

PPO/HMPPS Impact Symposium

10 South Colonnade, Canary Wharf

Thursday 28 March, 2019

 @PPOmbudsman

Agenda

09.30	Registration and coffee
10.00	Dialogue not debate Sue McAllister, Prisons and Probation Ombudsman
10.25	Smarter recommendations, lasting outcomes Elizabeth Moody, Deputy Ombudsman (Fatal Incidents Investigations)
10.50	Monitoring and supporting implementation of PPO recommendations Susannah Eagle, Deputy Ombudsman (Complaints Investigations)
11.15	Evolving PPO's learning lessons agenda: developing our outputs Kimberley Bingham, Deputy Ombudsman (Learning Lessons and Strategic Support)
11.40	HMPPS Wales case study Kenny Brown, Prison Group Director HMPPS Wales
12.00	HMPPS response Phil Cople, Director General Prisons
12.30	Q&A
13.00	Lunch
13.45	Introduction to the afternoon session
14.00	Right to reply – framing the change
14.45	Feedback to panel and discussion
15.30	Next steps and close

Housekeeping

- No planned fire drills or alarm tests
 - Starburst evacuation protocol
 - In the event of a fire please make your way through the fire exits (via the green emergency exit signs) out of the building.
 - Disperse to at least 100 meters behind another large building.
- Facilities Management teams will be in Cabot Square to manage the situation but use the MOJ staff helpline to get regular updates **0800 111 6776**.

Dialogue Not Debate

**Sue McAllister,
Prisons and Probation Ombudsman**

Presumptions

- We all want the same things
- We all have limited resources
- Focus on outcomes and what matters

Observations

- Policy and practice can be very different
- Our reports don't matter enough
- We have no teeth

Questions

- How can we learn from failure?
- What hinders or prevents getting it right?
- Where can PPO add most value?
- How can we help?

Smarter recommendations, lasting outcomes

Elizabeth Moody,
Deputy Ombudsman (Fatal Incident Investigations)

PPO recommendations

- Context
- Recommendations
- Acceptance rates v implementation rates
- Repeat recommendations
- Why don't you implement our recommendations?
- What can you do differently?
- What can we do differently?

Context

- PPO established 1994
- Range of settings
- Prisons remain our bread and butter
- 4,600 complaints so far this year
- 304 deaths so far

Recommendations by topic

Complaints

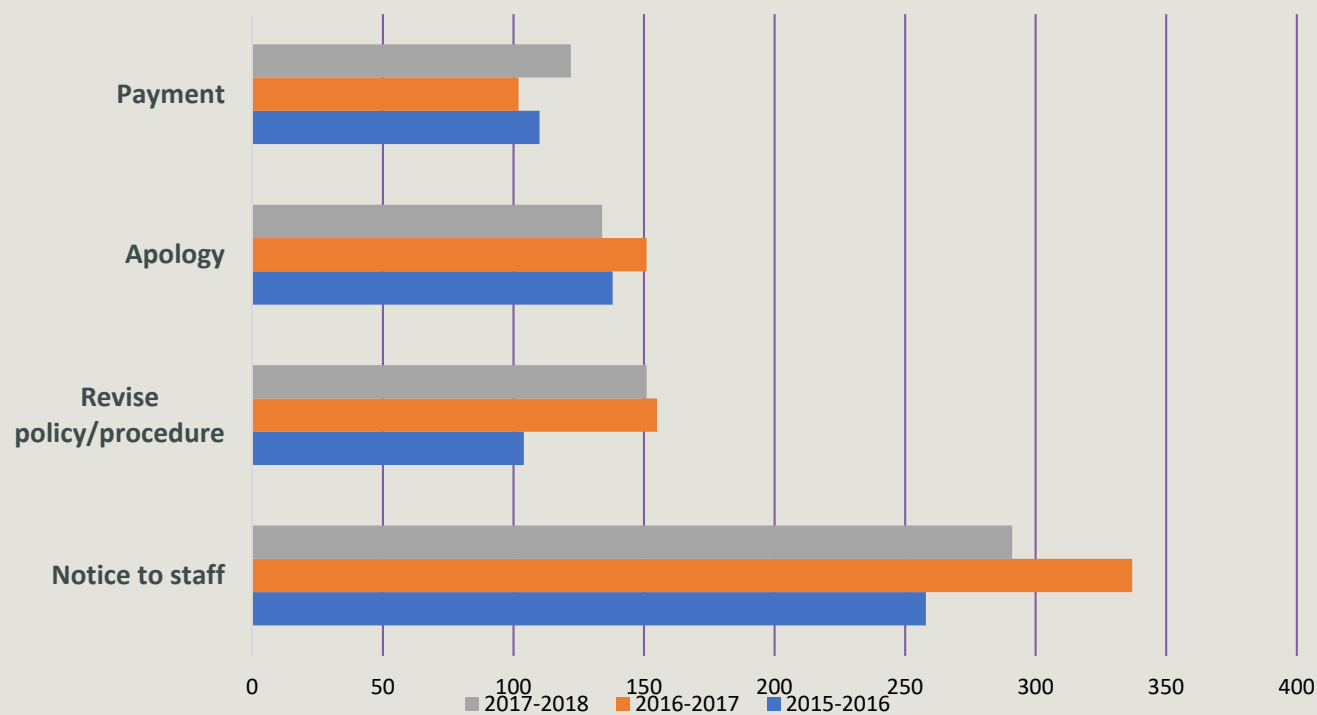
- Property 23%
- Staff behaviour 16%
- Administration 9%
- Work and pay 8%
- Adjudications 7%

Deaths

- Health provision 20%
- Emergency response 15%
- ACCT 13%
- Restraints 8%
- Administration 7%

Complaints recommendations by type

Number of complaint recommendations in the last 3 years



Acceptance and implementation

- Acceptance – virtually 100%
- Implementation – who checks?
- **In 2017-18 HMI Prisons found:**
 - 952 PPO FII recommendations
 - 80 implemented
 - 58 partially implemented
 - 10 poorly implemented
 - 16 not implemented
 - 788 unclear
 - Repeat recommendations

Why don't you implement our recommendations?

“When someone kills themselves in custody, there are investigations; by the police, the coroner, the prisons ombudsman and other interested groups. They all operate with perfect 20/20 hindsight. Too often, conclusions are reached with imperfect comprehension of the reality of prisons.”

Danny McAllister in *On Prisons: A Gaoler's Tales*

Why don't you implement our recommendations?

- You don't think we know what we are talking about
- Not a top priority
- Lack of resources
- Difficult to embed with frontline staff
- Not allowed to reject them?
- Nothing in it for you?
- PPO has no teeth

What could you do differently?

- Be honest
- It's good to talk
- Be imaginative
- Catch 'em young
- Local training
- Share reports with those involved
- Healthcare recommendations
- Monitor implementation – PGDs, HQ, private prisons

What could we do differently?

- Don't have the resources to monitor implementation
- Generic vs bespoke recommendations
- Different wording
- Escalation
- Different processes? Who sees our recommendations?
- Listen to feedback

Monitoring and supporting the implementation of PPO recommendations

**Susannah Eagle,
Acting Deputy Ombudsman (Complaints Investigations)**

What is our shared goal?

- **Safer, more decent prisons**
- Illustrated by:
 - A reduction in the number of avoidable deaths.
 - Better end of life care for those with terminal illnesses.
 - Fewer complaints.
 - Procedural fairness for complainants.

What's the point of a PPO recommendation?

- Bring about genuine improvements;
- Lead to lasting changes to policy and practice, locally and nationally;
- Put things right for individuals;
- Highlight good practice?

The current process

- Fatal Incidents:
 - Safer Custody Casework Team
- Complaints:
 - Prisoner Casework Unit

What works with this approach?

- HMPPS takes responsibility for deciding how best to implement the recommendation.
- Straightforward recommendations that can be easily accepted and actioned – along with evidence of the action taken.

What doesn't work?

- Impact is limited to local level;
- No direct negotiation/conversation between PPO and establishments;
- Time consuming
- Does that distance from negotiation mean that, from the outset, both parties have less investment in proposed solution?

Rejected recommendations

- PPO/Michael Spurr worked hard to reach position
- But, has this led to a pressure to accept without meaningful implementation?
- What impact does this have on our impact?

How might we do things differently?

- Could we/should we develop closer relationships with PGDs?
- Alter some PPO internal processes
 - E.g. complaint allocation process
 - Handling of property complaints
- Are we making the right recommendations?

Monitoring implementation

- HMIP
 - Can be long delay between recommendation and inspection
 - Currently, only follow up FII recommendations
- IMB
 - Could/should we develop their role?

Implementation: What's our role?

- Remit
- Resources
- Independence

An overview of the Learning Lessons Programme

**Kimberley Bingham,
Deputy Ombudsman (Learning Lessons)**

Agenda

- Overview on the Learning Lessons programme
- What works, where it falls short
- Thoughts on next steps
- Measuring impact
- What do you want to see from us to capture attention and deliver change?

Why a Learning Lessons programme?

- Use the outcomes of investigations to share more widely
- Recommendations address particular incidents at a particular establishment
- Bulletins share learning more broadly, encourage good practice and influence policy

What does the programme cover?

- First publication in March 2010 on learning from fatal incidents in the previous year
- Two types of publications:
 - Action focused bulletins on narrower questions
 - thematic reports looking in depth at a broad theme
- 42 publications since March 2010

Prisons & Probation Ombudsman Independent Investigations

Prisons & Probation
Ombudsman
Independent Investigations

Learning lessons bulletin PPO Investigations | Issue 3

January 2017

Transgender prisoners

This learning lessons bulletin explores the care and management of transgender individuals while in prison. It draws on recommendations from our investigations into deaths in custody, as well as our complaint investigations, and outlines six lessons we can learn from past cases.

My office has historically received few complaints from prisoners identifying themselves as transgender, and, fortunately, has investigated relatively few deaths of transgender individuals in custody. However, more recently, these numbers have been climbing. Last year, in quick succession, two transgender women tragically took their own lives while in custody. These events made the need to address this issue all the more pressing.

Prisons are always difficult environments, never more so than in recent months, but they have a fundamental responsibility to keep prisoners safe and to protect and support those with particular vulnerabilities. Transgender prisoners are among the most vulnerable, with evident risks of suicide and self-harm, as well as facing bullying and harassment. Undoubtedly, managing transgender prisoners safely and fairly poses challenges for prison

staff in the "hyper-gendered" world of prisons, but law and policy are unequivocal that this is what is required.

This bulletin is timely, not only because of the two high profile deaths of transgender prisoners, but also because of much wider public debate about

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Prisons are

Nigel I

Prison

Ombu

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Investigations

into the deaths of

Approved

Premises residents

where abuse of drugs or

alcohol was involved.

Foreword

Approved Premises (APs), previously known as

probation or bail hostels, hold individuals who require

additional support and supervision in the community

following their release from prison or while on bail or

court orders. This publication looks at the learning from

our investigations into the deaths of residents in APs

where abuse of drugs and alcohol was involved.

Some of the cases we investigate demonstrate good

practice by AP staff in the management and care given to

those who misuse drugs and alcohol. However, we

also see cases with too little focus on the risk of

relapse and overdose. As a result, this bulletin identifies

a particular issue about the implementation and

effectiveness of testing regimes in APs.

The rise of New Psychoactive Substances (NPS) use

in the prison estate is well documented and is widely

recognised, in the words of the previous Ombudsman,

as a "game changer". However, it is clear from our

investigations that the implications of NPS for the AP

estate have not yet been fully understood or addressed

by the National Probation Service.

Some of our investigations identified deficiencies in

information sharing and in welfare checks. Ensuring

a good flow of information between stakeholders is

critical, particularly for managing substance misuse

where there is a clear requirement for effective multi-

disciplinary working. Our investigations found this

did not always happen. Checks on the welfare of AP

residents are another important way to ensure the risks

associated with substance abuse are well managed, but

our investigations found checks were not always carried

out effectively.

We also identified an overarching need for the National

Probation Service to improve the AP manual to give staff

better guidance on NPS use, information sharing and

making welfare checks.

We know offenders can be at heightened risk of death

following their release into the community. I hope this

bulletin will help AP staff apply the learning from our

investigations to improve the ways they identify, monitor

and address the risk factors associated with substance

misuse.

Elizabeth Moody

Acting Prisons and

Probation Ombudsman

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Learning from
PPO investigations

Older Prisoners

June 2017

Learning from
PPO investigations

Prisoner mental health

January 2016

Who uses our publications?

- General Stakeholder Survey asks about our publications
- The survey tends to be completed by Governors
- MoJ
- Other Ombudsmen and scrutiny organisations
- Students and academics
- **But we don't think officers on the landings see them**

What does the programme achieve?

- Opportunity to share our unique voice
- Distillation of the cases we have investigated
- Comment on the worst, and the best, of what we have seen
- Influenced policy

What could we do differently?

- People appreciate bulletins ... but so what?
- There is value in sharing the learning from cases
- We want to provide something that will make a difference
- We want to provide something that gives you what you and your teams need

What could we do differently?

- There's a wealth of lessons
- The issue isn't so much knowing what the problems are
- The issue is getting the traction for dealing with them

What impact are we having?



Subscribe: <http://eepurl.com/04et9>

What impact are we having?

- We still expect to produce bulletins and thematics
- We are also looking at one-page infographic summaries
- A toolkit for Governors
- Look out for publications on:
 - Natural cause deaths of younger men
 - Our field work project on why men complain

What impact are we having?

- Collaborating with academics on measuring impact
- Giving more data to Governors, directly
- Quarterly updates to PGDs, comparing similar prisons

- What do you think?
- What else could we do to get our learning across?



Gwasanaeth Charchardai
a Phrawf EM yng Nghymru

HM Prison & Probation
Service in Wales

HMPPS in Wales

PPO Presentation

Discussion:

- Concerns
- Process Implemented
- Oversight
- Improvements

Caveats

This process is not perfect

This process may not work for every
group

Concerns

‘The number of self-harm incidents was high and significant recommendations from the Prisons and Probation Ombudsman (PPO) on deaths in custody had not been met.’

HMP Swansea, HMCIP Report August 2017:

‘There had been four self-inflicted deaths in the period before the 2014 inspection. The Prisons and Probation Ombudsman (PPO) had made a number of recommendations as a result of those deaths. On this occasion we found that since that inspection there had been four more such deaths, but significant and highly relevant PPO recommendations had not been implemented. This was inexcusable.’

Process, what we changed:

Immediately following a death in custody:

- Worked with GLD and PPO to develop a checklist of items required following a death in custody.

On receipt of the initial PPO draft report:

- Prison Group Safety Lead liaises with the establishments and organises a multi-disciplinary team to discuss the actions and recommendations.

Process, what we changed:

On receipt of the initial PPO draft report:

- Following the multi-disciplinary meeting the Prison Group Safety Lead develops an initial draft of the actions and receives approval from the team before submission.

On receipt of the initial PPO draft report:

- The Prison Group Safety Lead works with the Safety Team caseworker to re-draft the actions and receives a final approval from the multi-disciplinary team.

Requests to Alter / Reject Recommendations:

- Work with the Safety Caseworker and the PPO Investigator to discuss concerns and appropriate methods of escalation.

Process, what we changed:

On receipt of the final PPO Report:

- The final report, recommendations and actions are shared with all establishments in Wales from the Director, with a request that they all take action to ensure they are complaint

On receipt of the final PPO report:

- The Prison Group Safety Lead adds the recommendations and action to the overall PPO recommendations for the establishment

Process, what we changed:

Ongoing Actions:

- On a regular basis establishments are asked to provide an update against their PPO recommendations and provide evidence of them being undertaken.

Ongoing Actions:

- Quarterly meeting with the Executive Director to challenge and provide oversight of actions being completed

Improvements Experienced:

- Reduction in workload for the establishments
- Consistent approach to developing actions:
 - Awareness of similar recommendations
 - Awareness of repeat recommendations for the group
- Awareness and Collaboration between establishments
 - Earlier awareness of actions allowing establishments to take proactive measures – issue guidance / training etc.
 - Working together on repeat recommendations
- Number of recommendations now implemented :
 - February 2018 – 60% fully implemented
 - 17 from 28
 - February 2019 – 85% fully implemented
 - 36 from 43

ANY
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A response from HMPPS

**Phil Copple,
Director General, Prisons**

Any questions?

Right to reply – framing the change

Table discussion and feedback to the panel

Questions to consider

- How can we learn from failure?
- What hinders or prevents getting it right?
- Where can PPO add most value?
- How can we help?

**Thank you for
your time, your
participation and
your ideas.**

**If you have any further
questions or suggestions on
the topics discussed:**

Email Olly.barnes@ppo.gov.uk

If you have yet to do so, please do subscribe to
receive The Investigator, PPO's quarterly
newsletter, at: <http://eepurl.com/04et9>