Prisons & Probation Ombudsman
Independent Investigations

PPO/HMPPS Impact Symposium

10 South Colonnade, Canary Wharf

Thursday 28 March, 2019

@PPOmbudsman

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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 12.30	**HMPPS response** Phil Copple, Director General Prisons 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**

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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

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Presumptions

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

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Observations

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

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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)

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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?

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Context

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

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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%

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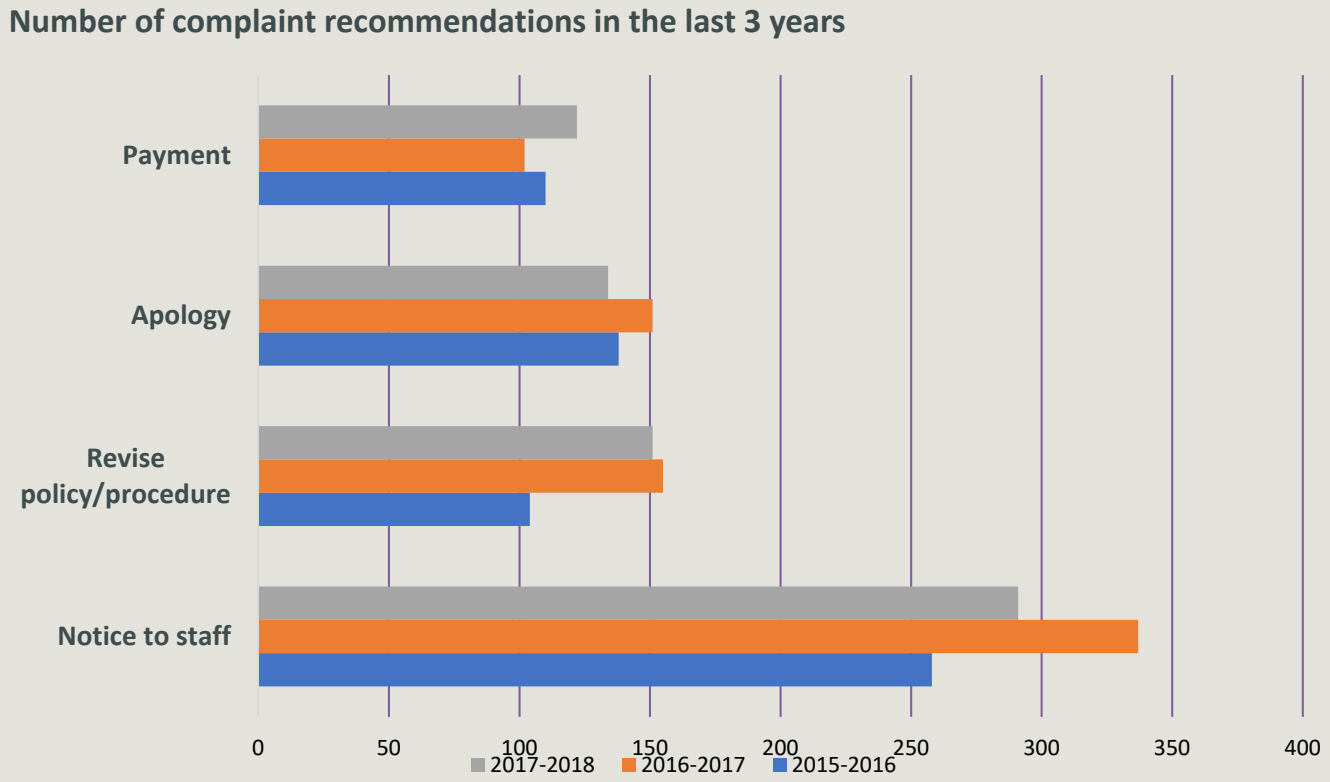
Complaints recommendations by type



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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

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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*

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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

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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

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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)

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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.

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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?

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The current process

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

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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.

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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?

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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?

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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?

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Monitoring implementation

- HMIP
  - Can be long delay between recommendation and inspection
  - Currently, only follow up FII recommendations

- IMB
  - Could/should we develop their role?

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Implementation: What's our role?

- Remit
- Resources
- Independence

An overview of the Learning Lessons Programme

Kimberley Bingham,
Deputy Ombudsman (Learning Lessons)

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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?

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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

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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

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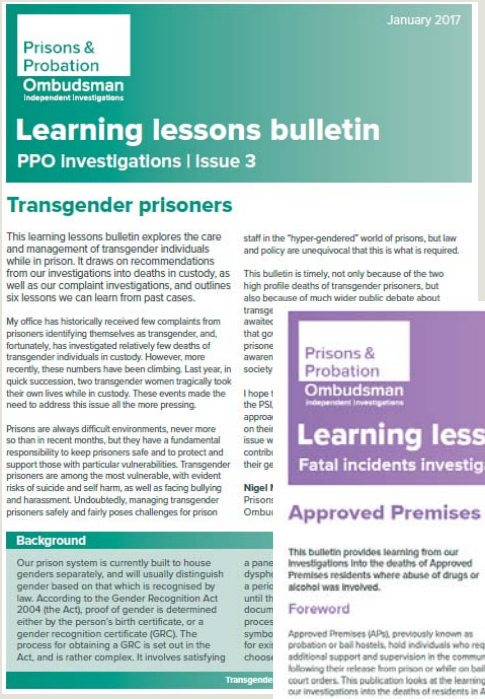

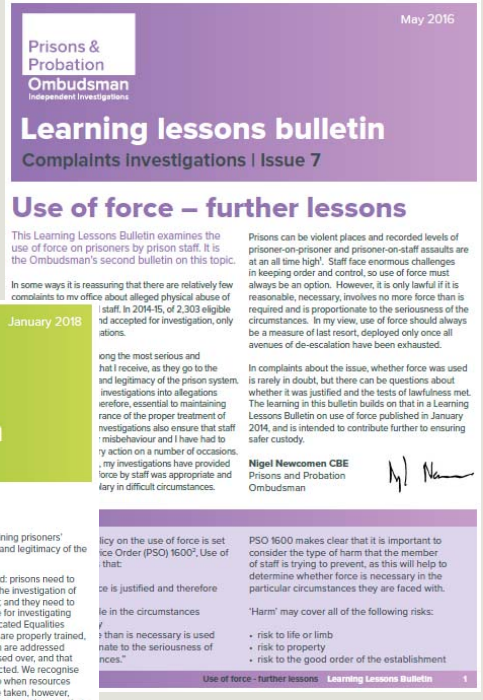

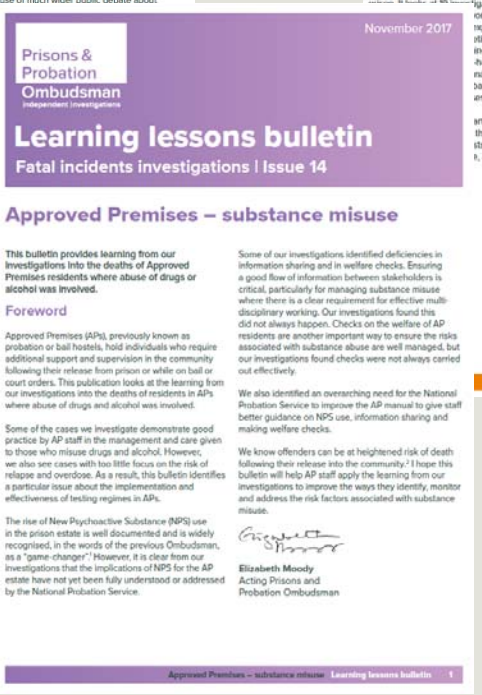

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Who uses our publications?

- 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**

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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

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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

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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

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What impact are we having?

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

The Ombudsman's Opening

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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

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What impact are we having?

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

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- 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
QUESTIONS

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QUESTIONS

A response from HMPPS

Phil Copple,
Director General, Prisons

Any questions?

Right to reply – framing the change

Table discussion and feedback to the panel

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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?

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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

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