

## PPO/HMPPS Impact Symposium

**10 South Colonnade, Canary Wharf** 

Thursday 28 March, 2019





#### 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 Copple, 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

#### Agenda

14.45

15.30

**Next steps and close** 

Feedback to panel and discussion



### 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%

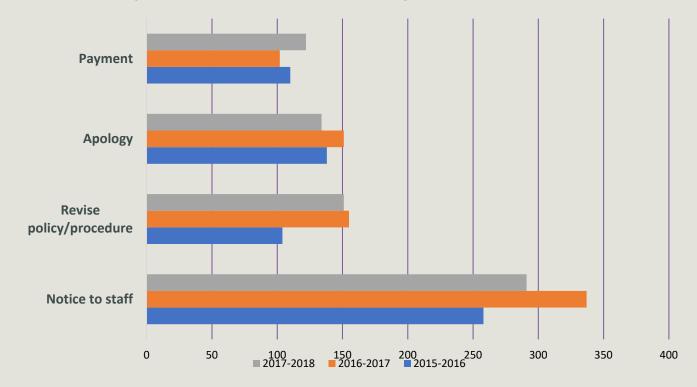
#### **Deaths**

- 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 <u>bulletins</u> 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

#### Learning lessons bulletin

PPO investigations I issue 3

#### 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 high profile deaths of transgender prisoners, but 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 awaren recently, these numbers have been climbing. Last year, in society 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 support those with particular vulnerabilities. Transgender prisoners are among the most vulnerable, with evident risks of suicide and self harm, as well as facing bullving and harassment. Undoubtedly, managing transgender prisoners safely and fairly poses challenges for prison

Our prison system is currently built to house genders separately, and will usually distinguish gender based on that which is recognised by law. According to the Gender Recognition Act 2004 (the Act), proof of gender is determined either by the person's birth certificate, or a gender recognition certificate (GRC). The process for obtaining a GRC is set out in the Act, and is rather complex. It involves satisfying

staff in the "hyper-gendered" world of prisons, but law

This bulletin is timely, not only because of the two also because of much wider public debate about

that go Prisons & Probation Ombudsman

their ge

#### Learning lessons bulletin

Fatal incidents investigations | Issue 14

#### Approved Premises - substance misuse

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 ball hostels, hold individuals who require additional support and supervision in the community following their release from prison or while on ball 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 bulletin will help AP staff apply the learning from our a particular issue about the implemental effectiveness of testing regimes in APs.

The rise of New Psychoactive Substance (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 multidisciplinary 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

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

We know offenders can be at heightened risk of death

Gignett Acting Prisons and Probation Ombudsma

d Pranduce - substance misuse Learning lessons bulletin 1

Prisons & Probation

#### Learning lessons bulletin

Fatal incidents investigations I Issue 13

#### Self-inflicted deaths among female prisoners

Foreword

This bulletin was prompted by the recent dramatic and depressing rise in self-inflicted deaths of women in figations between 2013 and

romen took their own lives. explain this apparently rising ofin does identify a number ing. This learning focuses on -harm prevention procedures nagement of risk, addressing bating bullying and ensuring

artening that many of the those in previous publications sts it is not a lack of

sustained action. While we often identify examples of excellent and compassionate care by individual staff, and also recognise that prisons have been under enormous strain in recent years, there can be no excuse for not

> Prisons & Probation

#### Learning lessons bulletin

Complaints investigations | Issue 9

#### Complaints about discrimination

This bulletin contributes to an emerging conversation about how prisons can better engage with and resolve prisoners' complaints about discrimination. It looks at more than 200 complaints about discrimination in prisons investigated by the Prisons and Probation Ombudsman (PPO) over the past five and a half years. It analyses recurrent issues and identifies four lessons which we hope will help improve the way prisons prioritise and investigate complaints about discrimination.

to address any problems identified. What our investigations show however is that all too often discrimination complaints are not investigated

As a public body HM Prison and Probation Service as a public body, IAM Prison and Probation Service (HMPPs) has a duty to ensure equality and prevent discrimination. One important way in which HMPPs can fulfill its responsibilities is by ensuring complaints about discrimination are investigated promptly and effectively and, where necessary, taking action discrimination complaints are not investigate them often lack the training and confidence to address equalities issues effectively, and that prisons often fail to collect the equalities data needed to carry out a meaningful Ombudsman

reassignment, marriage and civil partnership, reassignment, inaninage and cvin partners sinp, pregnancy or maternity, race, religion or belief, sex, and sexual orientation. The public sector equality duty gives public sector organisations, like prisons, specific responsibilities under the Act

The Equality Act 20101 identifies nine protected to eliminate discrimination and advance equality of opportunity.<sup>2</sup> However, there is established and emerging evidence that suggests there are disproportionate outcomes for people in the criminal justice system with some of these protected characteristics.

investigation. This risks undermining prisoners

The solutions are straightforward: prisons need to

confidence in the effectiveness and legitimacy of the

The solutions are straightforward: prisons need to allocate sufficient resources to the investigation of complaints about discrimination; and they need to ensure that the staff responsible for investigating these complaints (whether dedicated Equalities Officers or managers generally) are properly trained, that allegations of discrimination are addressed

directly and not ignored or glossed over, and that equalities data is routinely collected. We recognise

equalities data is routinely collected. We recognise that this is not always easy to do when resources are tight. Unless these steps are taken, however, prisons – and the wider public – cannot be sure that they are treating prisoners fairly and equally.

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Prisons & Probation Ombudsman

#### Learning lessons bulletin

Complaints investigations | Issue 7

#### Use of force – further lessons

This Learning Lessons Bulletin examines the use of force on prisoners by prison staff. It is the Ombudsman's second bulletin on this topic.

In some ways it is reassuring that there are relatively few In some ways it is reassuming that there are relatively new complaints to my office about alleged physical abuse of lastf. In 2014-15, of 2,303 eligible did accepted for investigation, only ations.

ong the most serious and hat I receive, as they go to the ry action on a number of occasions , my investigations have provided lorce by staff was appropriate and lary in difficult circumstances.

le in the circumstances

than is necessary is used

nate to the seriousness of

Prisons can be violent places and recorded levels of prisoner-on-prisoner and prisoner-on-staff assaults are at an all time high! Staff face enormous challenges in keeping order and control, so use of force must always be an option. However, it is only lawful if it is reasonable, necessary, involves no more force than is required and is proportionate to the seriousness of the circumstances. In my view use of force should always be a measure of last resort, deployed only once all avenues of de-escalation have been exhausted.

In complaints about the issue whether force was used investigations into allegations erefore, essential to maintaining and legitimacy of the prison system. Is rarely in doubt, but there can be questions about whether it was justified and the tests of lawfulness met. The learning in this bulletin builds on that in a Learning rance of the proper treatment of nvestigations also ensure that staff imisbehaviour and I have had to safe roustody.

> Nigel Newcomen CBE Ombudsman



ice Order (PSO) 16002. Use of consider the type of harm that the member of staff is trying to prevent, as this will help to determine whether force is necessary in the particular circumstances they are faced with. ce is justified and therefore

'Harm' may cover all of the following risks:

- · risk to life or limb
- risk to property
   risk to the good order of the establishment

of force - further lessons | Learning Lessons Bulletin







## 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: <a href="http://eepurl.com/04et9">http://eepurl.com/04et9</a>

The Ombudsman's Opening



### 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?



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



# '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.'

### 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.

### 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.

### 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

### **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





HM Prison & Probation Service in Wales

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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

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