made is not as important as the nature. We have focused on the systemic and endemic issues our investigations bring to light.

We are holding senior managers, including Governors and Directors, to account for the decisions they make. But we are also trying to ensure that we understand the context and rationale for those decisions, and to reflect steps they have already taken to resolve issues our investigations raise. Sometimes, liaising with senior managers reassures us that appropriate actions have already been taken and that we do not need to make a recommendation. We monitor progress during subsequent investigations. If we identify a systemic or endemic issue, we work with senior leaders to devise recommendations most likely to lead to sustained change.

The focus on systemic and endemic issues has led to a number of recommendations requiring national policy changes. These recommendations best demonstrate the impact of our work. Making national recommendations requires us to work collaboratively with colleagues in relevant policy teams to ensure that the recommendations are realistic and achievable, and it reduces the risk that our recommendation is rejected (something that is fortunately very rare).

During the reporting year, our national recommendations included:

- reviewing the policy for prisoners for whom English is not their first language to ensure that interpreting services are used consistently when needed
- recognising that asking to see a Listener (a prisoner trained by the Samaritans to offer peer support) can be an indication of raised risk of suicide and self-harm
- ensuring that prison transfers properly consider the individual needs of the prisoner

- ensuring that staff training and guidance equips staff to enter cells in an emergency to preserve life
- ensuring that prisoners who attend video link court appearances are subject to the same welfare checks as prisoners who attend court in person
- amending the policy on cell clearance to make specific reference to medication
- ensuring that staff understand what to do if the results of an X-ray body scan are inconclusive
- updating the policy to provide guidance on family liaison where there are contact restrictions in place
- amending the policy so that appearances at family court are recognised as a potential trigger for suicide and self-harm

Sometimes a national PPO recommendation can shine a light on a particular issue, often one that HMPPS is already grappling with. We know that when we make a recommendation, it can help to bring partners together to work more effectively, or to raise the profile of an issue.

One report issued this reporting year concerned an elderly prisoner with complex care needs. We recognised the considerable difficulties in providing appropriate care to a prisoner with multiple mental and physical health problems in a prison setting (and that this was unlikely to be an isolated case given the percentage of older prisoners in the prison population). Working with policy partners, we recommended that HMPPS work with the Department for Health and Social Care, NHS England and others involved in social care to develop a pathway for prisoners who have been assessed as needing residential social care.

“

We know that when we make a recommendation, it can help to bring partners together to work more effectively, or to raise the profile of an issue.

Sometimes our investigations identify issues that do not meet the threshold for a recommendation. We use a ‘to note’ system to flag these issues to the senior manager (normally the Governor/Director or Head of Healthcare) and expect them to consider the most appropriate way to respond. If we find that an issue we noted in one investigation is repeated in a subsequent investigation we can, of course, escalate it to a recommendation.

Good practice

We routinely acknowledge good practice where we identify it in the course of an investigation. We think it is as important that the services in remit learn from what is working well.

Our good practice findings this year included a regional approved premises area that had introduced an early learning investigation after a death, a social group for older prisoners and the benefit of patient liaison staff, as well as praising individual staff for commendable work.

Collaboration

Making recommendations is not the only way in which we can drive change and have impact. This year, multiple investigations raised questions about how prison staff

could best transfer key information to 999 operators in medical emergencies, and how to ensure that once an ambulance arrived, paramedics were not unduly delayed in reaching the patient.

In February 2024 we brought together key representatives from HMPPS, NHS England and the ambulance service at an in-person round table event, hosted at the PPO's office. The pragmatism, collaboration and open-mindedness of those who attended was incredibly rewarding and several actions for joint working were agreed. Of course, this work needs to deliver tangible change, and while we agreed to pause further recommendations on these issues for the time being, we have been clear that we will be keeping up the pressure.

The inappropriate use of restraints on elderly, poorly, immobile prisoners has long been a cause of concern and frustration for the PPO. We understand the tension between security and humanity. Our investigations often highlight good practice at prisons who make defensible, proportionate decisions about the use of restraints. But a number of our investigations highlight poor practice. Working with policy colleagues who had already begun work to address this, we devised a recommendation allowing senior HMPPS staff to robustly monitor and account for the use of restraints across prisons in England and Wales. That recommendation led to HMPPS colleagues undertaking a more in-depth analysis of the issue. Their work confirmed the same problems that our investigations so often highlight. As a result, the policy group has committed to redesigning the escort risk assessment to ensure a consistent approach, and devising ways to ensure that staff understand their responsibilities. This work, which we fully support and endorse, will continue into 2024/25.

> "We routinely acknowledge good practice where we identify it in the course of an investigation. We think it is as important that the services in remit learn from what is working well.

Resources

As a demand-led function, the allocation of resources within the team is always a key consideration. This year, we have piloted a new approach to reporting some natural causes deaths.

In natural causes investigations, the focus is to establish whether the clinical care the prisoner received was equivalent to what they could have expected to receive in the community. Clinical reviewers commissioned by NHS England and Healthcare Inspectorate Wales produce a report that sits alongside the PPO's fatal incidents report. In natural causes investigations, the role of the PPO investigator is to consider a range of non-clinical issues – including whether early release on compassionate grounds was appropriately considered and pursued, whether family liaison was timely and appropriate, or whether restraints were used when they should not have been. Where we are satisfied that there are no non-clinical issues of concern to report in 2023/24, at the time of writing we are trialling producing a very short report and leaving the clinical review to address equivalence of care. This approach has not changed how we investigate the prisoner's death, only the way in which we report it.

> The inappropriate use of restraints on elderly, poorly, immobile prisoners has long been a cause of concern and frustration for the PPO. We understand the tension between security and humanity.

We have been monitoring feedback during the pilot and will consider any disadvantages of the approach against the benefits. Early indications are that the timeliness of reports on natural cause deaths has shown a steady improvement since the pilot began in October 2023. The PPO's vision is to deliver high quality and timely investigations, and we must continue to ensure that we allocate our resources according to risk and impact.

Our relationship with clinical reviewers and NHS England colleagues is key to delivering our vision in FII. In 2023/24, we began work with NHS England to review and refresh the guidance documents for commissioners and clinical reviewers. The work will culminate in joint training for PPO fatal incident investigation staff and NHS England commissioners.

In 2023/24, we have continued to drive our work on post-release death investigations. We have been conducting these investigations since September 2021, and published our first evaluation of the work at the beginning of 2023. Also in this reporting year, we began work on our second research project, using the data gathered from all our completed post-release death investigations. We have delivered updated training to all investigators responsible for carrying out post-release investigations and our growing expertise has helped us to identify key themes among this very vulnerable group of people, and to develop stronger links with partners involved in this area of work.

We have identified our priorities for fatal incident investigations in 2024/25, which will be set out in the Business and Strategic Plans, and I anticipate it being another busy year, challenging ourselves to deliver real impact from our investigations.

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 2023/24 we issued 433 final investigation reports following deaths in custody and made recommendations in 230 of these cases.

We made 718 recommendations, with an average of 3.1 per case.

At the time of writing, most of our recommendations had been accepted (578) and we were awaiting the service response to 138 recommendations. One of our recommendations was rejected by HMPPS. One of our recommendations was partially accepted because the Home Office disagreed with the clinical reviewer's conclusion regarding actions following abnormal test results.

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
- those with terminal diagnoses should have individualised palliative care plans
- 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

General administration

Recommendations about general administration include the following guidelines:

- ensuring retainment of documents and providing them to the PPO in cases of a death in custody
- ensuring provision and good working condition of CCTV
- adhering to guidelines regarding segregation, including ensuring that a designated officer is allocated to each prisoner
- addressing staffing shortages
- adhering to and amending policy frameworks when necessary
- conducting roll checks at prescribed times, and recording the time of roll check in the daily diary

Emergency response

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

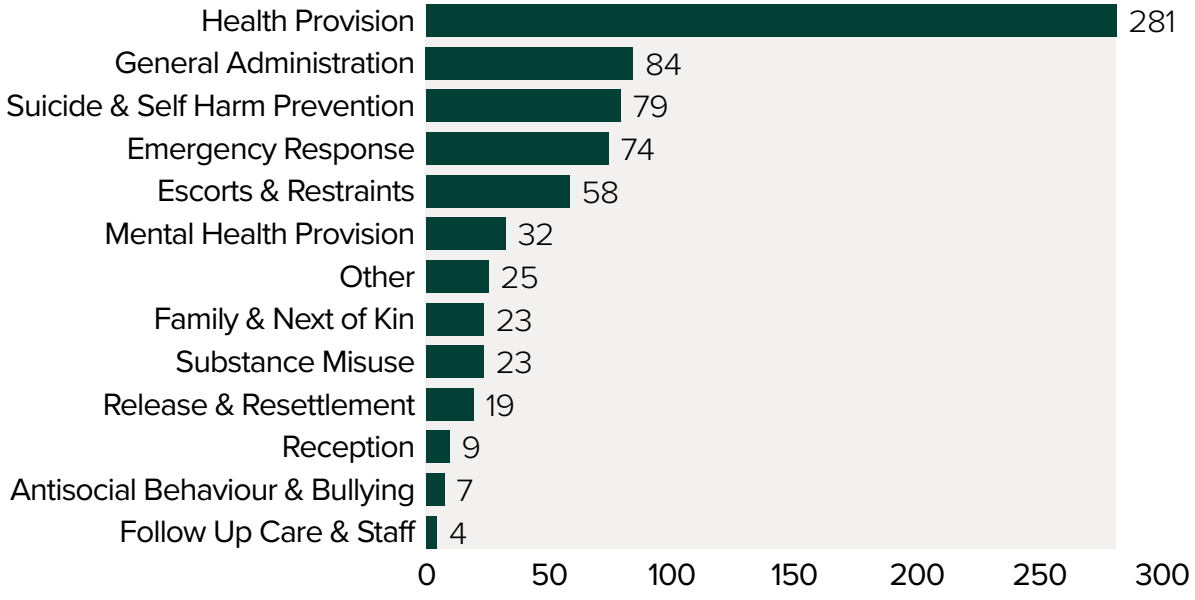
- radioing the correct emergency code immediately
- ensuring the control room calls an ambulance immediately, including communicating all relevant information to the paramedics
- carrying and having access to the correct equipment, including emergency bags and radios
- entering cells without delay and 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, healthcare and probation staff

Recommendations following death, by category (2023/24):



Special investigations

By Adrian Usher
Ombudsman

One of the important capabilities that the PPO possesses is the expertise to be able to deliver special investigations. There are times when government departments want a review of something that has occurred within services in our remit or an investigation that could not or should not be carried out by other investigative agencies such as the police.

Historically, this is a function that has been performed sporadically but I am keen to make more departments across government aware of our ability to carry out special investigations in this area. The PPO employs skilled and experienced investigators who understand the policies and practices of the services in our remit. Crucially, they are also able to penetrate and understand the various cultures that permeate the many establishments within which they conduct their investigations.

> “
>
> One of the important capabilities that the PPO possesses is the expertise to be able to deliver special investigations.

The thousands of investigations carried out by the PPO every year are concerned with everything from lost property to self-inflicted deaths and homicide. The aptitude gained by individual investigators and the office as a whole place us in a unique position in being able to provide independent investigations into all manner of issues that would normally fall beyond our remit. My office stands ready to provide such investigations in a timely, efficient fashion.

In 2023/24, the PPO began two special investigations:

Yarl’s Wood

On the evening of the 28 April 2023, concerted indiscipline broke out at Yarl’s Wood immigration detention centre and in the hours that followed, 13 detainees escaped. All were subsequently recaptured.

The Home Office commissioned the PPO to conduct a special investigation into the events of that night and to identify any underlying root causes. The investigation began in June 2023 and was completed by the end of August 2023. In September 2023, the Home Office accepted all 13 recommendations made by the Ombudsman.

Medomsley Detention Centre

Medomsley Detention Centre was in operation between 1961 and 1987. Its primary function was to deliver training to male young offenders aged between 17 and 21 serving short sentences for relatively minor offences. Sexual and physical abuse was widespread and was predominantly carried out by the staff who worked there. Three separate police investigations have been carried out and over 2000 victims have been identified. Criminal convictions were secured against several former staff members who served prison sentences. However, many of the victims have always thought that the focus of those criminal investigations was too narrow and did not uncover the full extent of what had occurred at Medomsley or why it was not stopped.

In October 2023, the Lord Chancellor and Secretary of State for Justice commissioned the PPO to report on how such serious abuse had taken place for over a quarter of a century and what opportunities were missed to prevent it. This is a very significant undertaking for the PPO, and at the time of writing, it is currently estimated that it will take around 18 months to complete.

Given that the PPO has completed a special investigation in 2023/24, provided useful learning for the Home Office in a prompt manner, and has been entrusted with a very significant investigation into historic sexual and physical abuse, this should give confidence to the public and to HM Government that we are exclusively positioned and equipped to deliver further special investigations when called upon.

> “
>
> The aptitude gained by individual investigators and the office as a whole place us in a unique position in being able to provide independent investigations into all manner of issues that would normally fall beyond our remit.

Operational learning and impact

By Kimberley Bingham
Deputy Ombudsman,
Learning, Analysis and Business Services

This has been an exciting year for the Learning, Analysis and Business Services function. Adrian has brought new ideas to the PPO and my function has been at the forefront of driving them.

Adrian put a renewed emphasis on learning this year and we have found new ways of looking at our cases to find the common themes and important aspects that need to be shared with frontline staff.

This year we started work on a project to understand more about property handling in prisons. We will be publishing findings and sharing learning with prisons later in 2024/25. We also started the second analysis of our post-release death investigations, using data from cases completed since September 2021. Findings and learning will be published later in 2024/25.

Publishing thematic learning from PPO investigations

Use of Force:

We published our second Policy into Practice publication [5] in February 2024. It focused on HMPPS' Use of Force Policy Framework that was issued in November 2023. We looked at aspects of the policy that come up in complaints to us about use of force and used case studies to explain how the policy can be applied in practice.

The publication included:

- the importance of trying to de-escalate situations, and how body worn video cameras (BWVC) can act as a de-escalation tactic when an officer is faced with confrontation or conflict
- highlighting how BWVC footage can provide evidence of actions taken leading up to and during a use of force incident
- the importance of healthcare's role following a use of force incident

Self-inflicted deaths of IPP prisoners:

In 2022 there was an increase in self-inflicted deaths of prisoners serving Imprisonment for Public Protection (IPP) sentences. The PPO continued to see self-inflicted deaths of IPP prisoners in 2023. We investigated 13 deaths in 2022/23 and 4 deaths in 2023/24. As a result, we analysed PPO fatal incident investigations to produce learning to help HMPPS identify and address the risk factors associated with IPP sentences.

5 Prisons and Probation Ombudsman (2024), Policy into Practice Use of Force policy framework. Available online at: **https://cloud-platform-e218f50a4812967ba1215eaecede923f.s3.amazonaws.com/uploads/sites/34/2024/02/PIP-Use-of-Force-February-2024.FINAL_.pdf**

> “
>
> ...we have found new ways of looking at our cases to find the common themes and important aspects that need to be shared with frontline staff.

In September 2023, the PPO published a **Learning Lessons Bulletin on the self-inflicted deaths of IPP prisoners**.[6] We concluded that an IPP sentence could be considered a potential risk factor for suicide and self-harm. The bulletin highlighted potential triggers such as parole hearings, recall, prison transfers and re-categorisation. It also summarised learning in relation to sentence progression and the provision of the key worker scheme.

We were pleased that HMPPS responded positively to the learning in the bulletin which was widely shared and well received externally.

Providing expertise to stakeholders: information sharing between healthcare and prisons

As well as publishing learning from our investigations, the PPO shares learning with stakeholders through our membership of advisory panels and groups. Through membership of one of these groups, the PPO's research and operational learning teams were able regularly to update HMPPS and NHS England on findings relating to information sharing between healthcare and prison staff.

Highlights included:

- prison and healthcare staff responsible for receiving prisoners into prison do not always have access to all the records needed to fully assess the prisoner's risk of suicide and self-harm
- there have been occasions when the handover from a previous prison has impacted on the receiving prison's ability to make fully informed decisions about an individual's needs and risks
- a single comprehensive record of a prisoner's clinical history is important and good information sharing between prison staff and healthcare staff will help to keep this single record updated and accurate

Providing evidence to parliamentary committees: prison population and estate capacity

In September 2023, the Justice Select Committee (JSC) launched a new inquiry into the future prison population and estate capacity. The call for evidence included looking at the current strategy for safely and effectively managing the prison population and the implications of the rise in the prison population for the resources required to manage prisons safely and effectively. The JSC also wanted to know about the impact of an ageing prison infrastructure.

6 Prisons and Probation Ombudsman (2023), Learning Lessons Bulletin Self-inflicted deaths of IPP prisoners. Available online at: **https://s3-eu-west-2.amazonaws.com/cloud-platform-e218f50a4812967ba1215eaecede923f/uploads/sites/34/2023/09/14.322_PPO_LL_Bulletin_Issue18_FINAL.pdf**

We used findings from PPO investigations to inform our evidence to the JSC. We highlighted that an increasing prison population combined with staff shortages means that prisons have to run reduced regimes, and important work such as key worker sessions are not being delivered as intended. We emphasised how meaningful contact between staff and prisoners can 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. Our investigations have shown that some prisons have to prioritise the prisoners they assess as vulnerable, but the criteria used to do this can be unclear.

We said that prison capacity pressures are having an impact on prison transfers, and this can impact a prisoner's ability to maintain family contact, complete offending behaviour programmes and prepare for release. We also highlighted the issues that arise in complaints about poor prison infrastructure that at times was unsuitable.

I look forward to strengthening our learning focus in 2024/25 and continuing to shine the spotlight on the important issues that emerge from our cases.

Appendices

Stakeholder feedback – emerging findings

We collect feedback from our stakeholders to understand how they engage with our work, their level of satisfaction and to seek suggestions on how we can improve.

To obtain the feedback, the PPO runs four rolling stakeholder surveys:

- the general stakeholder survey (for those we engage with)
- the fatal incidents post-investigations survey (for those involved in deaths in custody and post-release death investigations)
- the bereaved families' survey (for the next of kin of deceased prisoners)
- the complainants' survey (for those who complain to us)

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 86 responses in 2023/24, compared to 80 responses in 2022/23.[7] The survey ran throughout March 2024 and responses came from prisons (including operational staff, non-operational staff, business staff and other services such as chaplaincy), probation, healthcare services, MOJ, HMPPS and others such as academics and third sector.

Overall satisfaction

- 71 of the 77 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 46 respondents who had read PPO reports (complaints, fatal incidents, or both), 37 found these reports to be quite or very clear.
- 47 out of the 86 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, 61 out of the 86 respondents who answered the question found the Learning Lessons Bulletin on self-inflicted deaths of IPP prisoners very useful or quite useful.
- 47 out of the 86 respondents who answered the question found the Policy into Practice publication on use of force very useful or quite useful.

Our website

- 67 of the 86 respondents who answered the question said they had visited the PPO website in the last 12 months.
- 66 of the 67 respondents who answered the question said they found it quite or

7 We include partial survey responses only where sufficient information has been provided, (please see the About the data section for more detail). This is also the case for the post-investigation surveys.

very easy to find what they were looking for on the website.

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 208 responses (from 607 surveys sent) in 2023/24. This is a 16% increase from last year, when we received 178 responses (from 604 surveys sent). We received responses from liaison officers, establishment heads, healthcare leads and coroners.

Overall satisfaction

- 88% of respondents (of the 208 who answered the question) rated the quality of the investigation as satisfactory or better.
- 87% of respondents (of the 208 who answered the question) rated the quality of the communication with the PPO as satisfactory or better.
- 75% of respondents (of the 208 who answered the question) rated the time it took the PPO to complete their investigation as satisfactory or better.

Reports and recommendations

- 95% of respondents (of the 191 who answered the question) stated the report we issued met their expectations.
- 91% of respondents (of the 187 who answered the question) stated that the PPO report contained about the right amount of detail.
- 88% respondents (of the 147 who received recommendations and answered the question) said they found the recommendations made by the PPO quite or very worthwhile.

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 25 responses (from 179 surveys sent) during this data collection period, compared with 26 responses (from 211 surveys sent) in 2022/23. This includes substantial partial responses.

Overall satisfaction

- 12 out of 25 respondents who answered the question felt that the overall quality of the PPO's investigations was very good or good, and 6 deemed it poor or very poor.
- 14 out of 25 respondents who answered the question felt satisfied or very satisfied with the PPO's communication, and 7 felt dissatisfied or very dissatisfied.

Reports

- 15 out of 22 respondents who answered the question felt the initial (draft) report met their expectations.
- Of the 21 respondents who answered the question, 17 thought there was about the right amount of detail, with 3 respondents thinking there was not enough.

Complainants' survey

We send surveys to a sample of those whose complaints we have investigated in the past year – both upheld and not upheld complaints. 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 889 surveys sent) in 2023/24, in comparison with 348 (from 957 surveys sent) in 2022/23:

- 121 responses came from those whose complaints were ineligible. These complaints were not investigated, and the complainants received letters explaining why
- 227 respondents had eligible complaints. 100 had their complaints upheld or partially upheld and 127 had their complaints not upheld[8]

Complaint handling

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

- 47% of respondents whose complaints were upheld (of the 95 who answered the question) said they were able to get free photocopies of their complaint form.
  - 46% of respondents said they could not, and 6% said they did not know.
- 43% of respondents whose complaints were not upheld (of the 125 who answered the question) said they were able to get free photocopies of their complaint form.
- 31% of respondents whose complaints were ineligible (of the 119 who answered the question) said they were able to get free photocopies of their complaint form.

Quality of investigation and service

- 80% of respondents (of the 96 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, 25% of respondents (of the 122 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 114 who answered the question, 39% of respondents rated the service they received as either satisfactory or better.

Reports and letters

- 93% of respondents whose complaints were upheld (of the 97 who answered the question) said they understood the report or letter they received. 2% of respondents stated they had not received a report or letter.
- 87% of respondents whose complaints we did not uphold (of the 126 who answered the question) said they understood the report or letter they received. 6% of respondents stated they had not received a report or letter.

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

- 52% of respondents whose complaints were ineligible (of the 116 who answered the question) said that our letter explaining why their complaint wasn't eligible was clear. 28% of respondents stated they had not received this letter.

Outcome

- 74% of respondents whose complaints were upheld (of the 95 that answered the question) stated that the PPO helped them with their complaint.
- In contrast, 16% of respondents whose complaints we did not uphold (of the 122 that answered the question) stated that the PPO helped them with their complaint.
- In addition, 56% of respondents whose complaints were upheld (of the 97 that 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, 18% (of the 126 that 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, 33% respondents stated they had (of the 100 that answered the question). Respondents were asked what they were planning to do with their ineligible complaint. Of the 121 that answered the question, 28% said they would send it to a different body. 13% stated they would send it back to the Ombudsman and 25% stated they would do nothing further.

About the data

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

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

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

Complaints

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

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

A complaint is upheld if, after investigation, we find in favour of the complainant – i.e. we find the service in remit has acted contrary to their local and/or national policy, or otherwise inappropriately or unreasonably. Upheld cases comprise of cases which are upheld and partially upheld. A complaint is 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 2022/23 was frozen in May 2023, and data for 2023/24 was frozen in May 2024. Data for each section was frozen on different days, so represents different cohorts of cases.

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

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

The number of eligibility letters sent in 2022/23 and 2023/24 refers to letters of eligibility that the PPO sent to complainants in both eligible and ineligible cases. In some cases, the PPO sent multiple eligibility letters about the same case. This happens when a case does not initially meet the eligibility criteria but is later deemed to be eligible when we receive further information. This includes the number of eligibility letters prepared and not sent. This only happens in a small number of cases when we receive a complaint, and we are unable to send the eligibility letter – for example if we do not have access to the complainant's release address.

A completed case in 2022/23 and 2023/24 is defined as one where the draft outcome has been approved. This excludes withdrawn 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 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 2024 population bulletin published on GOV.UK: **https://www.gov.uk/government/publications/prison-population-figures-2024**

Fatal Incidents 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, but these categories may differ from a coroner's conclusions. Classifications may change during an investigation. However, they are not altered following the conclusion of the inquest. A small number of classifications for previous years have been updated for this publication, so may not match what has previously been published.

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

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

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

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

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

COVID-19 related fatal incident investigation: A death 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 have a COVID-19 element. If information provided later shows the death does not fit our definition, it will be re-categorised. It is important to note, death certificates are not always consistently filled in.

Fatal incident data was frozen in May 2024.

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

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

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

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

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

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

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

Post-release deaths: On 6 September 2021, the PPO started 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 investigated. The PPO may exercise its discretion to investigate deaths of individuals who die beyond the 14-day threshold, such investigations will still be categorised as post-release cases. However, we refer to our investigations of deaths, where an individual is released directly to hospital or where an individual was released into the community but died before 6 September 2021, as a discretionary case rather than a post-release case.

Surveys

Throughout the surveys, some respondents did not answer all the questions, and depending on certain question responses, some respondents were not asked all questions. This year, we included partial survey responses, only where sufficient information had been provided – where respondents had completed a minimum of five questions. In the previous years, we included all partial survey responses in the data.

General stakeholder survey (GSS):

The GSS is an online survey that was promoted on X (formerly Twitter), LinkedIn, 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 2024, with a reminder email being sent two weeks later. The survey was then closed at the end of March 2024.

Bereaved families' survey:

The survey is sent monthly to family members/next of kin who have been sent a final report three months previously. Survey results presented in this Annual Report are reflective of cases where a final report was issued in December 2022 to November 2023.

Complainants' survey:

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

- a sample of eligible cases

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

We send our surveys 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 are reflective of cases closed between February 2023 and January 2024.

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

Post-investigation survey:

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

The results presented include cases which had their reports issued between March 2023 and February 2024. It is also sent to Coroners at the end of the financial year (March 2024) who have been involved in fatal incident investigations that had a fatal incident final report issued in 2023/24, with 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 2024.

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

Accepted recommendations include partially accepted recommendations.

Fatal incidents recommendations

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

The data provided was frozen in May 2024.

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

Performance against 2023/24 business plan

Objective one: Be visible, accessible and transparent to service users and stakeholders

Key deliverable	Measure of success	End of year update
Rebrand the PPO's complaints service across prisons and the youth estate to increase awareness and understanding of the PPO's role.	New branding for prisoner and young offender complaints investigations agreed. Rebrand communicated to the prison and youth estate using different communication avenues.	The Independent Prisoner Complaint Investigations (IPCI) has been launched across all prisons and the youth estate, with new IPCI posters and leaflets supplied to all establishments. Work is ongoing to produce the new IPCI material (posters and leaflets) for the youth estate.
Carry out a programme of visits to immigration removal centres (IRCs) and run workshops with detained individuals to raise awareness of the PPO complaints process and understand any barriers.	Increased number of contacts from those in IRCs. Identified and implemented any learning for the PPO to improve accessibility.	At the time of writing the PPO were in the process of planning visits to IRCs to raise awareness of the PPO complaints process.

Key deliverable	Measure of success	End of year update
Carry out a programme of engagement with probation services and those under probation supervision to raise awareness of the PPO complaints process and understand any barriers.	Increased number of contacts from those under probation supervision. Improvements made to remove any barriers. Identified and implemented any learning for the PPO to improve accessibility.	The PPO are in the process of planning their engagement with those under probation supervision.
Continue to raise awareness of the PPO to young people and women in prison.	At least one visit and prisoner engagement forum delivered in every women's prison, and in all of the youth estate. Increased number of contacts from young people and women in prison. Identified and implemented any learning for the PPO to improve accessibility.	Visits and engagement forums have taken place across the youth estate and in every women's prison. The visits took place between May and November 2022 and the follow-up work took place throughout 2023. At the time of starting the work, complaints received from those in the women's estate was very low, at 1.7% (of all prisoner complaints). This increased to 3.2% in 2022/23. During 2023/24, the use of our services by those in the women's estate decreased slightly to 2.9% of all prisoner complaints, but this is still notably higher than before the engagement work took place.

Key deliverable	Measure of success	End of year update
Implement a proactive and targeted communications strategy to increase awareness of the PPO to prisoners, those under probation supervision and detained individuals.	Developed and implemented a communications strategy.	A proactive and targeted communications strategy was implemented to create and launch IPCI in prisons and raise awareness of IPCI to prisoners and young people in custody. This included new IPCI promotional material, such as posters and leaflets.
Publish a Race Action Plan with a renewed focus on service users.	Demonstrable understanding of how PPO services are affecting black and minority ethnic service users.	A revised Race Action Plan will be published in 2024/25 with a focus on service users, including how to develop and embed a robust approach to investigating issues relating to diversity and inclusion.
Develop and embed a robust and consistent approach to investigating issues relating to diversity and inclusion.	Development of a consistent investigation methodology to identify discriminatory behaviour. Evidence from investigation reports demonstrating this aspect has been included in the investigation, where relevant.	Work is taking place to review the PPO's approach to investigating issues relating to diversity and inclusion and learn from partner organisations.
Hold workshops with d/Deaf prisoners to understand any barriers to accessing the prison complaints process or the PPO.	Identified and shared learning for prisons from the workshops. Identified and implemented any learning for the PPO to improve accessibility.	The PPO carried out workshops with d/Deaf prisoners and the findings have been shared with HMPPS.

Key deliverable	Measure of success	End of year update
Include names and inquest dates on the website when publishing fatal incident investigation reports.	Website updated to include names and inquest dates.	The PPO's website has been updated to include names and inquest dates when publishing fatal incident reports.
Publish summaries and outcomes of upheld and partially upheld complaints.	Upheld and partially upheld complaint investigation summaries published on the website at regular intervals.	Upheld and partially upheld complaint investigation summaries are published on the PPO's website every two months.
Respond to all Freedom of Information and Subject Access Requests within the prescribed timescales.	Success will be measured against a target of 100% of FOI and Subject Access Requests being completed on time.	During 2023/24, the PPO received 80 Freedom of Information requests and responded to them all within the prescribed timeframe. We received 151 Subject Access Requests and responded to 144 within the prescribed timescales.
Launch a new PPO website, providing accessible and transparent information.	Project to create a new website launched and progress made with development. Content of current website reviewed.	Work on developing the new website (including content and design) has started. User research and user testing is ongoing to ensure the website meets the needs of all users.
Publish information and guidance about how the PPO carry out investigations.	Publish the PPO's investigation methodology for complaints and fatal incident investigations.	The work being done to develop operational manuals for investigations will be used to inform the methodology.

Objective two: We will deliver investigative excellence in a timely manner.

Key deliverable	Measure of success	End of year update
Meet the timeliness targets for all **complaints investigations**: **Eligibility:** We will determine the eligibility of all complaints within 10 working days of receipt. **Standard complaints:** Complete our investigation and submit the initial report within 12 weeks (60 working days) of accepting the complaint as eligible. **Complex complaints**: Complete our investigation and submit initial report within 26 weeks (130 working days) of accepting the complaint as eligible.	Targets will have been met if at least 90% of complaints assessments are completed on time. Targets will have been met if at least 90% of standard and complex complaints investigations are completed on time	The PPO completed 1,805 standard complaints investigations, of which 55% were completed on time. The PPO also completed 10 complex cases, of which 40% were completed on time. [There were 15 suspended cases that have been excluded from these calculations]. This year 4,565 new cases were assessed for eligibility. Reporting issues mean our case management system is unable to calculate the timeliness of assessments. A solution has been identified and will be implemented in the 2024/25 business year.

Key deliverable	Measure of success	End of year update
Meet the timeliness targets for all **fatal incident investigations**: **Initial reports:** Natural cause deaths: Complete investigation and issue initial report within 20 weeks (100 working days) of the PPO being notified of the death. All other fatal incident cases: Complete investigation and issue initial report within 26 weeks (130 working days) of the PPO being notified of the death. **Final reports:** Finalise all investigation reports within 12 weeks (60 working days) of the initial report. **Publication:** Produce and publish anonymised reports for fatal incident investigations within 10 working days of being notified that the inquest has concluded and the investigation report has been finalised.	Targets will have been met if at least 90% of fatal incident reports are delivered to time and there is no longer a backlog of fatal incident investigations awaiting initial report. Targets will have been met if at least 90% of anonymised fatal incident reports are published on the website on time.	The PPO issued 441 initial reports, of which 40% were on time. The PPO also issued 433 final reports, of which 68% were on time. Between 5 June 2023 and 31 March 2024 there were 437 cases where the PPO had received the inquest results. In approximately 65% of these cases the anonymised investigation report was then published on the website within 10 working days.

Key deliverable	Measure of success	End of year update
Continue to review the investigation approaches and report templates for all types of fatal incident investigations to ensure they are proportionate and we are delivering investigative excellence.	Investigation methodology agreed and report templates reviewed.	The PPO reviewed the investigation approach and report template for foreseeable natural cause deaths. In October 2023, the PPO started a six-month pilot of a streamlined approach to reporting on some natural cause deaths. At the time of writing, a review of the pilot was taking place. Work will continue to review the approaches and report templates for other types of fatal incident investigations.
Develop operational manuals for fatal incident and complaint investigations to provide more accessible and up-to-date guidance to support our staff in carrying out their work.	Production of operational manuals for fatal incident and complaints investigations. Process in place to ensure operational manuals are kept up to date, using current learning to improve the methodology.	The PPO are in the process of producing the operational manuals.
Develop and embed an approach for identifying and sharing learning internally with staff, including learning from prevention of future death (PFD) reports and PPO surveys.	PFD reports are regularly reviewed, and any learning is shared internally. Process embedded for identifying and sharing learning from PPO surveys.	The PPO have carried out a review into the learning from PFD reports. This will now be embedded into a regular feedback process.

Objective three: Increase the impact of our work on the actions of the services in our remit and the day to day lives of those in custody.

Key deliverable	Measure of success	End of year update
Embed a learning strategy for identifying and sharing both thematic and real-time learning with services in remit.	A clearly defined learning strategy.	The PPO are in the process of developing the learning strategy which will be embedded during the 2024/25 business year.
Introduce a monthly communication to share real-time learning with prisons.	Communication produced and distributed monthly.	A communication sharing learning and positive practice has been sent to prison Governors / Directors every month since October 2023.
Produce and publish thematic learning publications to increase the PPO's impact.	The publication of 4 x quarterly thematic learning publications and 2 x Policy into Practice publications. Recommendations from our learning lessons bulletins are accepted by the relevant services in remit and actions have been taken.	During 2023/24 the PPO published the following publications: ■ Learning Lessons Bulletin: Self-inflicted deaths of IPP prisoners ■ Policy into Practice: Use of Force

Key deliverable	Measure of success	End of year update
Implement proactive and targeted communications to ensure publications are widely disseminated and have impact.	Each learning product has a unique, targeted and proactive communications plan. Awareness of PPO publications amongst stakeholders using stakeholder surveys.	Each learning publication had its own communication strategy to launch the publication to the targeted audience. At the time of writing, the Learning Lessons Bulletin on self-inflicted deaths of IPP prisoners: ■ was opened and read over 3,800 times in our external marketing emails ■ was seen just under 44,000 times on social media ■ generated support and statements online from other stakeholders in the criminal justice sector ■ generated media articles At the time of writing, the Use of Force Policy into Practice publication: ■ was opened and read over 4,200 times in our external marketing emails ■ was seen over 7,600 times on social media ■ generated support online from stakeholders in the criminal justice sector

Key deliverable	Measure of success	End of year update
Continue to develop and establish effective partnerships with stakeholders to share expertise and learning and increase impact.	The success measure will be based on the output achieved from joint working with stakeholders.	Examples of effective partnerships and joint working include: ■ working with HMPPS to promote the importance of information sharing between healthcare and prison staff which is a common area of concern in PPO fatal incident investigations ■ working with the youth estate and women's prisons to gather and share learning to improve complaints handling and raise awareness of the complaints process ■ discussions with HMPPS about emergency response in prisons ■ sharing learning from post-release death investigations at an event for HM Inspectorate of Probation staff
Continue to use learning from our investigations to influence national policies within the services in remit, by responding to policy consultations.	PPO responds to relevant policy consultations with influential evidence.	The PPO has provided learning and evidence to a total of 18 HMPPS and Home Office policy consultations, with national policy changes being implemented as a result.

Key deliverable	Measure of success	End of year update
Review approach to making recommendations following fatal incident investigations.	Introduction of Governor to note findings. Improvement in timeliness for receiving action plans in response to PPO investigation reports.	The PPO has implemented a new approach to making recommendations. Lower-level findings now result in a finding in the report for the Governor to note, rather than a formal recommendation. The PPO issued 12 national recommendations to HMPPS, compared with 9 the previous year. In 2023/24 there were 244 initial reports issued with recommendations requiring an action plan response from the establishment and/or HMPPS within 6 working weeks. The action plan was returned to the PPO on time in 106 (43%) of these cases.

Objective four: We will use our resources efficiently and effectively.

Key deliverable	Measure of success	End of year update
Establish an effective performance management approach.	Performance framework designed and embedded.	Performance management tools have been designed and an approach established. This work will be embedded during the 2024/25 business year.
Identify any training needs across the organisation and develop a training programme for both new and existing staff.	An evaluation of current training needs for existing staff carried out. Development of a training programme for new and existing staff. Development of a process for monitoring Continuous Professional Development (CPD)/ training that is carried out.	A Learning Needs Analysis is being carried out across the organisation to identify training needs and inform a training programme for new and existing staff.
Continue to refine and improve our databases, data collection and data management to improve methods for monitoring casework and identifying trends/themes.	Demonstrable improvements made to data recording, collection and management.	The PPO has continued to refine our databases and data collection to improve methods for monitoring casework and identifying trends/ themes. We have made changes to the case management system to improve data collection and we are in the process of rolling out dashboards.

Financial data

	2022/23		2023/24		Change 2022/23 to 2023/24	% change year on year
Budget allocation	£6,179,000		£6,727,000		£548,000	9%
Actuals	**2022/23**	**% of total 2022/23**	**2023/24**	**% of total 2023/24**	**Change 2022/23 to 2023/24**	**% change year on year**
Staffing costs	£5,651,327	95%	£6,049,930	95%	£398,603	7%
Non-staff costs	£348,502	6%	£436,279	7%	£87,777	20%
Credit*	-£75,000	-1%	-£103,000	-2%	-£28,000	-37%
Total spend	**£5,924,829**	**100%**	**£6,383,209**	**100%**	**£458,380**	**8%**
Underspend	**£254,171**		**£343,791**		**£89,620**	**35%**

Credit* – In 2022/23, the PPO received a credit of £75,000 from the Home Office and in 2023/24, the PPO received a credit of £103,000 from the Home Office.

It has been necessary to correct the financial data for 2022/23 because staffing costs had incorrectly been allocated to non-staff costs and the credit received from the Home Office was not included in our Annual Report for 2022/23. This correction is necessary due to external parties confirming the wrong information last year. As a result, the staffing costs for 2022/23 have been amended from £5,564,651 to £5,651,327, the non-staff costs from £435,178 to £348,502, the credit from £0 to -£75,000, the total spend from £5,999,829 to £5,924,829 and the underspend from £179,171 to £254,171.

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 at the following address to request a printed copy:

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