Prisons & Probation Ombudsman
Independent Investigations

Annual Report 2018–19

CP 175

Prisons & Probation Ombudsman

Annual Report 2018–19

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by Command of Her Majesty

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CP 175

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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 Her Majesty's Prison and Probation Service (HMPPS), the National Probation Service for England and Wales, the Community Rehabilitation Companies for England and Wales, Prisoner Escort and Custody Service, the Home Office (Immigration Enforcement), the Youth Custody Service, 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 (ToR), the latest version of which can be found in the appendices.

The PPO has three main investigative duties:

- complaints made by prisoners, young people in detention,[1] offenders under probation supervision and immigration detainees
- deaths of prisoners, young people in detention, approved premises' residents and immigration detainees due to any cause
- using the PPO's discretionary powers, the investigation of deaths of recently released prisoners or detainees

1 The PPO investigates complaints from young people detained in secure training centres (STCs) and young offender institutions (YOIs). Its remit does not include complaints from children in secure children's homes (SCHs).

Our vision

To carry out independent investigations to make custody and community supervision safer and fairer

Our values

We are:

Impartial: we do not take sides
Respectful: we are considerate and courteous
Inclusive: we value diversity
Dedicated: we are determined and focused
Fair: we are honest and act with integrity

Foreword

I became Prisons and Probation Ombudsman in October 2018, so was in post for half of the year covered by this annual report. I would like to pay tribute to Elizabeth Moody for her contribution as Acting Ombudsman for the first half of the year and to thank our two other Deputy Ombudsmen, Kimberley Bingham and Susannah Eagle, for their support since I took up the post. Colleagues across the PPO team have generously shared their knowledge and experience with me and have enabled me to set out my vision and priorities for my time in post. I am grateful to all of them and acknowledge the work that they do.

Building on progress

In February 2019 we agreed, and published, a protocol with the Ministry of Justice. In the absence of statutory footing, the PPO must make the best use of every available opportunity to strengthen its position with both the MoJ who sponsor us and the services within our remit for investigation. This protocol secured the kind of protection which both safeguards the organisation and will help to make us more effective in the future.

> “
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> ...the PPO must make the best use of every available opportunity to strengthen its position with both the MoJ who sponsor us and the services within our remit for investigation.”

We remain committed to securing statutory footing for the office of Prisons and Probation Ombudsman and will continue to seek the legislative opportunity to achieve that.

We published our Strategic Plan for 2019/21, where we outlined our key priorities for the next three years. They are to:

- improve **confidence** in the PPO
- build on our **effectiveness** and increase productivity
- strengthen our **impact**
- become a more **efficient**, flexible and resilient organisation

The coming year will see us build on the progress which has been made and strengthen our impact on the services in our remit.

Making a difference

The reports the PPO produces, in both our complaints and fatal incidents functions, are of a consistently high quality, grounded in evidence and valued by complainants, the families of those who have died and by other stakeholders including coroners and the organisations we investigate. Our outputs are strong, in spite of the challenges presented by an increase in demand for our services. We, and others, are clear about what we do and why we do it. We have now turned our attention to building on those strong outputs to improve the impact we have so that we play our part in contributing to safer, fairer and more humane outcomes for people in prison and the other services in our remit.

In our reports, we continue to make the same recommendations repeatedly, sometimes in the same establishments and, often, after those recommendations have previously been accepted and action plans agreed to implement them. We need to do more to understand, and support organisations to address the obstacles to implementing recommendations and making the improvements we all agree are needed. We have started to make our recommendations more specific and to focus them on the required outcomes rather than on processes, which are the responsibility of the services themselves. But, where the same failings are identified time and again, organisations must address those barriers which exist, whether they are structural, cultural, attributable to insufficient resources or to other things, and which prevent the changes to practice and behaviours which are necessary and which have been promised.

In March, we hosted a symposium for senior leaders across HMPPS where we discussed how we could support them to learn from the failings we identify in our investigations and prevent these repeat recommendations so that our work supports them to improve outcomes.

Complaints and procedural fairness

We investigate complaints in an impartial, confidential and independent manner. The ability to raise issues with us, and to have confidence in our handling of complaints, is particularly important at a time when prison regimes are impoverished and the levels of violence in many prisons are high. The complaints we received in 2018/19 reflect what we know about the struggles those working in prisons face to deliver ordered, safe and decent regimes and to get the basics right.

Complaints about lost or damaged property continue to dominate our caseload and the procedures for recording and managing prisoners' property remain outdated and inefficient. The new escort contracts, which start in 2020, have failed to address the need for prisoners' property to travel with them when they transfer between establishments. Prisons also vary in their capacity and commitment to have in place sensible and defensible arrangements for controlling and storing property and for dealing with complaints about lost or damaged property honestly and proportionately so that they need not be referred to this office.

We continue to receive complaints about staff conduct, including the use of force by staff. The roll out of body worn video cameras (BWVC) across the prison estate

has been a welcome initiative, alongside CCTV and hand-held video cameras, allowing staff to record any incidents involving the use of force so that video evidence is available in the event of any complaints about the conduct of staff or the management of the incident. We have been frustrated by the failure of some prisons to use BWVC consistently or to retain footage, despite a clear HMPPS requirement, and the consequent inability to provide us with footage in the event of a complaint. We received one complaint about the use of PAVA (an incapacitant spray similar to pepper spray) in one of the four pilot sites; our investigation will be published shortly.

Investigating fatal incidents

In 2018/19 we began 334 fatal incident investigations, an increase of 6% over the previous year.

We saw a 23% increase in self-inflicted deaths this year with worryingly high numbers in some prisons. In many cases, we had to make the same recommendations as in previous years, where remedial action had been promised. These included recommendations in relation to the management of ACCT (the process of supporting and managing prisoners at risk of suicide and self-harm). The quality of staff engagement with prisoners and the first response of staff when they found a prisoner who appeared to have died were identified as risks. In some cases, we concluded that swifter intervention, in line with the HMPPS policy and expectations, might have prevented a death.

In our investigations, we repeatedly identify failings in the way ACCT is managed in prisons. We welcome the plans to issue a new, simpler, ACCT form and a new guidance manual for staff. However, the key issues remain those of staff giving insufficient weight to known risk factors and an over reliance on the presentation of those who may be at risk. New forms and manuals will not solve these and staff at all levels must comply with the available guidance on what works so that support is meaningful and makes a difference.

Deaths from natural causes, including those which are foreseeable and, therefore, not preventable, fell by 4%, despite a continuing increase in the number of men in prison who are aged over 50. There is still no strategy within HMPPS for the management of older prisoners and any good practice we find is still the result of local initiatives or the actions of individual staff. We continue to highlight the inappropriate use of restraints on people who are very unwell, often immobile and presenting a low risk of escape or offending while being escorted to, or in, hospital. It is clear, from our interviews with staff and our own experience, that there remain structural and cultural barriers to prisons complying with the policy and legal requirements relating to the use of restraints.

The number of deaths in which drugs are identified as a factor is still worryingly high and psychoactive substances continue to present a significant challenge to prisons. A number of initiatives across HMPPS, and particularly in the prisons which were involved in the 10 prisons project, are aimed at reducing the availability of drugs. These include X-ray scanners, photocopying prisoners' incoming mail and barriers to

prevent drones from flying onto prison sites. HMPPS also published its national Prison Drugs Strategy together with guidance for staff, which we welcome. However, we do not know yet whether the obligations it places on individual establishments to act will deliver improved outcomes and we continue to make repeat recommendations in our reports.

> “The number of deaths in which drugs are identified as a factor is still worryingly high and psychoactive substances continue to present a significant challenge to prisons.”

Our thematic work and sharing learning

The work we do to identify lessons from collective analysis of our work and to share it with a wide range of stakeholders is now firmly embedded. This year we have focused on publications which complement the Learning Lessons bulletins to broaden our capacity to reach a wide range of the people who can use our learning to inform their practice.

In 2018/19 we introduced a new publication, The Investigator, allowing us to communicate with our stakeholders about the issues impacting prisoners and staff in real time.

In the past nine years, the PPO’s Learning Lessons team has published more than 40 bulletins and thematic reviews which look at the PPO’s casework to identify both good practice and, crucially, where the system is failing in its duty of care to prisoners, immigration detainees and young people in detention. Our goal with The Investigator was to be able to talk to our stakeholders – including the officers working for the services in remit – in real time about the things that matter.

The Investigator features articles, supported by case studies and some straightforward numbers, dealing with difficult subjects in a no-nonsense and practical fashion. We will also try to feature some of the good work we see from the services in remit.

Crucially, we want our thematic publications to be accessible to staff working on the front line, not just senior managers, so that the learning really does have an impact and lead to better outcomes and to safer, fairer conditions of detention. That is why we will be doing shorter, more immediate bulletins and asking for feedback on what is useful and how we can improve.

We were invited to contribute to conferences and other external events throughout the year and this gave us an opportunity to share what we do and what we find, as well as allowing us to build, and strengthen, our relationships with other organisations. Among the events we attended were the IMB National Conference, the Ombudsman Association AGM and numerous Prison Group Director’s regional meetings.

We have forged new links with the Ombudsman Association and, bilaterally, with fellow ombudsman organisations so that we can learn from them and share good practice.

Making the PPO more efficient and accountable

In common with other public services, the PPO has seen demand for our services increase, at a time when budgets have reduced, presenting us with the challenge of matching our programme of work to available resources. We have looked at where our work can make most difference – by contributing to safer, fairer services in remit – so we can focus on those areas, while meeting our legal obligations and fulfilling our Terms of Reference and the protocol we have agreed with the Ministry of Justice.

Within our team, we have listened to what our staff told us in a recent staff survey and have made some internal changes to reflect their concerns and suggestions. As part of our commitment to empower our staff, we have strengthened our leadership arrangements so our senior leadership team now includes our assistant ombudsmen. We are encouraging colleagues to get out of the office and contribute to strengthening our relationships with the services in remit and with other partners and stakeholders, where time and resources allow. We are also planning to enable secondments into, and from, the PPO team and to support people with lived experience of custody to join us.

> “
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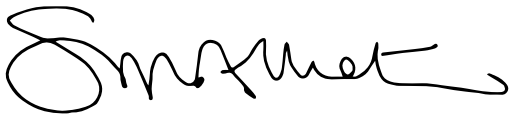
This has been a busy year for the PPO and we have responded to the challenge of increased demand for our services, including some particularly complex and high-profile cases. We have reduced the number of cases awaiting investigation and have made changes to the way we work so that our resources are directed appropriately and proportionately. We remain wholly committed to delivering our independent scrutiny and to playing our part in making custody safer, fairer and more decent.



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The year in figures

Complaints

In 2018/19 we received **4,968 complaints**, a 4% increase compared to last year. Of these:

- **the most common complaint category was property (36%)** – administration (9%) and staff behaviour (6%) were the next most common categories.
- **39 were about immigration removal centres**, 7 fewer than last year.
- **281 were about probation services**, 19 fewer than last year – of these we accepted 38 for investigation (a high proportion of those not accepted had not followed procedures).

We made **5,029 eligibility assessments**. Of these:

- **69% were completed in time** – this is fewer than last year when we assessed 72% of cases on time and falls short of our target of assessing 80% of cases on time.

Our caseloads increased by 4% this year. This followed a 3% decrease the previous year. In 2018/19 we **started investigations into 2,584 cases** compared to 2,480 in 2017/18.

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 our resources. In 2018/19 we **declined to investigate 262 complaints**, 79 fewer than last year.

38 complaints were accepted for investigation but withdrawn by the ombudsman. An additional 19 complaints were withdrawn by complainants themselves.

We completed **2,569 investigations**, a 9% increase compared to last year. Of these:

- **39% were completed on time**, compared to 38% last year – this fell short of our target of completing 60% of cases on time.
- **38% came from the high security estate** (which makes up 11% of the prison population) – 28% of complaints from prisoners in the high security estate were upheld compared to 32% of complaints from other prisoners.
- 32% of cases were found in favour of the complainant, 6% less than last year.

Fatal incidents

In 2018/19, we started investigations into **334 deaths**, a 6% increase compared to last year. The majority of these deaths were of prisoners (96%). We began investigations into:

- **180 deaths from natural causes**, 4% fewer than last year.
- **91 self-inflicted deaths**, 23% more than last year.
- **4 apparent homicides**, a decrease from 7 last year.
- **36 other non-natural deaths**, a slight decrease from 39 last year.
- **12 deaths of residents living in probation approved premises**, one more death than was investigated last year.
- **1 death of a resident of the immigration removal estate**, 4 fewer than last year.
- **1 discretionary case** – the death of an individual who died four days after being released from prison custody.

Fortunately, this year we began **no investigations of fatal incidents in secure accommodation**, compared to 2016/17 when we began 2 investigations into deaths in secure children's homes.

In 2018/19 we made **723 recommendations** following deaths in custody:

- 138 related to healthcare provision (19%).
- 117 related to emergency response (16%).
- 86 related to general prison administration (12%).
- 80 related to suicide and self-harm prevention (11%).

This year we issued **308 initial and 262 final reports** compared to 310 initial and 331 final reports last year. In 2018/19:

- 93% of initial reports and 72% of final reports were issued on time, surpassing our targets of issuing 70% of initial and final reports on time.
- the average time to produce an initial report for a natural cause death was 19 weeks and for all other deaths 25 weeks.

Complaints

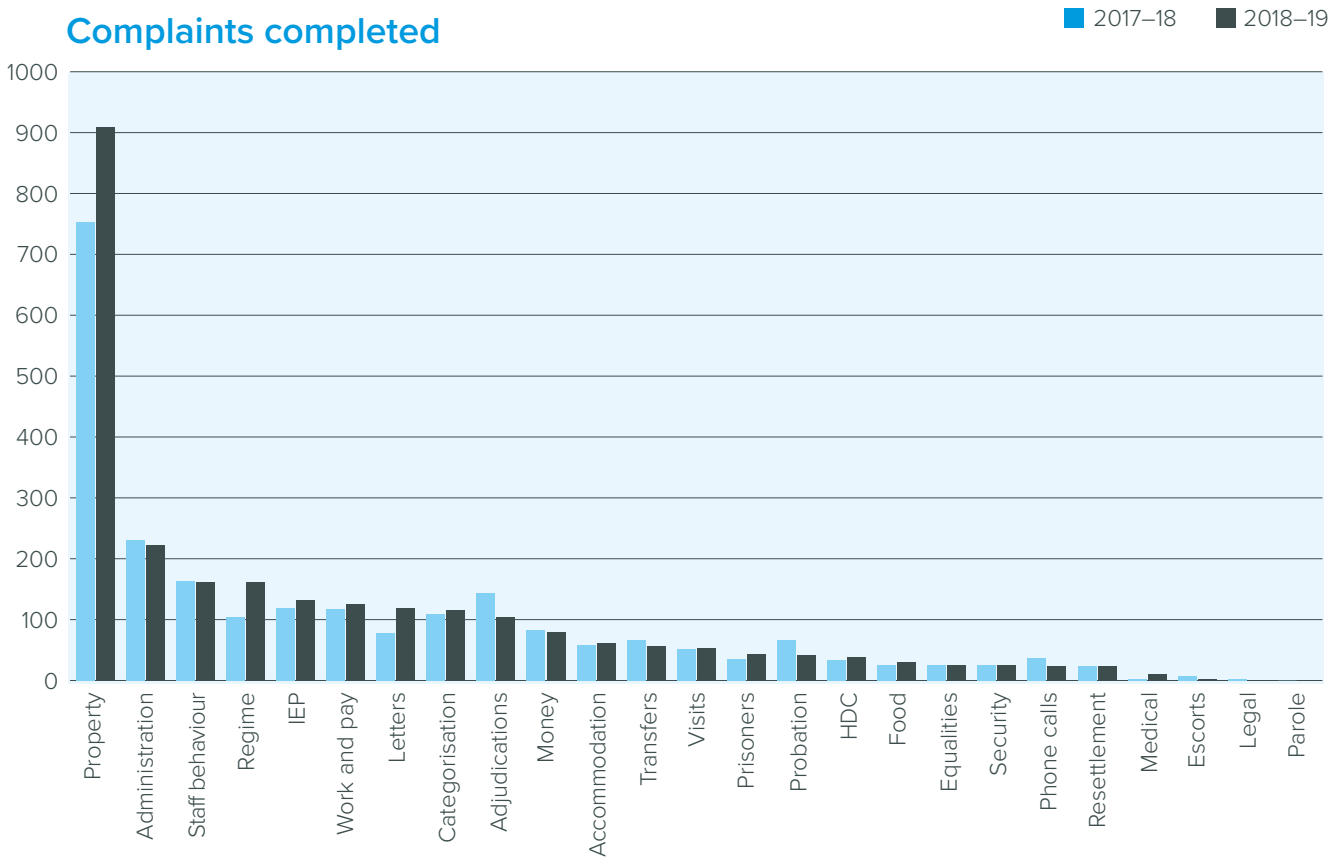
4,968 **complaints**
a 4% increase
compared to last year

2,569 **investigations completed**
a 9% increase
compared to last year

32% were **found in favour** of the complainant, 6% less than last year

39% **were completed on time**, compared to 38% last year

Complaints completed



Fatal Incidents

334 deaths
a 6% increase compared to last year

91 self-inflicted deaths
23% more than last year

180 deaths from natural causes
4% fewer than last year

308 initial reports issued
93% on time

723 recommendations made by PPO following deaths in custody related to (among others):

- **138** healthcare provision
- **80** suicide and self-harm prevention
- **117** emergency response
- **86** general prison administration

Fatal incidents investigated

Investigating complaints

Last year's annual report reflected on turbulent times in prisons in England and Wales, citing record levels of violence and self-harm. Although the conditions in prisons have received fewer newspaper column inches during this reporting year, in fact, incidents of violence and self-harm have increased again. As HMPPS grapples with the problem, we continue to see our role in investigating and resolving complaints as key in the safety agenda. We do not underestimate the importance of our role in providing an effective, efficient and independent resolution to unresolved complaints.

It is vital that prisoners are informed about, understand and trust the role the PPO plays in the complaints system. Our research project into prisoners' perceptions of the complaints process is well underway. The findings will help us to understand their experiences of the HMPPS complaints system and, importantly, what happens when they complain to the Ombudsman.

We are committed to identifying weaknesses in our own processes and better ways to operate. We have already made some changes to how we handle the complaints we receive. We have introduced a triage process to identify complaints that can be resolved swiftly and easily; we focused our attention on the large number of cases in our queue, which had not yet been picked up for investigation; and we considered the value of operating a live telephone service against our ability to focus on efficiently investigating the complaints we receive.

In 2017/18, we were surprised by a drop in the numbers of complaints received and investigated. In 2018/2019, we both received and investigated 4% more complaints than the previous year. It is very pleasing to report – and a reflection of the continued hard work and commitment of complaints staff at the PPO, and of some of the changes we have already made – that we saw improvements in our productivity. We assessed more complaints more quickly; we investigated 9% more complaints than last year; we investigated 15 more serious cases than last year; and more cases were completed in time.

"It is vital that prisoners are informed about, understand and trust the role the PPO plays in the complaints system."

As we would expect, the vast majority of complaints we received were from adult male prisoners and covered a wide range of issues from the seemingly trivial to the undoubtedly very serious.

We have tended to report the percentage of complaints we upheld in the reporting year as a measure of the quality of prisons' initial handling of complaints, and of our own work. However, the reasons why we do or do not uphold a complaint can be complex and are not always the best illustration of the quality of complaints investigations. This year, we upheld 32% of cases, a decrease from 2017/18. However, that figure does not include those cases where we did not uphold the original complaint, but identified areas for improvement in the course of our investigation and made recommendations to the service. In 2019/20, we will be thinking about other ways to reflect quality and our impact.

Last year, we highlighted our ongoing frustrations with the responses we received from individual prisons, including missing or incomplete paperwork and the slow (or sometimes completely absent) responses to repeated requests for information.

This remains an area of great concern, and with the support of governors and area directors in HMPPS, we are piloting new arrangements that we hope will bring improvements.

Property

This year, we completed 21% more investigations into property complaints than last year, and they continued to amount to about a third of our total caseload (36% of all the complaints we investigated). We upheld a significant proportion (46% this year).

We have long recognised the importance of property to prisoners in helping them maintain a sense of identity and some freedom of choice. Our investigations continue to highlight serious flaws in the outdated and inconsistent practices in handling prisoners' property. Mishandling property, and then mishandling the complaints prisoners make as a result, is a costly exercise. We have begun to think about how we can manage property complaints differently and more efficiently. We know that HMPPS is also focusing attention on this area. We hope to be able to share our expertise and get involved in some of its work to review the relevant policies in 2019/20.

“We have long recognised the importance of property to prisoners in helping them maintain a sense of identity and some freedom of choice.”

The complaint by Mr A is a good example of apparently poor property handling by a prison, compounded by very poor handling of the ensuing complaint.

The day after Mr A arrived at the prison following transfer, he complained that a bag of his property was missing. Mr A said that the missing property had arrived at the receiving prison but that his property and property belonging to a number of other prisoners was placed together on one table in the reception area. He said that he was given several bags of property but when he reached the wing, realised that one of the bags belonged to another prisoner. He said that he handed this property back to wing staff but did not receive the missing bag of his own property.

The prison responded to Mr A's complaint saying that he had become responsible for his own property when it was handed to him in reception and nothing more could be done to trace what he said was missing.

To investigate Mr A's complaint, we made several requests for information to the prison. Although staff responded to some of our emails, after two months they had failed to provide any of the information we had requested. We were left with no alternative but to accept Mr A's version of events and recommended that the prison compensate him for the loss of his property.

This year, we investigated a number of similar property complaints from one prison. The issue – the prisoner escort contractor in the area rigidly applying volumetric controls to prisoners' property and refusing to take any excess property – was widespread across prisons, but might have been compounded by the transient nature of the population at this local prison. Mr B was one such case we investigated.

Mr B complained that the prison had failed to forward on to him three boxes of his property when he transferred. He said that, on the day of transfer, the prisoner escort company refused to take all of his property because it exceeded volumetric controls. The prison assured Mr B that his property would be forwarded to him within a few weeks of his transfer but, several months later, his property was still missing so he complained to the Ombudsman. Because his was one of a cluster of cases raising the same complaint, we visited the prison to discuss how they could resolve the complaints. The prison had accumulated a large amount of property to be reunited with its owners but we found them poorly organised and not sufficiently proactive about doing so. Following our investigations, the prison undertook to change their processes. Mr B finally received his property having waited for about a year. We advised the prison that, in future, we would be likely to recommend financial compensation if the prison excessively delayed sending on property.

Use of force

As we have noted in previous years, complaints about staff behaviour remain a thankfully small percentage of those we receive, but they are among the most serious we investigate. Although the number of recorded assaults in prisons continued to rise and reached a record high[2] in 2018, we did not see that mirrored in the number of complaints about staff use of force we received.

This year we began 56 investigations into use of force, two fewer than last year. We recognise this to be an area of growing concern and ensuring our staff are properly trained to investigate these complaints has been a key focus. It is pleasing to report improvements in the time it has taken us to complete these complex and serious investigations.

We maintain the position that the use of force must be available to staff as an option, but our investigations ensure that it is only used when strictly necessary and proportionate to the circumstances. The pilot programme to introduce PAVA incapacitant spray to a small number of prisons during this reporting year was an interesting development – and one we shall keep our eye on, with our first PAVA related complaint due to be published in 2019/20.

2 Ministry of Justice Safer Custody Statistics, England and Wales: Deaths in Prison Custody to March 2019, Assaults and Self-harm to December 2018, published 25 April 2019. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/797074/safety-custody-bulletin-q4-2018.pdf

> “We maintain the position that the use of force must be available to staff as an option, but our investigations ensure that it is only used when strictly necessary and proportionate to the circumstances.”

As we built our expertise in use-of-force cases, we upheld a higher proportion (48%, compared to our general uphold rate of 32%). We made recommendations in the majority of use-of-force complaints and these followed consistent themes: prisons failing to conduct a local investigation into the incident; staff not correctly completing mandatory paperwork after an incident and prisons failing to secure vital evidence (such as CCTV or body-worn video camera footage). The case of Mr C demonstrates the importance and evidential value of such footage.

Mr C complained that prison staff had used unnecessary force against him. He also alleged that an officer had assaulted him by striking him on the throat. The prison referred the matter to the local police for investigation, who decided not to pursue a criminal investigation.

During our investigation, we asked for a copy of CCTV footage of the area outside Mr C’s cell, where he said the incident occurred. The prison was unable to locate a copy and we eventually obtained the footage from the local police. The footage showed the officer hitting Mr C in the throat, which forced him back into his cell.

The prison said that Mr C had refused to obey a lawful order in relation to misusing his emergency call bell and so the officer’s use of force was justified. However, the relevant prison service policy makes clear that non-compliance with an order is insufficient grounds to initiate force, and that alternatives should be explored before using force, which should always be a last resort.

In his account, the officer said he was scared and feared for his own safety, and pushed Mr C in the upper chest area to get him to go back into his cell. Our investigation concluded that the officer did not try to de-escalate the situation by talking to Mr C before using force, and that elements of the officer’s account did not correspond with what we saw in the CCTV footage. We concluded that the force used was not necessary, reasonable or proportionate and made a number of recommendations.

Prisoner-on-prisoner assaults

Despite the fact that we know levels of violence between prisoners are rising (there were 24,424 prisoner-on-prisoner assaults in 2018, a record high and an increase of 15% on 2017),[3] very few of the complaints we receive or investigate relate to the behaviour of other prisoners and few prisoners complain about prisons failing to keep them safe. That is not, in itself, surprising. There may be many reasons why prisoners do not make complaints about issues involving other prisoners, not least the fear of reprisals or a lack of confidence that there is anything either HMPPS or the Ombudsman can do once an incident has occurred.

“There may be many reasons why prisoners do not make complaints about issues involving other prisoners, not least the fear of reprisals or a lack of confidence that there is anything either HMPPS or the Ombudsman can do once an incident has occurred.”

When we do receive such complaints, they are a stark reminder of the impact of violence on prisoners’ every day experiences.

Mr D, via his solicitors, complained that the prison had failed to properly investigate two incidents of sexual assault against him by a group of other prisoners (including Mr D’s cellmate), and had not done enough to keep him safe before the incidents.

The police had investigated both incidents and, as a result, several of the prisoners had been convicted of charges including sexual assault by penetration and assault occasioning actual bodily harm.

Mr D’s solicitors asked the prison to carry out an internal investigation, in line with HMPPS policy, to ensure that matters not addressed by the police investigation had been considered. The prison did not respond. During our investigation, HMPPS said that they considered the police investigation had been sufficient and that, due to the passage of time since the incidents (which occurred in December 2014), there was limited value in undertaking an internal investigation.

We found that the prison had little recorded information about the two incidents and had not retained any possibly useful CCTV footage. There were few entries in the prison records of any of the men involved and no evidence that any had been subject to close monitoring. The lack of information made it difficult for us to establish whether the prison did enough to keep Mr D safe prior to the assaults.

3 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/797074/safety-custody-bulletin-q4-2018.pdf

We concluded that the lack of notes in the men's prison records meant that the prison had been in breach of three HMPPS policies and suggested that staff did not have sufficient information to identify the men's risks, vulnerabilities or needs. We could not say with confidence that the prison had taken adequate steps to protect Mr D before the assaults.

We concluded that it was not unreasonable that the prison did not carry out an internal investigation at the same time as the police investigation given the serious nature of the allegations. However, we concluded that the prison should have conducted an internal investigation when asked to do so by Mr D's solicitors. We were disappointed that the prison had not recognised the opportunity to learn lessons to prevent a repeat. We did not think there was any value in the prison conducting an investigation some four years after the incidents, but made a number of recommendations about the management of the unit where the incidents happened, and the handling of such incidents in future, all of which the prison accepted.

Adjudications

We often receive complaints about matters related to the prison adjudication process – although these have reduced in number in recent years, in line with the corresponding reduction in the provision of legal aid to prisoners. This year, 4% of the complaints we investigated were about adjudications, fewer than last year.

Adjudication complaints usually relate to one or more of three distinct areas – the charge itself, the way the adjudication hearing was conducted, or the punishment received. The Ombudsman's role is not to re-hear the evidence in these cases, but to ensure that all relevant prison service procedures have been adhered to, from the initial charge through to the final outcome.

The adjudication process and relevant policy is complex and so our investigations occasionally uncover procedural errors that the complainant was not aware of. In such cases, we may recommend that an adjudication is quashed for a reason other than that offered by the prisoner in his complaint. In other cases, such as Mr E's, we do not uphold the complaint, but make other recommendations to improve adjudication processes.

Mr E complained about the outcome of an adjudication after he damaged the television in his cell. Mr E was found guilty of the charge and received a punishment. He appealed the finding of guilt arguing that he had recognised mental health needs and was being monitored under ACCT at the time of the adjudication, and so did not think the adjudication should have gone ahead.

The Prisoner Casework Unit in HMPPS considered Mr E's appeal and upheld the finding of guilt but reduced the punishment. Mr E complained to the PPO. Initially, we concluded that, on the evidence available, the finding of guilt and the level of punishment were reasonable. Mr E asked us to review our conclusions, bearing in mind his mental health at the time of the adjudication. We agreed to do so in the light of new information he supplied to us, and his complaint was reviewed by a senior manager.

The HMPPS policy covering prisoner discipline procedures notes that a list of all prisoners due for adjudication should be sent to the prison's healthcare department ahead of the adjudication, so that any medical concerns can be drawn to the adjudicator's attention. The prison told us that they did not routinely do this and instead relied upon the adjudicator adjourning the hearing if he or she had any concerns about the prisoner's health. There was insufficient evidence for us to conclude that Mr E's mental health problems at the time were so serious as to mean the adjudication should not have gone ahead so we did not uphold that element of Mr E's complaint. However, we recommended that the governor amended adjudication processes to ensure the healthcare department received a list of all prisoners facing adjudications in advance, in line with the policy, to provide meaningful information about any health concerns. The prison accepted the recommendation.

Accommodation

Last year, we noted a rise in complaints about the conditions in which prisoners live and the potential impact of the liquidation of Carillion, who had held the contract for prison maintenance. This year, we received a similar number of complaints about accommodation. Mr F's complaint suggests that there remains a problem with out-sourcing maintenance work to private companies.

Mr F complained that while he was held in the segregation unit, the cell call system in his cell was out of order for 10 days. He said the prison took too long to repair it and that he should have been moved to a different cell. In their response, the prison apologised for the delay but said the call system had been repaired at the earliest opportunity. Mr F remained dissatisfied.

The maintenance contract at the prison is held by Amey. The most recent annual report by the local Independent Monitoring Board and inspection by HM Chief Inspector of Prisons raised concerns about the level of service offered by Amey and commented on a backlog of uncompleted jobs.

We concluded that prison staff had managed Mr F (who was voluntarily resident in the segregation unit) well – checking on him at least once an hour. However, we were very concerned to learn that the cell call system was out of order for a prolonged period of time, which contravenes HMPPS policy. We concluded that it was not appropriate for Amey to decide how to prioritise the maintenance calls they received and criticised their lack of systems for recording the work they had carried out. We recommended that the prison's senior managers worked with Amey to improve the situation and upheld Mr F's complaint.

Contracted-out prisons

HMPPS policies apply to both state-run and contracted-out prisons. In 2018/19, 18% of complaints we investigated were from prisoners in contracted-out prisons. Generally, the complaints raised concerned the same issues as those raised by prisoners in state-run prisons. However, the case of Mr G raised some interesting questions about how HMPPS achieves effective oversight of contracted-out prisons.

Mr G complained about being downgraded to basic regime under the Incentives and Earned Privileges (IEP) scheme. Initially, we did not uphold his complaint because we could find no evidence that he had ever been downgraded on the national prison case management programme, NOMIS. However, the prison informed us that Mr G had indeed been downgraded to basic while there following a serious incident. The prison told us they had recorded the downgrade on their own local case management system, but not on NOMIS. They confirmed that the local case management system was not accessible to staff in other prisons.

HMPPS policy is clear that information such as an IEP review must be recorded on NOMIS because of its importance in other processes, including risk assessments.

We concluded that the prison was not only in breach of HMPPS policy, but also putting staff and prisoners at a disadvantage by not sharing relevant information in the correct way. We made sure that our recommendations following this investigation were shared not only with the prison director, but also the HMPPS contract manager, who provided evidence of the action they were taking to address the problem.

Legally privileged mail

Items of legally privileged correspondence are covered by Prison Rule 39 (and so often referred to as Rule 39 mail), meaning that they can only be opened by the prisoner not by prison staff, as would normally be the case. As we have reported in previous years, we continue to receive complaints about the handling of Rule 39 mail.

Last year, we noted that we had begun to receive complaints from prisoners about the measures prisons were taking to reduce the amount of PS (psychoactive substances) entering prisons through prisoners' mail. We support measures taken to reduce the supply of drugs in prisons, provided that they comply with existing prison service policies, are proportionate to the risks identified and are regularly reviewed. We have investigated some cases, such as Mr H's, where we did not find this to be the case.

“We support measures taken to reduce the supply of drugs in prisons, provided that they comply with existing prison service policies, are proportionate to the risks identified and are regularly reviewed.”

Mr H complained that the prison had refused to recognise that correspondence between him and his legal adviser was entitled to Rule 39 privilege. During our investigation, we found that the prison had reviewed their decision and agreed that the correspondence should be treated in line with Rule 39 procedures.

However, we found that the prison had changed the process for issuing Rule 39 mail. Prisoners now had to attend an appointment and open Rule 39 mail in front of staff from the security department, who would conduct a physical examination of the contents. Prisoners were told that, if they failed to attend the appointment, the Rule 39 mail would not be issued to them, but would instead be placed into their stored property and they would not be able to access it.

Although we were satisfied that Mr H's original complaint had been resolved, we considered that the new procedures were contrary to prison service guidance. We were also concerned that the procedures could amount to the obstruction of justice, if prisoners were denied access to their legal mail.

We recommended that the prison amended the procedures to ensure they were fully compliant with HMPPS policy and ensured that any Rule 39 mail that had already been placed in stored property was given to the prisoners concerned. The prison accepted the recommendations.

Equalities

This year, we investigated 26 complaints explicitly relating to equalities.

Last year, we highlighted that black, Asian and minority ethnic (BAME) complainants were over-represented compared with their populations in prison. Our research into the experiences of BAME complainants continues with focus groups and interviews with prisoners and staff taking place at a number of selected prisons. We anticipate that this important piece of work will tell us more about how BAME complainants experience both the HMPPS and PPO complaints processes, and identify areas for learning.

As we have highlighted previously,[4] prisons can do much to assure prisoners of their commitment to ensuring equality and preventing discrimination by investigating complaints of discrimination promptly, effectively and in line with HMPPS policies. It is frustrating to find this is still not always the case as the following case study illustrates.

> “Our research into the experiences of BAME complainants continues with focus groups and interviews with prisoners and staff taking place at a number of selected prisons.”

Mr I complained that a supervising officer (SO) had been racist when he told Mr I that he looked and acted like a monkey. The prison responded that the SO absolutely denied the allegation and warned Mr I not to make false allegations about staff. Mr I appealed and said that other prisoners had witnessed the exchange, and that it would have been captured by the wing CCTV. The prison replied that the initial response to Mr I’s complaint was sufficient. Mr I submitted a Discrimination Incident Reporting Form (DIRF), but the prison did not respond to it.

We concluded that the prison had failed to adequately investigate Mr I’s complaint and had not followed mandatory instructions in the relevant HMPPS policies about responding to DIRFs. The prison told us that, due to staff shortages, the equalities officer was deployed on other duties and that they had a backlog of DIRFs which had not been properly dealt with. They said that they could not assure us that DIRFs would be managed in line with policy until the staffing shortages were resolved.

By the time we concluded our investigation, Mr I had been released from prison and we could not trace him. We could not establish whether the incident had occurred as he reported. We were concerned by the prison’s response and highlighted the importance of the equalities officer role. We recommended that, within two weeks of receiving our final report, the governor ensured that the equalities officer was able to properly investigate DIRFs, and that all complaints relating to discrimination, victimisation or harassment were managed in line with the relevant policies. HMPPS accepted our recommendations.

4 PPO’s Learning Lessons Bulletin: Complaints about discrimination (January 2018)

Complaints from female prisoners

As in previous years, we received a disproportionately small number of complaints from women in 2018/19. We completed investigations into just 41 complaints from women. The following complaint from Ms J illustrates that they face many similar issues to those in the male estate.

Ms J complained that she was not receiving her one-hour entitlement to fresh air because the association period took place in the evening, and staff had told her it was too dark to allow the prisoners outside. She said that walking outside helped her manage her depression and was her main source of exercise.

The prison told Ms J that, during the winter months, allowing the prisoners outside in the dark during their association period posed too great a security risk. They said that, instead, the women had opportunities to be in the open air when they walked between the wings and to other activities, such as work. Ms J argued that her walk to work meant that she was outside for less than five minutes.

Prison service guidance is clear that all prisoners must have at least 30 minutes in the open air each day, split between no more than two periods of 15 minutes. We concluded that the prison's reliance on using the walk to and from activities and lunch to give prisoners time in the fresh air meant that few were receiving their 30-minute entitlement. We found it unlikely that the prison was complying with the mandatory instruction. We recommended that the prison devise an appropriate summer and winter regime to take account of the hours of daylight, which they accepted.

Complaints from those under 21

As in previous years, the number of complaints from those under 21 remained disproportionately small: accounting for just 26 of the 2,569 that we investigated. We know there are a number of reasons why young people do not complain to us. Anecdotal evidence suggests that they find the complaints process overly bureaucratic or complicated. We continue to welcome the fact that we receive complaints from advocates, solicitors and charities made on behalf of young people. In the following case study the Howard League, acting on behalf of a number of young men at a Young Offenders Institution (YOI), submitted complaints about the use of segregation.

> “We continue to welcome the fact that we receive complaints from advocates, solicitors and charities made on behalf of young people.”

The Howard League complained that a number of young men had spent prolonged periods in the Segregation Unit, spending at least 22 hours a day in their cells without any meaningful human contact. They said that this breached YOI rules as well as the young men’s rights under Article 8 of the Human Rights Act.

In considering all of the complaints, we were satisfied that the decisions to locate each of the young men in the Segregation Unit were justified in the circumstances. However, in some of the cases, we were concerned that the segregation paperwork had not been fully completed and, in all cases, we were concerned about the quality and timeliness of the segregation review process and/or the regime that was available to each of the young men.

Although we appreciated the considerable challenges the YOI faced in managing some of the young men in the Segregation Unit, we concluded that more had to be done to improve the regime for those held in the unit. We upheld or partially upheld all the complaints and made a number of recommendations across the different investigations, all of which were accepted.

The most common cause of complaint from young people was missing property, but we also investigated two complaints about use of force. Prison service policy on the use of force against young people is clear that staff must always: view the physical restraint of a young person as the last resort; use techniques to de-escalate the situation before resorting to force; apply the least force necessary for the shortest period of time. These investigations require us to very carefully consider all the circumstances, as in the case of Mr K.

Mr K, then aged 17, complained that staff at the YOI had assaulted him by slamming his head against the floor and used excessive force while restraining him.

We viewed the CCTV footage covering the incident, which showed that Mr K had been using the wing telephone when he was assaulted by another prisoner. A large number of staff responded and began to restrain Mr K.

The staff eventually moved Mr K to his cell and it was here that Mr K claimed they assaulted him by slamming his head against the floor. Unfortunately, none of the staff involved were wearing body worn cameras so there was no footage of the incident.

We found that while the restraint and initial use of force was justified, the ongoing management of the incident was poor. We saw no obvious attempts by staff to talk to Mr K or de-escalate the incident before they restrained him; too many staff were involved in the restraint (we counted 11 at one point); and the incident paperwork suggested that pain-inducing techniques had been used, although we could not identify who had used these techniques or why. Some of the concerns we identified echoed those previously raised by HM Chief Inspector of Prisons during his last inspection of the YOI.

As a result of our concerns, we upheld Mr K's complaint and made a number of recommendations. The YOI did not accept our finding that the force used against Mr K was excessive.

Complaints from probation supervisees

We received 38 complaints from probation supervisees that were eligible for investigation this year, 31% fewer than in 2017/18. We do not yet understand the reasons for the decrease and intend to explore this further.

The nature of the complaints we investigated remained similar to previous years. Many supervisees were unhappy with the quality and accuracy of reports being written about them, and assessments of their risk of harm to others and further offending.

Last year, we noted that, in some cases, although we did not uphold the complaint, we found that the National Probation Service (NPS) or the Community Rehabilitation Company (CRC) had failed to investigate the supervisee's complaint effectively, or in line with their own prescribed internal complaints policy. This year it is pleasing to recognise a notable improvement in how the NPS and CRCs have managed complaints.

> "This year it is pleasing to recognise a notable improvement in how the NPS and CRCs have managed complaints."

However, some of the complaints we investigated, such as that of Mr L, highlighted the complex nature of probation complaints.

Mr L, who had been diagnosed with Asperger's Syndrome just prior to sentencing, complained about his offender manager (OM). His parents, who were permitted to represent him, also complained about how the OM had portrayed them in a medical note for an NHS Trust, and how the NPS had investigated their complaints.

At the appeal stage, the NPS concluded that their initial investigation had been sufficient but upheld some aspects of the complaint against the OM. The NPS assured Mr L and his parents that the OM would be subject to appropriate management oversight in future. Mr L's parents were dissatisfied and complained to the Ombudsman.

We considered that the NPS investigation was thorough and that, for the most part, the conclusions drawn were reasonable. We felt the NPS had appropriately identified and responded to many of the issues raised by Mr L and his parents, including recognising that the OM had handled Mr L's case insensitively. However, we were surprised that the NPS's written response to Mr L and his parents gave little consideration to his diagnosis of Asperger's Syndrome.

We partially upheld Mr L and his parents' complaint and recommended that the NPS apologised to them for not acknowledging Mr L's diagnosis of Asperger's Syndrome, and for the impact of the OM's management of his case. We also recommended that the OM undergo training in working with offenders with autism spectrum disorders.

Complaints from immigration detainees

We investigated 28 complaints from immigration detainees in 2018/19, seven more than last year. Most related to missing property, but about a quarter concerned staff behaviour.

Mr M complained that he had missed two court hearings because the IRC had failed to make the necessary arrangements. Mr M asked to be compensated for advance payments he had made to his barrister to represent him at the hearings.

The agencies involved claimed that severe weather on the day of the hearings had prevented them from producing Mr M at court. We found that much of the evidence gathered was conflicting, but concluded that, due to the severe weather, the IRC had not been able to discharge prisoners to court until the late morning, meaning Mr M missed his hearing. As these were circumstances outside anyone's control, we did not uphold Mr M's complaint. However, after our intervention, the Home Office agreed to compensate Mr M for the payments he had made to his barrister.

Investigating fatal incidents

We started investigations into 334 deaths in 2018/19, 6% more than in the previous year, and the second highest number in a year since the PPO started investigating deaths in 2004. This was largely due to an increase in the number of self-inflicted deaths, while deaths from natural causes fell slightly.

As in previous years, the great majority of the deaths we investigated occurred in prisons (96%) and were of adult males.

We aim to complete investigations into deaths from natural causes within 20 weeks and investigations into self-inflicted deaths within 26 weeks. However, we sometimes have to suspend our investigations while we wait for key information, such as the cause of death, toxicology tests or a clinical review. For that reason, the case studies in this section feature deaths we have investigated during 2018/19 and not all the deaths will necessarily have taken place during the year.[5]

5 Our investigation reports are published on our website (www.ppo.gov.uk) once the inquest has taken place.

Self-inflicted deaths

After a significant drop in the number of self-inflicted deaths in 2017/18, it was very disappointing to see numbers rise again in 2018/19. We began investigations into 91 self-inflicted deaths in 2018/19, an increase of 23% on the previous year.

There is no well-evidenced answer to why self-inflicted deaths remain at such a high level. However, although it is not realistic to expect that establishments will ever be able to prevent all such deaths, there are some established lessons about actions that can help to reduce the number of self-inflicted deaths, including:

- good quality risk assessment to identify those at most risk of suicide and self-harm (especially in the early days in custody)
- appropriate action to minimise or resolve the reasons for distress
- safety checks at appropriate intervals for those at risk
- multi-disciplinary working, especially for those with mental illness and substance misuse issues;
- an effective strategy to reduce the supply of and demand for illicit drugs (which are so often associated with debt and bullying)
- a prompt and effective emergency response to suicide attempts

> “…although it is not realistic to expect that establishments will ever be able to prevent all such deaths, there are some established lessons about actions that can help to reduce the number of self-inflicted deaths.”

These lessons are now well-known and it is therefore troubling that many of our investigations during the year found that the same failings keep occurring and we are repeating recommendations that we have made before.

ACCT

A key tool in helping to reduce the number of self-inflicted deaths is the prison service care planning system used to support prisoners at risk of suicide or self-harm: ACCT.[6] The purpose of ACCT is to try to determine the level of risk, how to reduce risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner’s main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be carried out at irregular intervals to prevent

6 Assessment, Care in Custody and Teamwork. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody). A similar system, known as Assessment, Care in Detention and Teamwork (ACDT), is used in Immigration Removal Centres.

the prisoner anticipating when they will occur. Regular multidisciplinary review meetings involving the prisoner should be held.

As part of the process, a caremap (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison.

Assessment of risk

One of our most frequent concerns is that staff have not adequately assessed the level of risk the individual poses to him or herself. Prison Service Instructions[7] list a number of risk factors and potential triggers for suicide and self-harm and it is important that staff take these into account.

Sometimes this is simply a matter of common-sense, as the case of Mr A shows.

Mr A, who was 33, was remanded in prison custody charged with a serious sexual offence. It was his first time in custody. He was found guilty and was sentenced to 14 years imprisonment. Neither Mr A or his family had expected such a long sentence. That night he hanged himself in his cell.

“

Prison Service Instructions list a number of risk factors and potential triggers for suicide and self-harm and it is important that staff take these into account.”

7 PSI 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody), and PSI 7/2015, Early Days in Custody – Reception in, first night in custody, and induction to custody.

We were concerned that Mr A should have been screened to assess his risk of suicide and self-harm when he returned from court, but this did not happen. He should also have been assessed by healthcare staff as his custodial status had changed from unsentenced to sentenced but, again, this was not done. We considered that reception staff should have identified Mr A's increased risk of suicide and self-harm and considered starting ACCT procedures.

In that case, staff did not consider whether Mr A was at risk of suicide or self-harm. A more common problem is that staff do consider whether a prisoner is at risk, often very conscientiously, but focus too much on the prisoner's demeanour and what they say, and do not give sufficient thought to their risk factors. Prisoners will not always want to share the extent of their distress with staff and the way they come across in a room full of people during an ACCT review will not necessarily reflect how they feel alone in their cell at night. The case of Mr B is a typical example of this.

Mr B, who was 21, was sentenced to 10 years in prison for a sexual offence against a child (a family member). It was his first time in prison. He had a history of suicide attempts and self-harm in the community, including overdoses and an attempted drowning, and had been diagnosed with a personality disorder, anxiety and depression.

When he arrived in prison a nurse assessed him as suitable to keep his anti-psychotic and antidepressant medication in his cell (rather than having to collect it every day and take it under the supervision of healthcare staff).

Mr B said he wanted to kill himself and prison staff started ACCT monitoring. The ACCT was closed nine days later when staff recorded that Mr B said he was settling in prison and that, although he still had thoughts of suicide, he had no intention of acting on them.

Over the next month, Mr B told a nurse that he had suicidal thoughts every day and that he had plans to kill himself if things did not change. The nurse did not consider he was at risk because he was smiling when he said this, and later told her that, although he thought about suicide, he did not intend to kill himself.

A few days later he cut himself with a razor and staff opened another ACCT. Mr B said that he had self-harmed to "ease the pain in his heart" and that he was worried about the length of his sentence and felt remorse for his offence. The ACCT was closed after three days when staff assessed that Mr B posed a low risk because he was talking about getting a job and had positive plans for the future, presented as 'well' and 'happy', and denied that he had any intention of killing himself.

The following morning, Mr B began vomiting and fitting and told staff that he had taken an overdose of his prescribed medication, which he had been stockpiling for this purpose. He went into cardiac arrest and died. The post-mortem found that he had died as a result of choking on his own vomit caused by a drug overdose. He had been in prison six weeks.

Mr B presented with many known risk factors for suicide and self-harm. These included the nature of his offence, first time in custody, a history of suicide attempts and of self-harm, and frequent thoughts of suicide, and he also suffered from a personality disorder which carried a raised risk of impulsive, self-harming and suicidal behaviour.

We concluded that, although staff appropriately placed Mr B on ACCT monitoring on two occasions, they stopped the monitoring prematurely because they placed too much emphasis on Mr B's assertions that he did not intend to kill himself and the fact that he appeared to be making plans for the future, although his risk factors remained unchanged.

We found many deficiencies in Mr B's ACCT management, including failure to gather relevant information before assessments and reviews, case reviews not being multidisciplinary, the caremap of the second ACCT not being completed and updated properly, and staff not being adequately trained in ACCT assessments.

We also found it very difficult to understand why the nurse had assessed Mr B as suitable to hold his medication in-possession given his known risk factors for suicide and self-harm and recent suicide attempts in the community.

Mental health

Mental ill-health is one of the most prevalent and challenging issues in prisons and is closely associated with high rates of suicide and self-harm in custody. In 2016, we published a thematic review of lessons to be learned from our investigations into self-inflicted deaths in prisons where mental health issues were involved.[8] We found that the first step in providing appropriate care to someone with mental health problems is the identification of their needs. Without accurate diagnosis, it is very difficult to provide appropriate treatment and support. Unfortunately, some mental health conditions cause sufferers to present difficult and challenging behaviour, which staff may deal with as a behavioural rather than a mental health problem. When this leads to a punitive rather than a therapeutic response, this may only worsen the prisoner's underlying mental ill-health.

We also noted that prisons need to be especially vigilant about the care of prisoners who are being considered for, or are awaiting, transfer to a secure hospital.

8 Learning from PPO investigations: Prisoner Mental Health (January 2016) available on www.ppo.gov.uk.

Mr C's case shows the need for such vigilance.

Mr C, who was 29, was serving an indeterminate sentence for public protection[9] for robbery with a tariff (the minimum amount of time he had to spend in prison before he could be considered for parole) of less than two years.

He had a significant learning disability, personality disorders, challenging behaviour, a history of substance misuse, self-harm and attempted suicide. He had initially progressed to an open prison but he absconded and was returned to closed conditions. Five years before his death he was found hanging in his cell. He was cut down and transferred to a medium secure psychiatric unit. He was later transferred back to prison because he became violent after using psychoactive substances (PS).

Mr C was under the care of the mental health team. His behaviour fluctuated, typically deteriorating whenever a parole hearing was imminent. He expressed despair about being in prison so long after the expiry of his tariff. He was transferred to the prison's inpatient healthcare unit after he told staff that he intended to kill himself. Mr C's care was complicated by his frequent PS use. He was managed under ACCT procedures in the last five months of his life.

A few months before he died, the Parole Board deferred a decision about his release. Mr C self-harmed, made a ligature and swallowed razor blades. During the last two weeks of his life, Mr C's mental health deteriorated further. He refused to take medication, would not engage with staff, remained in bed with his eyes closed, intermittently refusing food and soiling his bed. Psychiatrists referred him for an assessment for admission to a secure psychiatric hospital but this did not happen before Mr C died.

A week before he died, staff assessed Mr C's risk to himself as having reduced to 'low', on the grounds that he had not self-harmed for two weeks, and his observations were reduced from two an hour to one an hour. Three days before he died, staff held an 'enhanced' ACCT review (which is used when a prisoner needs additional case management to manage their "heightened or exceptional risk of harm to self, others and/or from others").

The day before he died, Mr C was found banging his head on the wall continuously until it bled. Staff considered constant supervision but decided instead to increase his nursing observations. In the event, these observations were not always carried out as frequently as they should have been. In the early hours of the following morning, an officer found Mr C hanged in his cell. He died in hospital the next day.

9 Imprisonment for public protection (IPP) sentences were introduced in 2005 and were designed to protect the public from serious offenders whose crimes did not merit a life sentence. Offenders sentenced to an IPP are set a minimum term (tariff) which they must spend in prison. After they have completed their tariff they can apply to the Parole Board for release. The Parole Board will release an offender only if it is satisfied that it is no longer necessary for the protection of the public for the offender to be confined. If offenders are given parole they will be on supervised licence for at least 10 years. If offenders are refused parole they can only apply again after one year. The sentence was abolished in 2012, although existing IPP prisoners continue to serve their sentences.

Mr C was an extremely challenging prisoner to manage and we found that both prison and healthcare staff treated him with care and compassion. His ACCT reviews were multi-disciplinary and, overall, we found much to commend.

However, we do not consider that Mr C should have been assessed as a low risk to himself during the last week of his life. Although he had not self-harmed for two weeks, the fact that he was not engaging with staff was, in itself, a cause for serious concern. His mental health had been deteriorating for some weeks and he had recently self-harmed. He was considered sufficiently mentally unwell to have been referred for a transfer to a psychiatric unit. He was also known to be very stressed about his forthcoming parole review.

We were also very concerned that both prison and healthcare staff told us that they could not recall a single case of a prisoner being transferred to a secure psychiatric hospital within the Department of Health's 14-day target. They said that the process typically took months.

Segregation

Segregation is an extreme and isolating form of custody used for prisoners who have misbehaved or who cannot be kept safely in normal prison accommodation. It inherently reduces protective factors against suicide and self-harm, such as activity and interaction with others, and for this reason should only be used in exceptional circumstances for those known to be at risk of taking their own life.

We recognise that some vulnerable prisoners may also be very challenging. This can leave prison staff with some very difficult decisions about where prisoners managed under ACCT procedures should be held in order to minimise the risk of harm to themselves and others. As a result, there will sometimes be exceptional circumstances to justify holding prisoners at risk of suicide or self-harm in segregation units. However, this should only happen when all other options have been considered and exhausted.

Mr D, who was 35, received an imprisonment for public protection (IPP) sentence for robbery with a tariff of two years and nine months. After five years in custody he was released, but three years later he returned to prison when he breached the terms of his licence.

During the three years after his return to prison, he repeatedly told staff he could not cope with his sentence and sought help from healthcare for anxiety. He was often challenging to manage.

Three weeks before he died, Mr D was moved to the segregation unit after he and two other prisoners barricaded themselves in a cell. That evening, Mr D made cuts to his wrist and staff began ACCT procedures. He was assessed by the mental health team, GPs and a psychiatrist. He was offered medication for anxiety and depression but often refused to take it because he said it made him feel worse.

Mr D said his IPP sentence was "killing him" and that he was concerned at plans to recategorise him from category C to B, which he feared would mean a move to a prison further from his family. He repeatedly told staff that he would kill himself after his next visit from his family.

Mr D's mother visited him a week later. On the same day, he was told he was being recategorised to B. At an ACCT review that afternoon, staff considered that Mr D's risk of suicide and self-harm had increased but they did not increase the frequency with which he was checked (which remained at once an hour). In the early hours of the next morning, an officer found Mr D hanged in his cell.

We were concerned at the length of time Mr D spent in segregation, which should only be used in exceptional circumstances when a prisoner is subject to ACCT procedures, and we saw no evidence that any alternatives had been considered. Important safeguards for segregated prisoners at risk of suicide or self-harm were not followed. For example, the mental health team did not assess Mr D within 24 hours of starting ACCT procedures, and segregation review boards did not take place when they should have. We considered that Mr D was not sufficiently protected by the ACCT procedures which became formulaic and not focused on his risk. There were failings in the way staff managed his risk, particularly in case reviews and caremaps, and the level of observations at the time of Mr D's death did not reflect the risk he posed to himself.

We also considered that Mr D's IPP sentence and the uncertainty about how long he might have to remain in prison caused him significant anxiety and it is hard not to conclude that they played a key role in his decision to kill himself.

Finally, the clinical reviewer concluded that the healthcare Mr D received for his mental health problems was not equivalent to that which he could have expected to receive in the community. It is likely that this also contributed to his death.

Emergency response

The PPO only investigates those cases where an individual has died. We know that, in addition to the number of self-inflicted deaths, there were also incidents where a prisoner was successfully resuscitated after a suicide attempt, albeit sometimes with life-changing injuries. We know from this that a confident and effective emergency response can save lives.

To achieve this, it is essential that uniformed and healthcare staff understand their responsibilities during medical emergencies, including:

- using the correct emergency code to communicate the nature of a medical emergency
- entering the cell to provide assistance where it is safe to do so
- arriving at the scene with relevant emergency equipment
- ensuring there are no delays in calling an emergency ambulance
- escorting paramedics through the prison promptly to the scene

Unfortunately, we still see too many cases where there are significant failings in the emergency response, as the case of Mr E illustrates.

Mr E, who was 38, was three years into a 20-year sentence for rape and robbery. It was not his first time in prison. He had a history of self-harm and was managed under ACCT procedures on occasions, most recently two months before he died.

He also had a history of substance misuse and repeatedly sought opioid-based medication for what he said was chronic pain. Prison GPs recognised the dangers of long-term opiate prescribing and appropriately offered him opiate substitution therapy to help him withdraw. Mr E was very resistant to this and staff suspected that he was obtaining opioid-based drugs illicitly from other prisoners.

Early one morning, an officer conducting a roll check saw Mr E hanging from a ligature in his cell. The officer did not enter the cell but called for assistance. Other officers arrived and, although Mr E showed no signs of life, they tried to resuscitate him until paramedics arrived and pronounced him dead. Mr E left a note in his cell saying he was being bullied by other prisoners and some prisoners told the PPO investigator that Mr E had had drug-related debts.

By its very nature, drug trafficking and bullying take place under the radar and we were satisfied that prison staff had no reason to believe that Mr E was at risk of suicide at the time of his death. However, we found a number of deficiencies in the emergency response.

Prison service policy[10] on entering cells at night says that, under normal circumstances, authority to unlock a cell at night must be given by the night orderly officer and a cell should be opened with a minimum number of staff present. However, the PSI goes on to say that the preservation of life must take precedence over this and where there is or appears to be a threat to life, staff may open and enter cells on their own if they feel safe to do so after performing a dynamic risk assessment.

Prison service policy[11] also requires prisons to have clearly understood emergency codes to communicate the nature of a medical emergency. Radioing a medical emergency code should prompt healthcare staff to attend immediately with the appropriate equipment, and the control room to call an ambulance immediately.

In Mr E's case, the officer could clearly see Mr E hanging and we considered that he should have entered the cell immediately to cut Mr E down without waiting for other staff to arrive.[12] We were also concerned that the officer radioed for staff assistance when he saw Mr E, instead of radioing a medical emergency code. As a result, there was a delay of 12 minutes before an ambulance was called.

Although these shortcomings did not affect the outcome for Mr E, who had been dead for some time when he was found, they could make the difference between life and death in other medical emergencies when every minute may count.

We were also concerned that, contrary to national guidelines,[13] the staff who found Mr E tried to resuscitate him, despite the presence of rigor mortis and their belief that Mr E had been dead for some time. While we understand the wish to attempt resuscitation, trying to resuscitate someone who is clearly dead is distressing for staff and undignified for the deceased.

“Radioing a medical emergency code should prompt healthcare staff to attend immediately with the appropriate equipment, and the control room to call an ambulance immediately.”

10 PSI 24/2011, Management and security of nights

11 PSI 03/2013, Medical emergency response codes

12 We have been concerned during the year by the number of relatively inexperienced staff who have told us that their understanding is that they must never enter a cell on their own under any circumstances. This is something the prison service needs to address.

13 European Resuscitation Council Guidelines for Resuscitation 2015, which were shared with prison managers in September 2016.

Deaths from natural causes

Deaths from natural causes continued to account for the majority (54%) of our fatal incident investigations and, as in previous years, the majority (53%) of deaths from natural causes in 2018/19 were of men over 60. This is largely explained by the increase in older prisoners and associated age-related conditions.

However, contrary to all expectations,[14] the number of deaths from natural causes has fallen for two years in a row, going from 212 in 2016/17 to 180 in 2018/19, a 15% drop. As the number of elderly prisoners remains high, the reasons for this fall are not yet understood.

Our natural cause investigations focus in particular on the need for prisons to provide appropriate healthcare at a level equivalent to that which could be expected in the community. In doing this, we rely heavily on the clinical reviews commissioned by NHS England and the Health Inspectorate Wales.

We also examine whether security measures and broader prison management were proportionate to the risk posed by the individual, and whether dying prisoners and their families were treated with appropriate sensitivity and respect.

Healthcare

In many of our investigations, we found evidence that healthcare staff had treated prisoners who had died from natural causes in a caring and compassionate manner, which was judged by the clinical reviewers to be equivalent to the treatment they could have expected to receive in the community. The case of Mr F is an example of good practice.

14 For example, Learning from PPO investigations: Older Prisoners (June 2017) available on www.ppo.gov.uk.

Mr F, who was 64 years old, was serving a 17-year sentence for sexual offences. About six years into his sentence, he told healthcare staff he had felt unwell for the previous 12 days. He was sent to hospital that day with a suspected chest infection, but tests showed he had lung and liver cancer.

Following his diagnosis, prison healthcare staff and hospital staff monitored and reviewed Mr F regularly. Comprehensive care plans were implemented by the healthcare team who also sought advice from specialist cancer care providers.

After further tests, hospital staff told Mr F his condition was terminal. Over the months that followed, both healthcare staff and hospital staff reviewed Mr F regularly in line with his care plans. He completed three cycles of palliative chemotherapy and began both radiotherapy and immunotherapy. Appropriate adaptations were made to his cell and he was well supported by both staff and prisoners.

Mr F's condition continued to deteriorate and he was admitted to hospital. Hospital staff considered there were no further active treatment options available to him and he was discharged back to prison. He was located in the prison's palliative care suite and 24-hour nursing care was put in place to cater for his increasing health needs. Mr F died from lung cancer and secondary liver cancer about two months after his terminal diagnosis.

We were satisfied that Mr F received a good standard of care at the prison. The day-to-day management of his condition was of a good standard and prison healthcare staff worked closely with both hospital staff and specialist care providers to ensure his health needs were met in line with best practice and National Institute for Health and Care Excellence (NICE) guidelines. The end-of-life care provided by the prison was also of a good standard. The clinical reviewer considered that the frequency and quality of the reviews completed by healthcare staff was higher than would be expected in the community and equivalent to that of a hospice setting.

However, unfortunately not all prisoners receive this standard of care. Too many investigations found instances of healthcare staff failing to make urgent referrals to specialists when they had concerns that a prisoner might have cancer. Delays can prevent early diagnosis, early treatment and even result in unnecessary deaths. Similar problems arose when healthcare staff failed to review and treat abnormal blood test results. Our investigations also found instances where clinicians were unaware of, or failing to keep up to date with, NICE guidelines for managing chronic conditions, such as chronic obstructive pulmonary disease or heart disease. This can result in unnecessary exacerbation of the condition and increased pain for the patient.

In most healthcare settings, we saw evidence of staff using some form of early warning score to assess and respond to acute illnesses. However, not all staff seemed to know what certain scores meant and how they ought to respond, which sometimes led to prisoners remaining in prisons, acutely ill, rather than being admitted to hospital.

It is important that prisoners receive effective continuity of care when they move into custody from the community, or from prison to hospital and back again, including good communication between healthcare professionals in both settings. On occasions, our investigations found examples of medical records, particularly community medical records and hospital discharge information, not being properly managed or shared and, as a consequence, prisoners did not receive appropriate treatment. Prisons also frequently failed to record the reasons for prisoners not attending planned appointments.

“It is important that prisoners receive effective continuity of care when they move into custody from the community, or from prison to hospital and back again.”

The case of Mr G illustrates a number of shortcomings.

Mr G, a 50-year-old foreign national, was remanded to prison on a European arrest warrant for extradition. He spoke limited English.

When he arrived in prison, healthcare staff noted that Mr G was frail with: a large skull depression from a brain injury; impaired vision, hearing and memory; reduced mobility due to right-sided weakness; and limited use of his right arm. He was considered vulnerable because of his health issues and he was located in the prison’s vulnerable prisoner unit.

Prison and healthcare staff became increasingly concerned about his physical and mental health, as he became unkempt and incontinent and drank his own urine. A nurse asked the virtual ward team (which provides enhanced nursing care on wings) to consider Mr G, but no action was taken. A psychiatrist concluded that Mr G’s problems were due to his brain damage and consequent inability to communicate, as well as depression and social issues.

Mr G had limited contact with healthcare staff as he did not attend several appointments. About six weeks before Mr G’s death, a nurse passing his cell noticed it was squalid and smelt and that Mr G was in poor condition. She completed a full assessment of Mr G’s needs and took steps to begin addressing his health and social care problems. This included formal referrals to social services and to the virtual ward team.

About six weeks later, a prison officer found Mr G unresponsive in his cell. Resuscitation was not attempted because there were signs of rigor mortis. The post-mortem found that Mr G had died of a heart attack.

Mr G had significant physical, cognitive and communication difficulties as a result of historic brain injury. Our investigation found numerous failings and we agreed with the clinical reviewer that the standard of healthcare he received in prison was below that he could have expected to receive in the community. Although these failings are unlikely to have contributed directly to Mr G's death, we could not ignore the unacceptably poor treatment of a vulnerable man with enduring and complicated health needs.

We recognised that Mr G's problems would have made him challenging to support in any environment. Nevertheless, we did not consider that it was acceptable that this vulnerable man was left in the same clothes and a dirty bandage for six weeks because he was unable to dress himself, urinating on the cell floor and drinking his own urine. We considered that healthcare staff should have been more proactive in assessing his needs, putting care plans in place, arranging social care and considering him under the complex case arrangements.

Mr G missed several health appointments but, given his language difficulties, it is not clear whether he was aware of them or the healthcare processes, and the reasons for his non-attendance were not followed up. We were also concerned that Mr G was not referred to the prison's equalities officer so that consideration could be given to reasonable adjustments and how best to support him.

In Mr H's case, we were concerned that he did not receive a good standard of mental health care.

Mr H, who was 27, was serving an IPP sentence for robbery and sexual offences with a tariff of four years and had been in prison since 2006. Mr H had a personality disorder and was a prolific self-harmer. He had a long history of swallowing small metal objects and inserting wire and other objects into his penis. Prison staff monitored him under ACCT on 61 occasions while he was in prison. He was regularly admitted to hospital with abdominal pain caused by swallowing objects and underwent surgery on several occasions. Shortly before his death, Mr H complained of stomach pain and was taken to hospital as an emergency. Two days later he died in hospital of peritonitis caused by paperclips and wire lodged in his abdominal cavity, bowel and bladder which had accumulated over many years.

We were satisfied that prison staff did what they reasonably could to prevent Mr H self-harming, and that he received an appropriate standard of physical health care. However, the clinical reviewer concluded that the standard of mental health care provided to Mr H was not equivalent to that which he could have expected to receive in the community and we were concerned that mental health staff at the prison had not received training in the management of prisoners with personality disorders.

The case of Mr I below illustrates the problems that can arise when healthcare and prison staff do not communicate effectively.

Mr I, who was 55, was serving a 14-year sentence for sexual offences.

Four weeks before he died Mr I complained of pain in his abdomen. A prison GP saw him and diagnosed him with an acute abdomen (a medical term meaning sudden and severe abdominal pain which could be life-threatening). The GP asked for him to be sent to hospital for an urgent assessment. He was concerned that Mr I had pancreatitis and needed an abdominal scan.

A nurse told the prison's duty manager that Mr I needed to be escorted to hospital that day. That morning and again in the evening, the duty manager told the nurse that there were not enough staff to escort Mr I to hospital. Mr I stayed on his wing. A nurse checked his vital signs and gave him pain relief.

The next day, healthcare staff did not see Mr I and the duty manager did not arrange for him to be escorted to hospital as healthcare staff did not ask again.

The following morning, Mr I complained of pain. A nurse examined him and was concerned that he was still unwell and should have gone to hospital two days earlier. Another nurse told the duty manager that Mr I still needed to be escorted to hospital, and was told that he would be transferred later that day when more staff were available. That afternoon, a nurse saw Mr I and gave him pain relief. The duty manager finished her shift, and handed over her role to another prison manager at 5pm. It is not clear whether she told him that Mr I needed to be escorted to hospital. However, Mr I remained on the wing overnight.

The following morning, a nurse told the duty manager that Mr I needed to go to hospital immediately. The duty manager arranged for Mr I to be escorted to hospital that day.

Mr I was admitted to hospital. His condition deteriorated and he was diagnosed with cancer of the oesophagus. He died a month later.

We were very concerned that when a prison GP asked for Mr I to be escorted urgently to hospital, he remained in prison for another 72 hours as healthcare staff did not explain the urgency to prison staff. We were also concerned that, when he was not transferred immediately, healthcare staff did not review Mr I's condition and did not escalate the issue to the Head of Healthcare.

We considered that this was unacceptable and we shared the clinical reviewer's view that the healthcare Mr I received was not equivalent to that he could have expected in the community.

This was the fifth occasion in two years in which we had concluded that the healthcare at the prison was not of the required standard. We recommended that senior managers in HMPPS and NHS England should address this highly unsatisfactory state of affairs.

End-of-life care

The ageing prison population means that the prison service now has to accommodate prisoners with terminal and incurable illnesses. This has brought new challenges for both prison regimes and facilities. To overcome these challenges, a number of prisons have built palliative care cells or units for prisoners requiring specialist end-of-life care. Other prisons have developed links with local hospices to enable prisoners to receive treatment outside the prison. We welcome the publication of the Ambitions Partnership Dying Well in Custody Charter and self-assessment documents which were published in April 2018 and aim to promote quality palliative care for prisoners.

Our investigations over the last few years have found that, by and large, prisons are doing all they can to ensure that prisoners die in a dignified and humane way with the care and support they require. However, this is by no means always the case and there are particular lessons to be learned about care planning, applications for compassionate release, the involvement of family and the use of restraints on prisoners who are terminally ill and at the end of their life.

“

Our investigations over the last few years have found that, by and large, prisons are doing all they can to ensure that prisoners die in a dignified and humane way with the care and support they require.”

Mr J, who was 74, was serving an IPP sentence for sexual offences. He had been transferred to an open prison. He had a number of long-term health conditions, including type 2 diabetes, heart disease, high blood pressure and a history of back pain. He was also overweight and used a wheelchair to help him move around. He had a prisoner ‘buddy’ to help collect his meals and clean his room. He suffered a number of falls.

Mr J was moved to an unstaffed detached house, separate from the main prison, which is designed to help prisoners develop independent living skills before release. About three months later, he fell out of bed and could not get up. An officer found him over an hour later and called for assistance. Another officer attended. They called an ambulance and kept Mr J warm with blankets on the floor. He was taken to hospital where he was diagnosed with a spinal injury. His health deteriorated and he developed pneumonia and died of a heart attack in hospital 10 days later.

In general Mr J’s healthcare at the prison was at least equivalent to that he could have expected to receive in the community. However, we were concerned that an elderly man with a history of falls was located in an unstaffed detached building without a healthcare or social care assessment and without adequate support to ensure he was safe. When Mr J fell in his room at night, he had no means of calling for assistance and was fortunate to have been found as quickly as he was.

Restraints

When prisoners have to travel outside the prison, for example to attend hospital, a risk assessment is conducted to determine the level of the security arrangements required, including restraints. The prison service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity. Any restraints used should be necessary and decisions should be based on the security risk, taking into account factors such as the prisoner's current health and mobility.

Unfortunately, we continue to see very many cases in which very elderly, frail and/or very unwell prisoners with limited mobility were escorted to hospital in handcuffs and some remained restrained until shortly before they died. This is uncomfortable and undignified for prisoners and upsetting for their families. It is also distressing for prison staff to be chained to a dying prisoner.

Case law on this issue is clear following a judgement in the High Court – the use of handcuffs on a prisoner who is receiving treatment or care must be necessary and proportionate.[15] It is simply unacceptable that such inhumane practices are allowed to continue. This office has been vocal on this point for some time and the leadership of the prison service should reflect on why some establishments are able to address it successfully while others seem unable to do so.

The case of Mr K is just one example.

> Mr K, who was 75 years old, was serving an IPP sentence for sexual offences. He had a complex medical history including a cardiac pacemaker, high blood pressure and type 2 diabetes.
>
> Mr K was diagnosed with a urine infection. An ambulance was called and he and was taken to hospital. Two officers escorted him and he was restrained by an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer).
>
> The manager who authorised the restraints assessed Mr K's risk to the public as high but his risk of hostage taking, escape and external assistance was low. The risk assessment also noted that Mr K could only move short distances, used a walking stick, needed help for all his care needs and had very poor vision.

We found it difficult to understand how the prison concluded that restraints were necessary for an elderly and infirm man, with limited mobility, and who was escorted by two prison officers. Too much weight was given to Mr M's original offences rather than his actual risk at the time.

15 R (on the application of Graham) v Secretary of State for Justice [2007] All ER (D) 383 ... Court, Mitting J) The Queen's Bench Division of the UK.

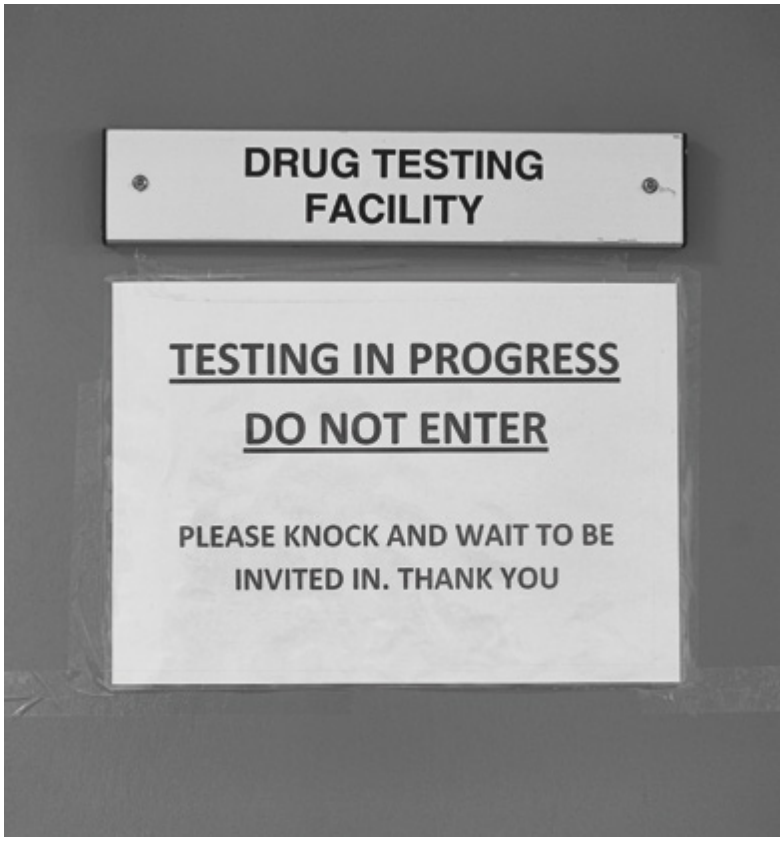
Drug-related deaths

It is difficult to give an exact figure for the number of drug-related deaths we have investigated as the term covers such a range of circumstances. We can say that there were 36 'other non-natural deaths' in 2018/19. This included a small number of cases where post-mortem and toxicology reports were unable to establish the cause of death, but most of these deaths were drug-related. There were a further 23 deaths awaiting classification at the end of the year and experience suggests that the majority of these deaths will also prove to have been drug-related.

These figures cover deaths where an accidental or intentional drug overdose was the primary cause of death or where drug use was a contributory cause of death. However, that does not give the full picture of the damage that drugs are causing in prisons, approved premises and immigration removal centres. Toxicology tests are not always undertaken and, even where they are, they will not always detect some of the many strains of psychoactive substances. At least one homicide has occurred when gangs were vying for the control of drugs on a wing,[16] and it is impossible to say how many suicides may have been prompted by drug-related debts and bullying or by the mood-altering effects of drugs.[17]

Psychoactive substances (PS) continued to be a serious problem across the prison estate, and increasingly in immigration removal centres and probation approved premises as well. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting, and can be particularly dangerous when taken in combination with some prescription medications. People under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is also potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

Although PS was involved in many drug-related deaths, cocaine, heroin and prescription drugs were also involved.



16 See also the case of Mr P in this report in which the victim was incapacitated by drug use.

17 See, for example, the case of Mr E in this report.

The ready availability of drugs

One of the most worrying aspects of the drug-related deaths we have investigated is the apparent ease with which prisoners were able to access drugs, even in segregation units and high security prisons. Although most prisons were doing their absolute best to limit the supply and demand for drugs, most of the governors and staff we spoke to told us that they were struggling to deal with the problem. We have been concerned that individual prisons were being left to develop and implement local drugs strategies in a piecemeal fashion without sufficient guidance and support from the centre. We have, therefore, welcomed the fact that in April 2019, HMPPS finally produced a strategy and guidance for reducing the supply of and demand for drugs in prisons, as well as building prisoners' recovery from drugs. Every prison is different and each prison will now need to use the guidance to identify their key drug issues and revise their local drugs strategy to address these issues. We hope this will produce a noticeable reduction in drug-related deaths in 2019/20.

"Although most prisons were doing their absolute best to limit the supply and demand for drugs, most of the governors and staff we spoke to told us that they were struggling to deal with the problem."

In the case studies below, we examine some of the many ways in which drugs have contributed to deaths.

Accidental or intentional overdoses

Mr L, who was 42, was serving a sentence for robbery. Mr L had a history of illicit drug use and was found to be under the influence of illicit substances, thought to be PS, on a number of occasions. On at least one occasion, Mr L had had to be given an injection of naloxone (used in an emergency to reverse the effects of opioid overdose). He continued to use illicit substances and talked openly about his use when challenged. After each event, staff warned him of the dangers of PS use and referred him to the substance misuse team for help and support, but Mr L did not engage with the services offered to him.

On the afternoon of Mr L's death, an officer saw Mr L slumped in the far corner of his cell. The officer walked to the wing office to ask his colleagues for help. When the officers entered the cell, they found Mr L unresponsive and immediately radioed a medical emergency code, and began cardiopulmonary resuscitation (CPR). Nursing staff and paramedics arrived but could not resuscitate Mr L. The post-mortem found that Mr L had choked to death on his own vomit as a result of PS use.

Mr L's death was the third PS-related death at the prison in 2018. We were satisfied that Mr L had been offered appropriate support for his drug misuse and that staff responded appropriately when he was found under the influence of drugs. Unfortunately, he chose to continue using drugs, with fatal consequences.

We were, however, concerned that the officer who found Mr L unresponsive in his cell on the day of his death showed no urgency and did not call an emergency medical code because he thought "it was just another PS-related incident". As a result, there was a delay before an ambulance was called and healthcare staff arrived. We cannot say whether this delay affected the outcome for Mr L. It is important that staff understand that PS use can be life-threatening, and that a prompt emergency response is essential when a prisoner is found unconscious, whatever the cause.

Exacerbation of underlying conditions

We have investigated a number of cases where an apparently fit young man died unexpectedly because drug misuse exacerbated an undiagnosed underlying condition. An example is the case of Mr M.

Mr M, who was 36, was serving a sentence for grievous bodily harm. He had a history of substance misuse in the community and he used PS frequently in prison, sometimes daily. Mr M made good efforts to address his drug use. He attended several courses and led group sessions to encourage other prisoners to stop using drugs.

On the day of his death, Mr M's cellmate woke in the morning to find him struggling for breath before he collapsed. The night patrol officer entered the cell promptly and began CPR. Nurses, emergency equipment and paramedics also arrived quickly but Mr M could not be resuscitated. The post-mortem examination and toxicology tests found that Mr M had used PS before his death and had died from the effects of PS on undiagnosed heart disease.

We considered that Mr M had received good support to address his substance abuse, and the clinical reviewer was satisfied that Mr M's heart disease was asymptomatic and that healthcare staff had not missed any opportunities to diagnose it. However, we were concerned that Mr M's death was the fourth PS-related death at the prison in 2018 and that the prison's strategy to reduce supply and demand was not sufficiently well developed.

Other drug-related dangers

Mr N, who was 31, was serving a sentence for robbery. He had a long history of substance misuse and was frequently found under the influence of PS or other illicit drugs in prison. He received support from the mental health team and substance misuse services but he failed to engage and continued using illicit drugs.

Mr N pressed his emergency cell bell one morning but it was 16 minutes before an officer answered it. He found Mr N's cell filled with smoke and Mr N calling out for help. Other staff arrived and put out the fire. When they entered the cell, they found Mr N sitting on the bed with his clothes burnt off and severe burns to most of his body. He was conscious but appeared unable to comply with staff instructions. Nursing staff treated him until paramedics arrived and took Mr N to hospital. His injuries were not survivable and he died of burns two days later.

It appears that Mr N had accidentally set himself on fire while smoking PS in his cell and may not have reacted initially because he was under the influence of the drug.

We were satisfied that the prison had offered Mr N support and advice with his substance misuse issues and that Mr N had received a standard of care for his injuries equivalent to that which he could have expected to receive in the community. We commended staff for the emergency care they provided to Mr N during a traumatic and distressing incident.

However, the 16-minute delay in responding to Mr N's cell bell before he was discovered with severe burns was unacceptable. Cell bells should be answered promptly, and HM Inspectorate of Prisons (HMIP) have an expectation, which we share, that they should be answered within five minutes (other than in exceptional circumstances). If the officer on duty had responded to Mr N's cell bell promptly, his life might have been saved. The burns specialist who treated Mr N said that in his opinion the delay "definitely affected the outcome" for Mr N. We recommended that the governor initiate a disciplinary investigation into the officer's behaviour.

Drug-related suicides

Mr O, who was 32, was serving a sentence for assault. Two weeks before he died, he was found under the influence of PS and referred to the substance misuse team. His cellmate told us that Mr O used PS every day and was in debt to another prisoner as a result.

The day before his death, Mr O told an officer he was in debt and asked if he could move to another wing. The following day he was told that a move was being arranged. His cellmate told us that Mr O was "panicking" about his drug debts. Shortly afterwards Mr O was found hanged in the toilet recess of his cell.

Mr O feared for his safety because of drugs debts. While prison staff took some action to address this during the last 24 hours of his life, we saw no evidence that they had considered the impact this had on his risk of suicide and self-harm or considered whether to start ACCT procedures.

We were also concerned that that there was no evidence that staff had any meaningful interaction with Mr O during his seven months at the prison. There were very few entries in his case notes and none relating to his welfare. One-to-one contact with staff is particularly important for prisoners, such as Mr O, who do not work or attend education and therefore spend much of the day locked in their cell. While more meaningful contact would not necessarily have identified Mr O's drug use at an earlier stage, it meant that prison staff had less opportunity to identify any issues he had.

We see too many cases where staff appear to have no meaningful contact with prisoners. We hope that the new key worker scheme will help to address this.

"One-to-one contact with staff is particularly important for prisoners, such as Mr O, who do not work or attend education and therefore spend much of the day locked in their cell."

Homicides

Homicides remain at mercifully low levels: there were four in 2018/19, just 1% of the total of 334 deaths and a drop from seven homicides the previous year. However, while uncommon, the killing of those in the care of the state is a particularly shocking and serious matter. At the same time, these are some of the hardest deaths to learn lessons from, not least because the PPO can only complete an investigation once any criminal proceedings have been completed.

The homicide in the following case study took place in 2017, but we were only able to complete our investigation in 2018/19.

Mr P, who was 22, was serving a life sentence for the murder of his baby daughter. He was located in the prison's vulnerable prisoner unit. About three weeks before his death, he began sharing a cell with another prisoner who was serving a sentence for a sexual offence.

Early in the morning, Mr P's cellmate pressed the emergency cell bell and told staff that he thought Mr P had self-harmed. Healthcare staff responded immediately but did not attempt resuscitation as Mr P was clearly dead. A post-mortem examination established that Mr P had died from head and neck trauma. Toxicology results also indicated that he had used PS before his death. His cellmate was subsequently convicted of his murder.

"...these are some of the hardest deaths to learn lessons from, not least because the PPO can only complete an investigation once any criminal proceedings have been completed."

Our investigation found that there was no information that suggested that Mr P's cellmate was a risk to other prisoners in general or to Mr P in particular. We were satisfied that prison staff could not have predicted the cellmate's actions.

However, we were concerned that the mix of prisoners in the vulnerable prisoner unit was a challenging one, and that there was no evidence that staff in the unit were sufficiently alert to the possibility that Mr P might be at risk because of his offence.

We were also concerned that Mr P's cellmate was able to assault him because Mr P was incapacitated by effects of using PS.

Women prisoners

In 2018/19, there were 11 deaths of women prisoners, a slight increase from eight deaths in 2017-18. Three were self-inflicted deaths, an increase from one in 2017-18. Of the remaining eight deaths, five were from natural causes, one was apparently drugs-related and two are awaiting classification.

In the case of Ms Q, we found that staff did not properly assess her risk of suicide and self-harm, the same issue we often find in our investigations into the self-inflicted deaths of men in prison.

> “We considered that staff placed too much reliance on Ms Q’s own statements and not on the objective risk factors.”

Ms Q, who was 46, was serving a sentence for arson. She had a diagnosis of bipolar affective disorder and had been sectioned under the Mental Health Act on three occasions.

Ms Q was monitored under ACCT procedures when she first arrived in prison because she spoke of hopelessness and wanting to end her life. When she was transferred to another prison, staff monitored her under ACCT again for the first six weeks because she was unsettled by the move. Ms Q subsequently told staff on several occasions that she was distressed that her son wanted no contact with her and that she would take her life when she was released from prison. Healthcare staff referred her to a counselling service.

A few days before Ms Q died, her close friend on the wing was moved to another wing in the prison, leaving Ms Q feeling isolated. The next day, Ms Q told a prison counsellor that she intended to take an overdose of paracetamol once she was released from prison and that she could not do this while in prison because she had no access to paracetamol. The counsellor told wing staff who decided to monitor Ms Q, but they did not start ACCT procedures. Ms Q was found hanged in her cell four days later.

We were concerned that prison staff focused on Ms Q’s assertions that she would take her life after her release from prison and, on that basis, assessed that she was not at imminent risk of suicide in prison. There was no recognition that Ms Q repeatedly expressed thoughts of taking her own life and had a range of risk factors for suicide and self-harm. We considered that staff placed too much reliance on Ms Q’s own statements and not on the objective risk factors.

The following case study is of a natural-cause death investigated in 2018/19, although the death occurred in 2017/18. We found that clinical care was poor and not equivalent to the standard of care the women could have expected to receive in the community.

Ms R, who was 45 years old, was serving a sentence of four years six months for robbery and assault. She had diabetes, which was well controlled by diet alone. She was otherwise reasonably fit and well. She had a history of challenging and inappropriate behaviour in prison.

Shortly before her death, Ms R was moved to the segregation unit because of her disruptive behaviour. When a nurse tried to give Ms R her medication, she sat and then lay down on her cell floor. She resisted staff attempts to lock her cell door and was restrained and placed in the cell. The incident was not filmed because staff did not switch on their body-worn video cameras.

Ms R was then left lying on her cell floor for 21 hours. She did not eat anything during that period and was not seen to drink any fluids. A nurse visited Ms R's cell three times but did not examine her. By the time a nurse did examine her, Ms R was seriously unwell and was taken to hospital. She died three days later from organ failure, caused in part by complications arising from her diabetes.

We concluded that there had been serious failings and a worryingly uncaring attitude on the part of prison and healthcare staff that led to Ms R's death. We also raised concerns about the use of segregation in Ms R's case. While there is no evidence that the use of force contributed to Ms R's death, we were critical that the use of force on Ms R was not filmed as it should have been and that Ms R was not examined by a member of healthcare staff after force was used on her, as required by prison service policy.

Approved premises

There were 12 deaths of residents of probation approved premises (APs) in 2018/19. All were male. Of these, three were self-inflicted deaths, four were from natural causes, four were from other non-natural causes, and one is still awaiting classification. This was one more death than in 2017/18, when the deaths also included one female AP resident.

The case study below illustrates some of the difficulties of managing former prisoners in approved premises.

Mr S, who was 39, had been in prison for four years for robbery. He was released on licence and was required to live at an AP.

Mr S had used heroin and other illicit drugs from the age of thirteen. One of his licence conditions required him to engage with services in the community to address his drug and alcohol misuse. He received a regular prescription of Subutex (a heroin substitute) and began to engage with a community substance misuse partnership. He continued to struggle with his use of illicit drugs but he engaged with his offender manager and keyworker who offered continuing support.

A couple of weeks after his release, the community substance misuse team stopped Mr S's Subutex as he had provided a urine sample that indicated that he was negative for opiates and therefore no longer needed Subutex. Mr S was extremely upset about this and a few weeks later, he told AP staff that he had attempted to take his own life due to his frustration about not having his Subutex. AP staff supported Mr S under care action plan procedures and he was monitored over the next 48 hours to ensure he was safe. They arranged for him to receive Subutex again.

While his Subutex was stopped, Mr S tested positive for cocaine on five occasions, for cannabis on three occasions and once for tranquilisers. He later disclosed to staff that he was also using PS. He was issued with a formal warning for his continued drug use. Staff continued to provide ongoing support and he eventually provided negative test results for all illicit substances – although he was not tested for PS.

One morning, Mr S left the AP and went out, as he was entitled to do. That afternoon, he was found hanging from a tree in an area frequented by drug users. He was taken to hospital where he died two days later. Mr S left a note in his pocket saying that he had let his son down because of his lifestyle choices.

No post-mortem or toxicology tests were carried out, but it is hard not to conclude that illicit drugs, and PS in particular, played a role in Mr S's decision to hang himself. He had a history of substance abuse, found it hard to resist the opportunities to access illicit substances in the community, attributed an earlier suicide attempt to his frustration at having his drug treatment withdrawn, and implied in his suicide note and comments to staff that he was struggling to keep away from drugs.

Although AP staff were alert to the risks drug abuse posed to Mr S and tried to support him appropriately, we considered that their inability to test him for PS use meant that they might not have understood how acute those risks were.

The majority of AP residents are former prisoners. Given the prevalence of PS use among prisoners, we are concerned that the National Probation Service has still not developed an effective strategy and testing regime to deal with suspected PS use in approved premises, although we are told this is under consideration.

Court cells

We investigated a death in court cells for the first time in 2018/19. The circumstances of the death were very disturbing.

Mr T, a 43-year-old foreign national, was arrested under a European arrest warrant to face extradition proceedings. He was held at a police station and was then taken to court by Prison Escort and Custody Services. It was one of the hottest days of the year and the temperature exceeded 30°C. During the journey, which took two and a half hours, Mr T remained locked in a cell in an escort vehicle. The vehicle stopped for just under an hour at another police station to pick up more prisoners, during which time the ventilation was switched off.

When Mr T arrived at the court, he was taken to a cell which was not ventilated as the court's air conditioning was not working. After a couple of hours in the cell, Mr T became noisy and started acting bizarrely. Three hours after that he was found unresponsive in the cell. Staff and paramedics were unable to resuscitate him.

The post-mortem found that the cause of Mr T's death was hyperthermia (heat stroke) and hypertensive heart disease. The police estimated that the temperature in Mr T's cell was between 34 and 40°C at the time of his death.[18]

We were very concerned that there were inadequate contingency plans when the court's air-conditioning failed. Staff were aware that the temperature in the cells was excessively hot and we considered it unacceptable that Mr T was left in those conditions for nearly five hours.

Our investigation also found failings in the way in the way staff managed Mr T during his transfer to and time in the court cell. We were concerned that there was a lack of clarity about who was responsible for the wellbeing of those held in the court cells and that no organisation appears to be responsible for investigating the health and safety aspects of escort vehicles and court cells. We were also concerned that there was no defibrillator available at the court.

“We were concerned that there was a lack of clarity about who was responsible for the wellbeing of those held in the court cells and that no organisation appears to be responsible for investigating the health and safety aspects of escort vehicles and court cells. ”

18 This estimate was disputed by HM Courts and Tribunals Service at the inquest in June 2019. The actual temperature is not known as no readings were taken in the cells during the day. At the inquest, the Metropolitan Police confirmed that they took a temperature reading in the cells at 9pm which read 26.2°C. This was about six hours after Mr T's collapse and the cell door had been left open during this time, meaning that the cell had benefitted from the portable air conditioning.

Immigration detainees

There was only one death of a detainee at an immigration removal centre (IRC) in 2018/19 (a death from natural causes). This was a welcome reduction from four deaths at IRCs, two of which were self-inflicted in 2017/18.

The case study below is of a detainee who died in 2017, but whose investigation we completed in 2018/19.

The detainee had been designated as an 'Adult at Risk' by the Home Office. The purpose of the Adults at Risk policy is to ensure that adults who would be particularly vulnerable if detained, or kept in detention, are identified, and consideration is given to whether their detention, or continued detention, is appropriate given their 'at risk' status.

Mr U, who was 27, was facing deportation from the UK after serving a prison sentence for assault. He was monitored under ACCT several times when he was in prison. He also spent four months in a secure mental health hospital before being transferred to an IRC pending deportation. The Home Office designated him an Adult at Risk given his history of attempted self-harm and mental health issues. He moved IRCs several times, sometimes at his own request.

Mr U's behaviour at the IRCs was erratic: he punched a member of staff, he set fire to items in his room on two separate occasions and he was suspected of using PS. Mr U was diagnosed with schizophrenia but refused to take antipsychotic medication or to engage with the mental health team. 11 months after being sent to an IRC, Mr U was found hanged in his room.

Our investigation found that the 'Adult at Risk' designation seemed to act as no more than an administrative label. There was no evidence that staff gave any consideration to his 'at risk' status when he arrived at the IRC and it generated no protective measures to address his acknowledged vulnerability. Staff responded to Mr U's poor behaviour by using punitive measures rather than considering whether it indicated a deterioration in his mental health and that he might need support. The investigation also found that when Mr U was transferred between IRCs, there was no proper handover of his healthcare. This was particularly important for Mr U given he was an 'Adult at Risk' and had complex mental health needs.

Although there was little to indicate Mr U was at imminent risk of suicide before his death, we were concerned that custodial staff at the IRC were insufficiently aware of his risks and personal history. They did not obtain most of his previous suicide and self-harm records or make sufficient use of those they had. Had they done so they would have had a better understanding of the risks he posed to himself.

We also completed an investigation into a homicide that took place in an IRC in 2016:[19]

19 Our investigation was suspended while the police investigation took place.

Mr V, who was 64, had only been in the IRC for two days when he was killed by another detainee, Mr AA. Mr V did not know his attacker and did nothing to provoke the attack. Mr AA had spent some years in prison and in other IRCs before being transferred to the IRC where Mr V was located. He had displayed aggressive and anti-social behaviour towards staff, prisoners and detainees. He also had a history of mental health issues.

On the day of the attack, Mr AA entered a detainee's room asking for a lighter. Three detainees were present, including Mr V. When they told Mr AA that they did not have a lighter, he became agitated and started punching Mr V repeatedly in the head and body. Mr V suffered serious injuries. He was taken to hospital but never regained consciousness and died that evening.

Our investigation found that the IRC did not have access to the intelligence reports on Mr AA from his time in prison and in the other IRCs because HMPPS did not share intelligence records with IRCs managed by private contractors. This meant that the IRC could not carry out a proper assessment of the risks Mr AA posed to himself and others. The day before he attacked Mr V, Mr AA was responsible for two incidents of anti-social behaviour, which should have triggered staff to monitor him more closely in line with the IRC's anti-bullying policy. This did not happen. We also found that Mr AA did not have a mental health assessment while at the IRCs, and staff failed to recognise the need to review, and possibly restart, his antipsychotic medication.

Under 21s

There was only one death of a young person under 21 in 2018/19, compared to four the year before. There were a further three deaths of prisoners aged 21.

Mr W, who was 19, was on remand in a young offenders' institution (YOI) for assault and wounding with intent. It was his first time in custody. He had a history of mental health and substance misuse issues and had taken an overdose of paracetamol 12 months earlier and had self-harmed by cutting when he was arrested. Staff at court completed a suicide and self-harm warning form which travelled with him to the YOI. When he arrived at the YOI staff did not consider opening ACCT procedures but referred him to the mental health and substance misuse teams.

Over the course of five weeks in the YOI Mr W self-harmed on three occasions, began a dirty protest and self-isolated and did not collect his meals. Staff monitored him under ACCT procedures. He said that he found it difficult being in custody, that he was distressed at having no contact with his family, especially his mother, and that he was struggling to cope with his emotions when he was alone in his cell.

On the morning of his death, staff suspected that Mr W had tied a noose around his neck, but he denied it. An ACCT review was completed but did not raise his level of risk or increase the frequency with which he was observed. He refused to leave his cell to collect his lunch. That afternoon he was found hanged in his cell.

Mr W had a number of significant risk factors: he was very young; this was his first time in custody and he had only been at the YOI for five weeks; he had a history of serious self-harm, substance abuse and mental health issues; and he had no contact with his family.

We were concerned that staff did not assess Mr W's risk of suicide and self-harm when he arrived at the YOI. Although they later monitored him under ACCT, there were deficiencies in the way they did so. We considered that staff failed to take Mr W's many risk factors sufficiently into account when assessing and managing his risk, and placed too much reliance on his presentation. No one from the healthcare team or the mental health team attended 8 out of 10 ACCT reviews. There was no evidence to indicate whether staff had made any progress in allocating Mr W work or education to reduce the amount of time he had to spend alone in his cell, and no one obtained his mother's contact details. We were also concerned that staff missed opportunities to identify and address Mr W's increased risk on the day he died.

Learning Lessons from PPO investigations

The PPO's investigations into complaints and fatal incidents can identify areas for improvement and might result in recommendations to the establishment in question. We believe that there is much to be learned from collective analysis of the outcomes of our investigations. The PPO has developed a small, dedicated Learning Lessons team who, over the past nine years, have published more than forty bulletins and thematic reviews. These publications look at the PPO's casework as a whole to identify both good practice and, crucially, where the system is failing in its duty of care to prisoners, immigration detainees and young people in detention.

During 2018/19 we started work on two Learning Lessons publications. The first of these was a bulletin on responses to medical emergencies, due to be published in 2019/20. The second was an analysis of the natural cause deaths of young men. It will be a companion piece to our older prisoners thematic of 2017 and will be published in 2019/20. We also began a research project conducting focus groups in prisons to find out more about complaints handling in prisons, the findings of which will be published in a thematic report in 2019/20

The Learning Lessons team has broadened its work during the year, collaborating more with academics, taking new approaches to our publications, evidence gathering and focusing on the impact we have. The PPO was pleased to support the work of Dr Philippa Tomczak of the University of Nottingham who will be looking at the implementation of the PPO's fatal incident recommendations.

The Investigator

January 2019 saw the launch of The Investigator. This is a new type of publication from the PPO, designed to provide frequent information and updates to our stakeholders that is short and to the point.

Our January issue featured informative articles including:

The worrying increase of drug-related deaths in custody

Four main themes have emerged from our investigations:

1. Drugs are readily available in most prisons outside the high security estate, and are increasingly available in immigration removal centres
2. While the use of PS is the main drug problem in most prisons, there is also a problem in some prisons with illicitly traded prescription drugs
3. In many cases staff tell us they were unaware a prisoner was using drugs or being bullied over drug-related debts
4. Even prisons with sound local drug policies are telling us that they are struggling to stem the supply and demand for drugs or to intervene effectively

On this last point, most of the governors and staff we spoke to told us that they were struggling to deal with the problem, even where prisons have sound local drug strategies and appear to be doing their absolute best to limit the supply and demand for drugs. We outlined our concern that:

- prisons were being left to develop and implement local strategies themselves and in a piecemeal fashion
- prisons' capacity to identify PS was lagging behind developments in the drugs market
- prisons were taking different responses to those who are found in possession or to have used drugs, with some taking a punitive approach and others seeing this as counter-productive – governors told us that they want evidence-based advice on what works

Retention of video footage for use-of-force complaints

HMPPS expects all prisons to retain footage relating to serious incidents (such as use of force or assault) for a minimum of 12 months. We highlighted a case where a prison had not retained footage from a handheld camera that could have provided evidence. The case illustrated the lack of consistency in the retention of all forms of video footage in prisons and the impact that has on our ability to conduct fair and conclusive investigations.

Our second issue was published in May 2019 and provided highlights of the PPO/HMPPS Impact Symposium that took place in March 2019.

We will be monitoring feedback from stakeholders and we will adapt this publication based on the suggestions and views of the audience.

PPO/HMPPS Impact Symposium 2019

28 March 2019 saw the PPO/HMPPS Impact Symposium. This built on the Learning Lessons seminars that we had been hosting every year at Newbold Revel since 2013.

Our goal with the Impact Symposium was to discuss with senior HMPPS leaders:

- Why don't prisons implement PPO recommendations? What barriers do they encounter?
- How can we monitor and support the implementation of PPO recommendations?
- What more can we do to ensure that learning from PPO investigations is communicated to and embedded with front-line staff?

It was a full day's event, with a mix of presentations from our senior team, responses from HMPPS and group discussions. We were very pleased with the level of representation from HMPPS and delighted that the prisons Executive Director Phil Copple was able to attend and outline his thinking. There were some very useful outcomes and we are continuing the dialogue by sending a member of the PPO senior team to prison group directors' team meetings to share and discuss the challenges and any barriers to implementation.

Our Learning Lessons work strand continues to attract a wide and varied following, from those who work with or within the prison system, to the public more broadly. Ultimately, we hope that this will continue to help us to fulfil our aim to promote safer and fairer custody and community supervision.

Appendices

Statistical tables

Complaints

Table 1. Complaints received

	Total 2017/18	% of total 17/18	Total 18/19	% of total 18/19	Change 17/18 - 18/19	% change year on year
Prison	4,434	93%	4,648	94%	214	5%
Probation	310	6%	281	6%	-29	-9%
Immigration detention	46	1%	39	1%	-7	-15%
Secure training centre	0	0%	0	0%	0	0%
Total	**4,790**	**100%**	**4,968**	**100%**	**178**	**4%**

Table 2. Complaints accepted for investigation

	Total 2017/18	% of total 17/18	Total 18/19	% of total 18/19	Change 17/18 - 18/19	% change year on year
Prison	2,404	97%	2518	97%	114	5%
Probation	55	2%	38	1%	-17	-31%
Immigration detention	21	1%	28	1%	7	33%
Secure training centre	0	0%	0	0%	0	0%
Total	**2,480**	**100%**	**2,584**	**100%**	**104**	**4%**

Table 3. Complaints investigations completed

	Total 2017/18	% of total 17/18	Total 18/19	% of total 18/19	Change 17/18 - 18/19	% change year on year
Prison	2,292	97%	2,512	98%	220	10%
Probation	51	2%	35	1%	-16	-31%
Immigration detention	21	1%	22	1%	1	5%
Secure training centre	1	0%	0	0%	-1	-100%
Total	**2,365**	**100%**	**2,569**	**100%**	**204**	**9%**

Table 4. Prisons complainants 2018/19 (completed complaints)

	Number of complainants	% of complainants	Number of complaints	% of complaints
Male prison estate	1632	98%	2,471	98%
Female prison estate	34	2%	41	2%
Total	**1666**	**100%**	**2,512**	**100%**

Table 5. Complaints completed per prison complainant 2018/19

	Number of complainants	% of complainants	Number of complaints	% of complaints
11+	10	1%	148	6%
6 to 10	40	2%	286	11%
2 to 5	291	17%	753	30%
1	1325	79%	1325	53%
Total	**1666**	**100%**	**2,512**	**100%**

Table 6. Categories of complaints completed 2018/19

	Not upheld	Upheld	Total	Uphold rate
Property	495	414	909	46%
Administration	154	68	222	31%
Staff behaviour	118	44	162	27%
Regime	116	45	161	28%
IEP	108	25	133	19%
Work and pay	95	30	125	24%
Letters	81	38	119	32%
Categorisation	101	14	115	12%
Adjudications	83	22	105	21%
Money	49	30	79	38%
Accommodation	46	16	62	26%
Transfers	45	11	56	20%
Visits	42	11	53	21%
Prisoners	31	12	43	28%
Probation	27	15	42	36%
HDC	36	2	38	5%
Food	21	10	31	32%
Equalities	16	10	26	38%
Security	21	4	25	16%
Phone calls	22	2	24	8%
Resettlement	20	4	24	17%
Medical	6	4	10	**
Escorts	2	1	3	**
Legal	1	0	1	**
Parole	1	0	1	**
Total	**1,737**	**832**	**2,569**	**32%**

** Only given where 20 or more complaints were completed

Table 7. Prison complaints completed 2018/19

Prisons	Upheld	Not upheld	Total	Uphold rate	Population	Upheld complaints per 100 prisoners
Wakefield	40	122	162	25%	723	5.5
Long Lartin	34	112	146	23%	565	6.0
Frankland	42	100	142	30%	842	5.0
Lowdham Grange	36	68	104	35%	883	4.1
Full Sutton	20	65	85	24%	525	3.8
Rye Hill	16	65	81	20%	661	2.4
Swaleside	22	55	77	29%	1058	2.1
Littlehey	18	46	64	28%	1210	1.5
Isle of Wight	18	45	63	29%	1039	1.7
Gartree	14	48	62	23%	698	2.0
Whitemoor	14	47	61	23%	442	3.2
Berwyn	27	32	59	46%	1283	2.1
Belmarsh	16	38	54	30%	828	1.9
Whatton	13	36	49	27%	832	1.6
Dovegate	20	28	48	42%	1155	1.7
Pentonville	23	21	44	52%	1082	2.1
Highpoint North/South	15	27	42	36%	1284	1.2
Bullingdon	19	21	40	48%	1049	1.8
Doncaster	14	26	40	35%	1107	1.3
Woodhill	15	24	39	38%	599	2.5
Birmingham	15	23	38	39%	939	1.6
Leyhill	11	22	33	33%	513	2.1
Lindholme	11	20	31	35%	944	1.2
Wymott	5	26	31	16%	1147	0.4
Risley	7	23	30	23%	1057	0.7
The Mount	12	17	29	41%	988	1.2

Prisons	Upheld	Not upheld	Total	Uphold rate	Population	Upheld complaints per 100 prisoners
Hewell	11	18	29	39%	1098	1.0
Forest Bank	11	17	28	39%	1408	0.8
Oakwood	14	14	28	50%	2053	0.7
Manchester	8	19	27	30%	931	0.9
Nottingham	13	14	27	48%	794	1.6
Garth	15	10	25	60%	818	1.8
Brixton	10	11	21	48%	751	1.3
Onley	5	15	20	25%	729	0.7
Peterborough	9	11	20	45%	1143	0.8
Thameside	7	13	20	35%	1184	0.6
High Down	10	9	19	**	1124	0.9
Wayland	4	15	19	**	923	0.4
Ashfield	4	14	18	**	399	1.0
Parc	6	11	17	**	1627	0.4
Stocken	6	11	17	**	833	0.7
Wealstun	5	12	17	**	810	0.6
Channings Wood	7	8	15	**	696	1.0
Holme House	4	11	15	**	1206	0.3
Humber	4	11	15	**	941	0.4
Northumberland inc Acklington/Castington	4	11	15	**	1336	0.3
Bure	3	11	14	**	651	0.5
Wandsworth	4	10	14	**	1468	0.3
Durham	4	9	13	**	948	0.4
Elmley	5	8	13	**	1096	0.5
Dartmoor	5	7	12	**	631	0.8
Ranby	3	9	12	**	985	0.3

Prisons	Upheld	Not upheld	Total	Uphold rate	Population	Upheld complaints per 100 prisoners
Winchester	7	5	12	**	540	1.3
Bedford	5	6	11	**	353	1.4
Bronzefield	3	8	11	**	502	0.6
Grendon/Springhill	1	10	11	**	541	0.2
Isis	3	8	11	**	620	0.5
Lewes	8	3	11	**	613	1.3
Stafford	3	8	11	**	746	0.4
Wormwood Scrubs	4	6	10	**	1106	0.4
Bristol	5	4	9	**	432	1.2
Buckley Hall	3	6	9	**	435	0.7
Featherstone	1	8	9	**	619	0.2
Leeds	5	4	9	**	1055	0.5
Lincoln	4	5	9	**	538	0.7
Stoke Heath	5	4	9	**	717	0.7
Haverigg	2	6	8	**	261	0.8
Kirkham	2	6	8	**	645	0.3
Moorland	2	6	8	**	934	0.2
Norwich	2	6	8	**	702	0.3
Altcourse	5	2	7	**	1032	0.5
Aylesbury (YOI)	6	1	7	**	256	2.3
Erlestoke	4	3	7	**	504	0.8
Hollesley Bay	1	6	7	**	478	0.2
Lancaster Farms	2	5	7	**	553	0.4
Rochester	2	5	7	**	682	0.3
Send	5	2	7	**	227	2.2
Standford Hill	1	6	7	**	462	0.2

Prisons	Upheld	Not upheld	Total	Uphold rate	Population	Upheld complaints per 100 prisoners
Sudbury	3	4	7	**	571	0.5
Wetherby (YOI)	3	4	7	**	254	1.2
Cardiff	3	3	6	**	679	0.4
Exeter	2	4	6	**	486	0.4
Guys Marsh	2	4	6	**	392	0.5
Hull	0	6	6	**	995	0.0
Leicester	6	0	6	**	299	2.0
Swinfen Hall	1	5	6	**	581	0.2
The Verne	1	5	6	**	385	0.3
Chelmsford	2	3	5	**	635	0.3
Downview	0	5	5	**	284	0.0
Huntercombe	3	2	5	**	465	0.6
Liverpool	3	2	5	**	687	0.4
North Sea Camp	0	5	5	**	409	0.0
Thorn Cross	1	4	5	**	383	0.3
Coldingley	1	3	4	**	418	0.2
Maidstone	0	4	4	**	582	0.0
Preston	1	3	4	**	701	0.1
Warren Hill	1	3	4	**	247	0.4
Ford	1	2	3	**	541	0.2
Foston Hall	1	2	3	**	268	0.4
Hindley	0	3	3	**	547	0.0
New Hall	0	3	3	**	405	0.0
Portland	1	2	3	**	519	0.2
Brinsford	0	2	2	**	541	0.0
Deerbolt	2	0	2	**	414	0.5

Prisons	Upheld	Not upheld	Total	Uphold rate	Population	Upheld complaints per 100 prisoners
Eastwood Park	0	2	2	**	411	0.0
Feltham (YOI)	2	0	2	**	497	0.4
Hatfield	0	2	2	**	370	0.0
Styal	1	1	2	**	469	0.2
Swansea	0	2	2	**	382	0.0
Usk and Prescoed	1	1	2	**	525	0.2
Werrington (YOI)	0	2	2	**	117	0.0
Askham Grange	0	1	1	**	107	0.0
Drake Hall	0	1	1	**	324	0.0
Total	**811**	**1701**	**2512**	**32%**	**82417**	**1.0**

** Only given where 20 or more complaints were completed

*** Prison population figures taken from March 2019 monthly population figures

Table 8. IRC complaints completed 2018/19

Immigration	Upheld	Not upheld	Total	Uphold rate
IMM Brook House IRC	0	6	6	*
IMM Yarl's Wood IRC	1	4	5	*
IMM Colnbrook IRC	0	3	3	*
IMM Harmondsworth IRC	2	1	3	*
IMM Morton Hall IRC	2	1	3	*
IMM Loughborough Reporting Centre	1	1	2	*
Total	**6**	**16**	**22**	**27%**

Table 9. Probation complaints completed 2018/19

Probation	Upheld	Not upheld	Total	Uphold rate
NPS North East	0	8	8	*
NPS London	4	1	5	*
NPS Midlands	1	4	5	*
NPS South East & Eastern	3	2	5	*
NPS North West	1	2	3	*
NPS South West & South Central	3	0	3	*
NPS and Partnerships in Wales	0	2	2	*
CRC Kent Surrey & Sussex	0	1	1	*
CRC London	1	0	1	*
CRC Warwickshire & West Mercia	1	0	1	*
CRC Bristol, Gloucestershire, Somerset and Wiltshire	1	0	1	*
Total	**15**	**20**	**35**	**43%**

Fatal incidents

The PPO does not determine the cause of death. Deaths are categorised into classifications for allocation and statistical purposes based on information available at the time. Classifications may change during the course of an investigation, however they are not altered following the conclusion of the inquest.

Fatal incident investigations started	Total 17/18	% of total (17/18)	Total 18/19	% of total (18/19)	Change 17/18 – 18/19	% change year on year
Natural	188	59%	180	54%	-8	-4%
Self-inflicted	74	23%	91	27%	17	23%
Other non-natural**	39	12%	36	11%	-3	-8%
Homicide	7	2%	4	1%	-3	*
Awaiting classification	8	3%	23	7%	***	*
Total	**316**	**100%**	**334**	**100%**	**18**	**6%**

* The numbers are too small for the % change to be a meaningful indicator

**Other non-natural includes drug-related deaths, accidents and deaths where post-mortem and toxicology reports have been unable to establish cause of death

*** The number of awaiting classification cases in 2017/18 has been updated for this publication

Fatal incident investigations started	Total 17/18	% of total (17/18)	Total 18/19	% of total (18/19)	Change 17/18 – 18/19	% change year on year
Male prisoners (21 and over)	285	90%	308	92%	23	8%
Female prisoners**(21 and over)	10	3%	11	3%	1	*
Under 21 males	4	1%	1	0%	-3	*
Under 21 females	0	0%	0	0%	0	*
Male approved premises residents	10	3%	12	4%	2	*
Female approved premises residents	1	0%	0	0%	-1	*
Male IRC residents	5	2%	1	0%	-4	*
Female IRC residents	0	0%	0	0%	0	*
Male discretionary cases	1	0%	1	0%	0	*
Female discretionary cases	0	0%	0	0%	0	*
Total	**316**	**100%*** **	**334**	**100%*** **	**18**	**6%**

* The numbers are too small for the % change to be a meaningful indicator

** Includes male to female transgender prisoners. We began an investigation into the deaths of two transgender prisoners in 2017/18

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

Fatal incident investigations started	Natural	Self-inflicted	Other non-natural*	Homicide	Awaiting classification	Total
Male prisoners (21 and over)	170	83	31	4	20	308
Female prisoners** (21 and over)	5	3	1	0	2	11
Under 21 males	0	1	0	0	0	1
Under 21 females	0	0	0	0	0	0
Male approved premises residents	4	3	4	0	1	12
Female approved premises residents	0	0	0	0	0	0
Male IRC residents	1	0	0	0	0	1
Female IRC residents	0	0	0	0	0	0
Male discretionary cases	0	1	0	0	0	1
Female discretionary cases	0	0	0	0	0	0
Total	**180**	**91**	**36**	**4**	**23**	**334**

*Other non-natural includes drug-related deaths, accidents and deaths where post-mortem and toxicology reports have been unable to establish cause of death

**Includes male to female transgender prisoners – we began investigations into the deaths of two transgender prisoners in 2017/18

Fatal incident reports issued	Total 2017/18	% in time*	Total 18/19	% in time*	Change 17/18 - 18/19 (volume)	% change year on year (volume)
Initial reports	310	98%	308	93%	-2	-1%
Final reports	331	73%	262	71%	-69	-21%
Reports published on website	297	N/A	338	N/A	41	14%

* In time for initial reports is 20 weeks for natural causes deaths and 26 weeks for all others (including those that are unclassified at the time of notification); In time for final reports is 12 weeks following the initial report

Prison fatal incident investigations started in 2018/19

Fatal incident investigations started (21 and over)	Natural	Self-inflicted	Other non-natural	Homicide	Awaiting classification	Total
Altcourse	4	2	0	0	0	6
Aylesbury	0	1	0	0	0	1
Belmarsh	2	0	0	0	0	2
Berwyn	2	0	0	0	0	2
Birmingham	3	1	0	0	1	5
Bristol	0	1	0	0	0	1
Brixton	1	0	1	0	0	2
Bronzefield	1	0	0	0	0	1
Bullingdon	1	2	0	0	0	3
Cardiff	4	0	0	0	0	4
Channings Wood	1	1	2	0	0	4
Chelmsford	2	2	1	0	1	6
Coldingley	0	1	0	0	1	2
Dartmoor	1	1	0	0	0	2
Doncaster	3	2	0	0	0	5
Dovegate	1	1	1	0	1	4
Downview	0	2	0	0	0	2
Drake Hall	1	0	1	0	0	2
Durham	2	4	3	0	1	10
Eastwood Park	1	0	0	0	1	2
Elmley	2	0	1	0	0	3
Exeter	2	1	0	0	1	5
Featherstone	2	0	1	0	0	3
Forest Bank	2	1	0	0	1	4
Foston Hall	1	0	0	0	0	1
Frankland	1	0	0	0	0	1
Full Sutton	4	0	0	0	0	4

Fatal incident investigations started (21 and over)	Natural	Self-inflicted	Other non-natural	Homicide	Awaiting classification	Total
Garth	1	3	0	0	2	6
Gartree	1	1	0	0	0	2
Grendon	1	0	0	0	0	1
Guys Marsh	0	0	3	0	0	3
Hewell	2	1	2	0	0	5
High Down	4	2	0	0	0	6
Highpoint (North and South)	1	0	0	0	0	1
Hindley	1	0	0	0	0	1
Hollesley Bay	1	0	0	0	0	1
Holme House	3	0	1	0	1	5
Hull	5	2	0	0	0	7
Humber	2	2	0	0	1	5
Isle of Wight	8	1	0	0	0	9
Kirkham	1	0	0	0	0	1
Lancaster Farms	1	1	0	0	0	2
Leeds	6	4	1	0	0	11
Leicester	0	1	0	0	0	1
Lewes	3	2	1	0	0	6
Leyhill	1	0	0	0	0	1
Lincoln	0	2	1	0	0	3
Lindholme	0	3	1	0	1	5
Littlehey	8	1	0	0	0	9
Liverpool	4	3	2	0	0	9
Long Lartin	2	4	0	0	0	6
Low Newton	1	0	0	0	0	1
Lowdham Grange	1	2	1	0	0	4
Manchester	2	3	0	0	1	6

Fatal incident investigations started (21 and over)	Natural	Self-inflicted	Other non-natural	Homicide	Awaiting classification	Total
Moorland	2	0	0	0	0	2
North Sea Camp	3	0	0	0	0	3
Northumberland	2	0	1	0	0	3
Norwich	2	1	0	0	0	3
Nottingham	1	3	0	1	0	5
Oakwood	5	0	1	0	0	6
Onley	0	1	0	0	1	2
Parc	5	1	1	0	2	9
Pentonville	0	1	0	0	0	1
Preston	1	0	0	0	0	1
Ranby	0	0	1	0	0	1
Risley	3	1	0	1	1	6
Rochester	0	1	0	0	0	1
Rye Hill	4	0	0	0	1	5
Stafford	2	0	0	0	0	2
Stocken	0	2	1	0	0	3
Styal	0	1	0	0	1	2
Swaleside	6	1	0	0	0	7
Thameside	2	0	0	0	1	3
Thorn Cross	0	0	0	1	0	1
Usk and Prescoed	2	0	0	0	0	2
Wakefield	7	1	0	0	0	8
Wandsworth	4	0	0	0	1	5
Wayland	0	1	0	0	0	1
Wealstun	0	1	0	0	0	1
Whatton	6	0	0	0	0	6
Whitemoor	1	0	1	0	0	2

Fatal incident investigations started (21 and over)	Natural	Self-inflicted	Other non-natural	Homicide	Awaiting classification	Total
Winchester	3	4	0	0	0	7
Woodhill	3	2	0	1	0	6
Wormwood Scrubs	3	3	0	0	0	6
Wymott	4	0	2	0	0	6
Total	**175**	**86**	**32**	**4**	**22**	**319**

IRC fatal incident investigations started in 2018/19

Fatal incident investigations started	Natural	Self-inflicted	Other non-natural	Homicide	Awaiting classification	Total
Harmondsworth	1	0	0	0	0	1
Total	**1**	**0**	**0**	**0**	**0**	**1**

* Other non-natural includes drug-related deaths, accidents and deaths where post-mortem and toxicology reports have been unable to establish cause of death

Approved premises fatal incident investigations started in 2018/19

Fatal incident investigations started	Natural	Self-inflicted	Other non-natural	Homicide	Awaiting classification	Total
Cardigan House (Vol)	0	0	1	0	0	1
Chorlton	0	0	1	0	0	1
Fleming House	0	0	0	0	1	1
Meneghy House	0	0	1	0	0	1
Nelson House	1	0	0	0	0	1
Rookwood	0	1	0	0	0	1
Southwood	1	0	0	0	0	1
St Catherines Priory	1	0	0	0	0	1
St Johns (Vol)	0	0	1	0	0	1
Staitheford House	0	1	0	0	0	1
Stonnall Road	1	0	0	0	0	1
Wilton Place	0	1	0	0	0	1
Total	**4**	**3**	**4**	**0**	**1**	**12**

*Other non-natural includes drug-related deaths, accidents and deaths where post-mortem and toxicology reports have been unable to establish cause of death

Establishments for under 21s – fatal incident investigations started in 2018/19

Deaths of under 21s	Natural	Self-inflicted	Other non-natural	Homicide	Awaiting classification	Total
Exeter	0	1	0	0	0	1
Total	**0**	**1**	**0**	**0**	**0**	**1**

*Other non-natural includes drug-related deaths, accidents and deaths where post-mortem and toxicology reports have been unable to establish cause of death

Discretionary fatal incident investigations started in 2018/19

Discretionary	Natural	Self-inflicted	Other non-natural	Homicide	Awaiting classification	Total
Wealstun - post release	0	1	0	0	0	1
Total	0	1	0	0	0	1

* Other non-natural includes drug-related deaths, accidents and deaths where post-mortem and toxicology reports have been unable to establish cause of death

Financial data

Finance	2017/18	% of total 17/18	2018/19	% of total 17/18	Change 17/18-18/19	% change year on year
Budget allocation	£5,395,000		£5,158,000		-£237,000	-4%
Staffing costs	£5,134,690	95%	£5,020,427	93%	-£114,263	- 2%
Non-staff costs	£283,774	5%	£385,233	7%	+£100,459	+35%
Total spend	**£5,418,464**	**100%**	**£5,405,660**	**100%**	**-£12,804**	**0%**

Recommendations

The Ombudsman's vision is that the PPO's independent investigations should contribute to making custody and offender supervision safer and fairer. A vital part of fulfilling this ambition involves making effective recommendations for improvement.

We make recommendations following both complaint and fatal incident investigations. In line with guidance issued by the Ombudsman in 2012, recommendations must be specific, measurable, realistic and time-bound – with tangible outcomes to structure learning and help reduce the likelihood of repeat failings.

When recommendations are made as a result of a fatal incident investigation, the service in remit is required to confirm whether they accept them. Where recommendations are accepted, there must be an action plan outlining what action will be taken and when, and who will be responsible for the action. For complaints, the organisation is required to confirm whether they accept our recommendations and to provide evidence of implementation.

Our analysis here shows that, as in previous years, almost all our recommendations were accepted (although we are still seeking a response for a third of our complaints recommendations).

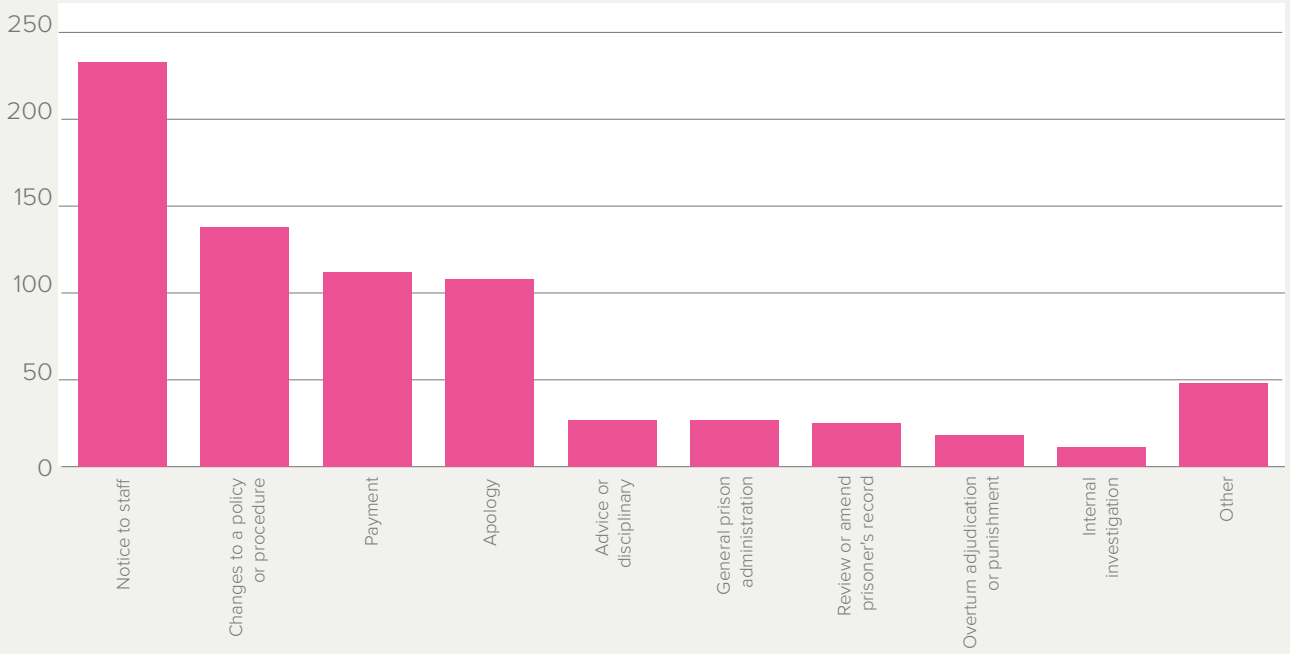
The PPO has implemented a feedback loop with the HM Inspectorate of Prisons, providing independent assessment about what has happened after making our recommendations. HM Inspectorate of Prisons routinely follow up our recommendations following fatal incident investigations and they also invite complaint investigators to identify any particular issues they wish to raise about a prison.

Our investigations provide an opportunity to understand what has happened and to correct injustices. Recommendations also enable us to identify learning for organisations, including sometimes at national level. We monitor all the recommendations that we make, so we can find and track areas of concern or interest. They offer an excellent data source for cross-case analysis, which can be disseminated in our Learning Lessons publications.

Complaints

- In 2018/19, we made 747 recommendations. We made recommendations in 333 cases, out of the 2569 complaints investigations we completed.
- We are awaiting a response to a third of these recommendations, and three have been withdrawn. The remainder (491) have been accepted, and we have received evidence of implementation for 99% of these.
- In 31% of recommendations, we advised a governor or director to issue a notice to staff, reminding them about a policy or procedure. In 18%, we recommended revising a policy or procedure.
- 15% of our recommendations were to make a payment to the complainant, 79% of which resulted from complaints about property.
- 14% of our recommendations were to issue the complainant an apology. In one case, we addressed a national director, recommending they apologise to the complainant in relation to a case of assault by staff.
- Other recommendations related to training for staff, conducting an audit of procedures, issuing a notice to prisoners or sharing one of our Learning Lessons bulletins.

Complaint recommendations, by action



Fatal incidents

- In 2018/19, we issued 262 final investigation reports following deaths in custody, and made recommendations in 224 of these cases. We made 723 recommendations, an average of three per case, and there were 20 cases in which we made seven or more recommendations. We made more recommendations per investigation for self-inflicted deaths: an average of five.
- Six of our recommendations were rejected by HMPPS.
- The majority of our recommendations related to healthcare provision (19%), emergency response (16%), general prison administration (12%) and suicide and self-harm prevention (11%).

Natural cause deaths

- 31% of our recommendations related to healthcare provision, 19% related to the inappropriate use of escorts and restraints and 12% related to general prison administration.
- Recommendations relating to healthcare provision included ensuring attendance at hospital appointments and avoiding delay, robust record-keeping and additional training for staff for particular medical conditions.
- Recommendations relating to general prison administration were about responding to cell bells promptly and conducting thorough wellbeing checks, as well as providing the Ombudsman with information following a death and implementing our recommendations.

Self-inflicted deaths

- 24% of recommendations related to suicide and self-harm prevention and 18% related to emergency response.
- Recommendations relating to suicide and self-harm prevention included training staff in assessing risk, holding multi-disciplinary case reviews for prisoners at risk, recording all known risk factors and sharing relevant information.
- Recommendations relating to emergency response were about ensuring staff act promptly in a life-threatening situation, by entering cells without delay and using the emergency code system, as well as understanding when resuscitation is appropriate.

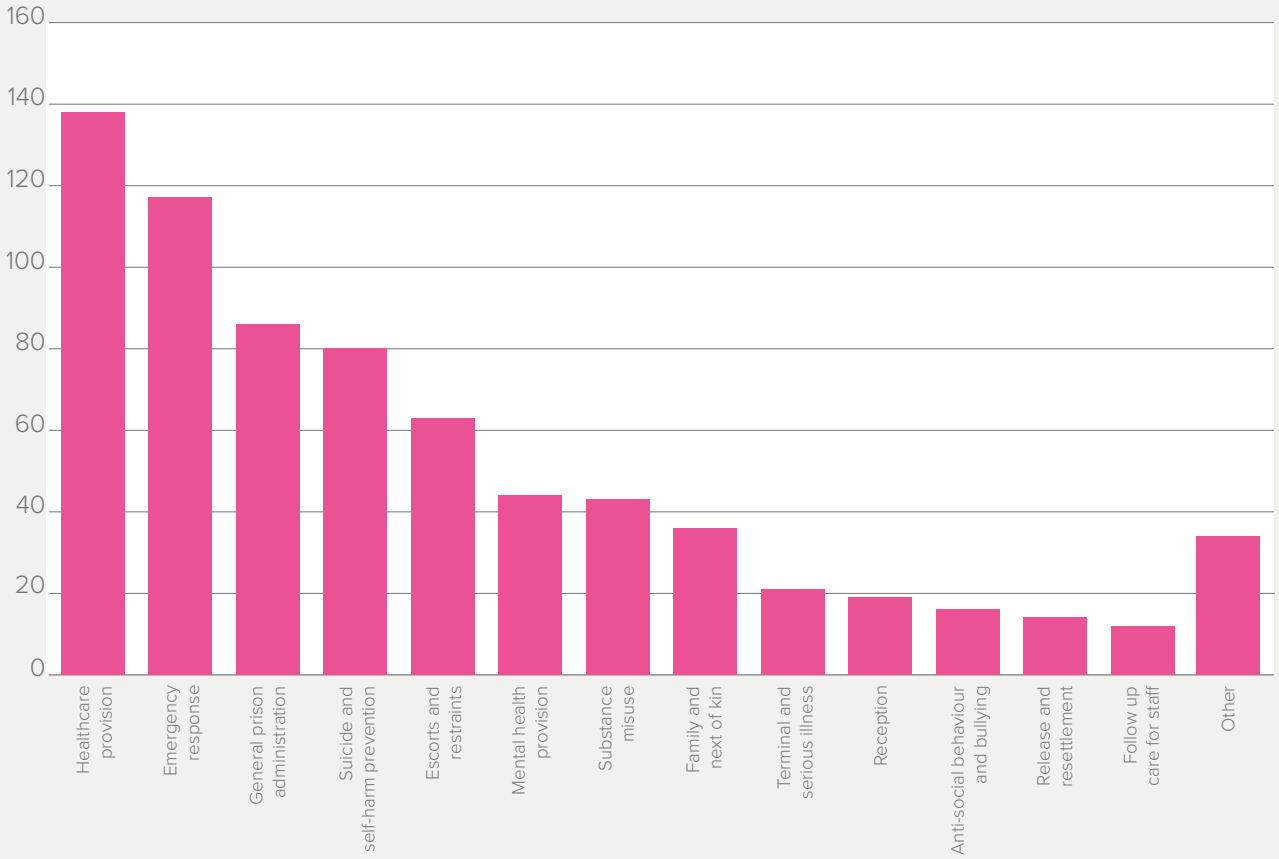
Other non-natural deaths

- 26% of recommendations related to substance misuse and 24% related to emergency response.
- Recommendations relating to substance misuse were about implementing strategies to reduce supply and demand, recording intelligence about the use or trafficking of drugs and referring prisoners for substance misuse support.

Homicides

- We completed investigations into four homicides and made recommendations in three cases. Six out of the 17 recommendations related to anti-social behaviour and bullying.

Recommendations following deaths, by category



Stakeholder feedback – emerging findings

We routinely collect feedback from our stakeholders in order to understand how they engage with our work, their level of satisfaction and their opinions as to how we can improve. To that end, the PPO runs four rolling stakeholder surveys to facilitate feedback broadly from:

- those with whom we engage (by way of our general stakeholder survey)
- those involved in deaths in custody investigations (by way of our fatal incidents post-investigation survey)
- those who complain to us (by way of our complainants' survey)
- the next of kin of deceased prisoners (by way of our bereaved families survey)

We regularly publish this data, and detailed reports from previous years can be found on our website.

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 174 responses in 2018/19, compared to 147 responses in 2017/18. Responses came from prisons, probation, healthcare services, central government, academia and the voluntary sector.

Overall satisfaction

- 92% of respondents rated the PPO overall as satisfactory or better.
- 90% of those involved with complaints and 95% of those involved with fatal incidents reported satisfaction with the investigations.

Timeliness

- 68% of respondents were satisfied or very satisfied with the time it took the PPO to deal with complaints investigations.
- 59% of respondents were satisfied or very satisfied with the time it took the PPO to deal with fatal incident investigations. This has reduced from last year, when 76% of respondents were satisfied for very satisfied with the time taken to conduct investigations. We will be reviewing our processes in the next year to find ways to conduct our investigations more efficiently.

Reports

- 55% of respondents found the reports very clear, and 39% of respondents found them quite clear. In 2019/20, the PPO will be looking at how we present our Fatal Incident reports to make them as clear as possible for our stakeholders.
- 98% of respondents who had read anonymised fatal incident reports on our website said they had found them useful.

Learning Lessons

- The most widely read Learning Lessons publication was our thematic review on older prisoners, which 61% of respondents reported having read.

Impact

- Most respondents felt the PPO is fair (82%), respectful (82%), impartial (76%) and independent (75%).

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. Additionally, we also survey coroners at the end of the year about their overall experiences with fatal incident investigations. The survey asks questions about their communication with the investigator, the quality of the investigation and resulting report, and what changed as a result of the investigation.

We received 175 responses in 2018/19. This is a 40% increase from last year, when we received 125 responses. We received 101 responses from liaison officers, 42 responses from establishment heads and 32 responses from healthcare leads.

Overall satisfaction

- 85% of respondents rated the quality of the investigation as good or very good.
- Communication
- 90% of respondents were satisfied with the communication they had with the PPO.
- 97% of respondents said the PPO investigator contacted them promptly following the death, and 90% said that the investigation process was explained to them.

Timeliness

- 86% of respondents were satisfied with the time it took the PPO to complete their investigation.

Reports

- 97% of respondents said the report we issued met their expectations.
- All respondents said that PPO reports were either quite clear or very clear.
- The majority of respondents said they found the recommendations useful (91%) and fair (90%), while all respondents found them to be clear.

Impact

- 94% of respondents agreed or strongly agreed that the PPO is professional.
- 89% of respondents agreed or strongly agreed that the PPO is fair.
- 88% of respondents agreed or strongly agreed that the PPO is influential.
- 81% of respondents agreed or strongly agreed that the PPO is independent.

Complainants' survey

We send surveys to those whose complaints we have investigated in the past year – both to those whose complaints were upheld, and those we did not uphold. We also sample those who have contacted us, but whose complaints were ineligible. Data collection is ongoing at the time of writing, but we summarise several preliminary results below.

We received 338 responses in 2018/19, in comparison with 306 responses in 2017/18. 110 responses came from those whose

complaints were ineligible. These complaints were not investigated, and the complainants received letters explaining why. Of the 228 respondents with eligible complaints, 114 had had their complaints upheld or partially upheld.

Quality of investigation:
For those with eligible complaints, we asked about their views on the overall quality of the investigation. This group is made up of those whose complaints we upheld, and those whose complaints we did not uphold.

- 53% of respondents whose complaints were upheld rate the quality of investigation as either good or very good. This number is 14% for those whose complaints were not upheld.
- 29% of those who received letters explaining their complaint was ineligible rated the service they received as either good or very good.

Quality of service:
For those whose complaints were ineligible, we asked their opinion about the overall quality of the service they received.

- Of those who received letters explaining their complaint was ineligible, 29% rated the service they received as either good or very good.

Reports and letters:
It is important that we communicate clearly and effectively with complainants, and that we write in such a way that our reasoning is understood.

- 74% of respondents whose complaints were upheld said the report they received was either clear or very clear. This was 54% for those whose complaints we did not uphold.
- 74% of respondents whose complaints were ineligible said that our letter explaining why was clear or very clear. This is an improvement from last year, when 57% of respondents whose complaints were ineligible felt the letter they received was clear or very clear.

Outcome:
We also survey complainants of both ineligible and eligible complaints to ask whether the PPO helped them achieve a satisfactory outcome.

- 52% of respondents whose complaints were upheld agreed that the PPO helped them reach a satisfactory outcome to their complaint. Only 12% of those whose complaints we did not uphold said we helped them achieve a satisfactory outcome.
- 17% of those whose complaints were ineligible said the PPO helped them achieve a satisfactory outcome.

Impact:
As with other surveys, we ask our complainants for their views on the office and the values that we promote.

- Of those whose complaints were upheld, 56% agree that the PPO is influential and 48% agree that we are independent.
- Of those whose complaints were not upheld, 24% agree that we are influential and 19% agree that we are independent.
- Of those whose complaints were ineligible, 28% agree that the PPO is influential.

Bereaved families survey

We also send surveys to families of the deceased following our investigations of deaths in custody. As the response rate is usually low, data from these surveys is collected over a two-year period and published every two years. For the 2017/18 financial year, a questionnaire was sent to bereaved families along with the final version of the report into our investigation. For 2018/19, the surveys were sent at the end of the financial year, due to internal staff and process changes. For this reason, some survey questions were also changed mid-cycle.

The data reported here is for the collection period April 2017 to March 2018 inclusive. Full results will be available on our website.

We asked families to provide feedback on several aspects of their interaction with the PPO, as well as how satisfied they were with our investigation and report. As with other surveys, we ask bereaved families to what extent we are upholding our values.

Responses

- We have received 41 responses so far during this data collection period, compared with 51 responses received during the previous collection period.

Overall satisfaction

- The majority of the respondents (81%) felt the draft report met their expectations.

PPO contact

- 68% of respondents said they received the right amount of contact with the PPO during the investigation, while the remaining respondents felt there was not enough contact.

PPO communication

- Communication with the PPO was generally rated positively, with 68% of respondents saying they were satisfied or very satisfied with the communication.

Impact

- 81% of respondents felt the PPO were respectful and professional, 78% found the PPO to be accessible, and 75% viewed the PPO as fair.

Terms of Reference

The Role

1. The Prisons and Probation Ombudsman (PPO) is appointed by the Secretary of State for Justice, following recommendation by the House of Commons Justice Select Committee. The Ombudsman is therefore an administrative appointment. These Terms of Reference represent an agreement between the Ombudsman and the Secretary of State as to the Ombudsman's role.

2. The Ombudsman is wholly independent. This includes independence from Her Majesty's Prison and Probation Service (HMPPS), the National Probation Service for England and Wales and the Community Rehabilitation Companies for England and Wales (probation), any individual Local Authority, the Home Office, the Youth Justice Board (YJB), providers of youth secure accommodation, the Department for Education (DfE), the Department of Health and NHS England.[20] This enables the Ombudsman to execute fair and impartial investigations, making recommendations for change where necessary, without fear or favour. The actual independence of the Ombudsman from the authorities in remit is an absolute and necessary function of the role.

3. The Ombudsman's office is operationally independent of, though it is sponsored by, the Ministry of Justice. The perceived and visible independence of the Ombudsman from the sponsorship body is fundamental to the work of the Ombudsman. No MoJ official may attempt to exert undue influence on the view of the Ombudsman.

4. The bodies subject to investigation by the Prisons and Probation Ombudsman will make sure the requirements of these Terms of Reference are set out clearly to staff in internal policies, procedures and instructions.

Right of access

5. The 'Head' of the relevant authority (or the Secretary of State for Justice, Home Secretary, the Secretary of State for Education or Secretary of State for Health where appropriate) will ensure that the Ombudsman has unfettered access to all relevant material held both in hard copy and electronically. This includes classified material, physical and mental health information, and information originating from or held by other organisations e.g. contractors (or their sub-contractors) providing services to or on behalf of those within remit, if this is required for the purpose of investigations within the Ombudsman's Terms of Reference. The Ombudsman will consider representations as to the necessity of particular information being provided, the means by which provision is achieved and any sensitivity connected with future publication, but the final decision rests with the Ombudsman who will define the documentation required based on the context of the investigation.

20 Referred to throughout as 'the authorities'.

6. The Ombudsman and his staff will have access to the premises of the authorities in remit, at times specified by the Ombudsman, for the purpose of conducting interviews with employees, detainees and other individuals, for examining source materials (including those held electronically such as CCTV), and for pursuing other relevant inquiries in connection with investigations within the Ombudsman's Terms of Reference. The Ombudsman will normally arrange such visits in advance.

7. The Ombudsman and his staff have the right to interview all employees, detainees and other individuals as required for the purpose of investigation and will be granted unfettered access to all such individuals.

Reporting arrangements

8. The Ombudsman will produce and publish an annual report, which the Secretary of State will lay before Parliament. The content of the report will be at the Ombudsman's discretion but will normally include:

   - anonymised examples of complaints investigated;
   - examples of fatal incidents investigated;[21]
   - recommendations made and responses received;
   - a summary of the workload of the office, including the number and types of complaints received, investigated and upheld and the number and types of death notifications received and investigated;
   - the office's success in meeting its performance targets;
   - a summary of the costs of the office.

9. The Ombudsman may publish additional reports on issues relating to his investigations, such as themed learning lessons publications. The Ombudsman may also publish other information as considered appropriate.

Matters subject to investigation

10. The Ombudsman will investigate:

    i) decisions and actions (including failures or refusals to act) relating to the management, supervision, care and treatment of prisoners, detainees, or young people in secure accommodation.[22] The Ombudsman's remit does not depend on the authority in remit or their staff, acting or failing to act, or taking decisions, themselves. The Ombudsman will therefore also look at the decisions and actions of contractors and subcontractors and of the servants and agents of the services in remit, including members of the Independent Monitoring Board and other volunteers, where these

21 Anonymised at the discretion of the Ombudsman

22 The PPO will investigate fatal incidents in secure children's homes (SCHs). This includes fatal incidents of young people placed in SCHs on welfare grounds. The Ombudsman will not investigate complaints from young people in SCHs.

are relevant to the matter under investigation;

ii) decisions and actions (including failures or refusals to act) relating to the management, supervision, care and treatment of offenders under probation supervision. The Ombudsman's remit does not depend on HMPPS, the National Probation Service or the Community Rehabilitation Companies, or their staff, acting or failing to act, or taking decisions, themselves. The Ombudsman will therefore also look at the decisions and actions of contractors and sub-contractors and of the servants and agents of HMPPS, the National Probation Service and the Community Rehabilitation Companies, including volunteers and supply chain organisations, where these are relevant to the matter under investigation; and

iii) decisions and actions (including failures or refusals to act) in relation to the management, supervision, care and treatment of immigration detainees including residents of immigration removal centres, those held in short term holding facilities or pre-departure accommodation, and those under immigration escort. The Ombudsman's remit does not depend on the Home Office, NHS England or their staff, acting or failing to act, or taking decisions, themselves. The Ombudsman will look at the decisions and actions of contractors and sub-contractors and of the servants and agents of the Home Office, including members of the Independent Monitoring Board and other volunteers, where these are relevant to the matter under investigation.

11. In addition, the Ombudsman will have discretion to investigate, to the extent appropriate, other fatal incidents that raise issues about the care provided by the relevant authority in respect of (i) to (iii) above.

Complaints

12. The Ombudsman's complaints investigations will support the UK's compliance with the requirements of Article 3 (read with Article 1) of the European Convention on Human Rights, specifically by ensuring the independent investigation of allegations of torture, inhumane or degrading treatment or punishment.

13. The aims of the Ombudsman's investigations are to:

- establish the facts relating to the complaint with particular emphasis on the integrity of the process adopted by the authority in remit and the adequacy of the conclusions reached;
- examine whether any change in operational methods, policy, practice or management arrangements would help prevent a recurrence;
- seek to resolve the matter in whatever way the Ombudsman sees fit, including by mediation; and

- where the complaint is upheld, restore the complainant, as far as is possible, to the position they would have occupied had the event not occurred.

14. The Ombudsman will consider the merits of the complaint as well as the procedures involved.

Persons able to complain

15. The Ombudsman will investigate eligible complaints submitted by the following people:

i) prisoners, detainees, and young people, including those in youth detention accommodation,[23] who have failed to obtain satisfaction from the internal complaints system in place at the relevant institution;

ii) offenders who are, or have been, under probation supervision, or accommodated in approved premises and who have failed to obtain satisfaction from the probation complaints system; and

iii) immigration detainees,[24] including residents of immigration removal centres, pre-departure accommodation, short-term holding facilities and those under managed immigration escort anywhere in the UK[25] who have failed to obtain satisfaction from the Home Office complaints system.

16. The Ombudsman will normally only act on the basis of eligible complaints from those individuals set out at paragraph 15 and not on those from other individuals or organisations. However, the Ombudsman has discretion to accept complaints from third parties on behalf of individuals set out at paragraph 15, where the individual concerned is either dead or is unable to act on their own behalf.

17. The Ombudsman also has discretion to accept complaint referrals (that it would be inappropriate for the authority to consider under its own internal complaints procedure) direct from HM Inspectorate of Prisons (HMIP) or the IMB, acting on behalf of the National Preventive Mechanism under OPCAT,[26]

23 For the purposes of complaints, this does not include secure children's home accommodation.

24 Defined throughout as those detained under the powers of the Immigration Act powers.

25 Complaints from individuals other than immigration detainees, as defined under the Immigration Act 1971 at the time of their complaint, will be investigated by the IPCC for England and Wales, the Police Investigations Review Commissioner in Scotland or the Police Ombudsman for Northern Ireland.

26 The Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) is an international human rights treaty designed to strengthen protection for people deprived of their liberty. It recognises that such people are particularly vulnerable and aims to prevent their ill-treatment through establishing a system of visits or inspections to all places of detention. OPCAT requires that States designate a 'national preventive mechanism' (NPM) to carry out visits to places of detention, to monitor the treatment of and conditions for detainees and to make recommendations regarding the prevention of ill-treatment. The UK ratified OPCAT in December 2003 and designed its NPM in March 2009. The UK's NPM is currently made up of 18 visiting or inspecting bodies who visit places of detention such as prisons, police custody and immigration detention centres.

where a detainee alleges that the authority has prevented them from communicating with HMIP, the IMB or PPO, or that they have been subject to victimisation or sanctions as a result of doing so.[27]

Eligibility of complaints

18. Before putting a complaint to the Ombudsman, a complainant must first seek redress through appropriate use of the relevant prison, youth detention accommodation,[28] probation, or Home Office complaint procedure.

19. Complainants will have confidential access to the Ombudsman and no attempt should be made to prevent a complainant from referring a complaint to the Ombudsman. The cost of postage of complaints to the Ombudsman by prisoners, immigration detainees and young people in detention, will be met by the relevant authority.

20. Where there is some doubt or dispute as to the eligibility of a complaint, the Ombudsman will contact the relevant authority in remit who will provide the Ombudsman with such documents or other information as the Ombudsman considers are relevant to considering eligibility.

21. If a complaint is considered ineligible, the Ombudsman will inform the complainant and explain the reasons, in writing.

22. The Ombudsman may decide not to accept a complaint otherwise eligible for investigation, or to discontinue any ongoing investigation, where he considers that no worthwhile outcome can be achieved, or the complaint raises no substantial issue.

23. The Ombudsman may also decide to discontinue an investigation where he considers the complainant's behaviour to be unreasonable.[29] The Ombudsman will inform the complainant of the reasons for this action.

Time limits

24. The Ombudsman will consider complaints for possible investigation if the complainant is dissatisfied with the reply from the authority in remit, or receives no final reply within six weeks of making the complaint (or 45 working days in the case of complaints relating to probation matters). Complaints relating solely to healthcare will be dealt with by the Parliamentary and Health Service Ombudsman.

25. Complainants submitting their case to the Ombudsman must do so within three calendar months of receiving a substantive reply from the relevant authority.

26. The Ombudsman will not normally accept complaints where there has been a delay of more than 12 months between the complainant becoming aware of the

27 The relationship between the named bodies is described in a separate protocol.

28 For the purposes of complaints, this does not include secure children's home accommodation.

29 As defined by the PPO policy on Dealing with Unreasonable Behaviour from Complainants.

relevant facts and submitting their case to the Ombudsman, unless the delay has been the fault of the relevant authority and the Ombudsman considers that it is appropriate to do so.

27. Complaints submitted after these deadlines will not normally be considered. However, the Ombudsman has discretion to investigate those where it considers there to be good reason for the delay, or where it considers the issues raised to be of sufficient severity to warrant an exception to the usual timeframe to be made.

28. The Ombudsman's targets around conducting investigations, responding to complainants, and publishing reports will be set out in an annual business plan.

Limitations on matters subject to investigation

29. The Ombudsman may not investigate complaints about:

i) policy decisions taken by a Minister and the official advice to Ministers upon which such decisions are based;

ii) the merits of decisions taken by Ministers, except in cases which have been approved by Ministers for consideration;

iii) actions and decisions (including failures or refusals to act) in relation to matters which do not relate to the management, supervision, care and treatment of the individuals described in paragraph 15 or outside the responsibility of the authority in remit. This exclusion covers complaints about conviction, sentence, immigration status, reasons for immigration detention or the length of such detention, and the decisions and recommendations of the judiciary, the police, the Crown Prosecution Service, and the Parole Board and its Secretariat;

iv) matters that are currently or have previously been the subject of civil litigation or criminal proceedings; and

v) the clinical judgement of medical professionals.

Fatal incidents

30. The Ombudsman's fatal incident investigations will support the UK's compliance with the requirements of Article 2 (read with Article 1) of the European Convention on Human Rights which ensures the right to life, specifically the need for the independent investigation of all deaths in custody.

31. The Ombudsman will investigate the circumstances of the deaths of:

i) prisoners and young people including those in youth detention accommodation[30] and those placed in Secure Children's Homes on a welfare basis. This generally includes people temporarily absent from the establishment but still subject to detention (for example, under escort, at court or in hospital). It generally

30 This covers deaths in young offender institutions, secure training centres and secure children's homes.

excludes people who have been permanently released from custody, including those who have been released on compassionate grounds;

ii) residents of approved premises (including voluntary residents) where the PPO considers this is necessary, including for Article 2 compliance;

iii) immigration detainees, including residents of immigration removal centres, pre-departure accommodation, short-term holding facilities and those under managed immigration escort anywhere in the UK and internationally;[31] and

iv) people in court premises or accommodation who have been sentenced to or remanded in custody.

32. The Ombudsman will act on notification of a death from the relevant authority and will decide on the extent of the investigation, which will be determined by the circumstances of the death.

33. The aims of the Ombudsman's investigations are to:

- establish the circumstances and events surrounding the death, in particular the management of the individual by the relevant authority or authorities within remit, but also including any relevant external factors;
- examine whether any change in operational methods, policy, practice or management arrangements would help prevent a recurrence;
- in conjunction with NHS England[32] or the relevant authority,[33] where appropriate, examine relevant health issues and assess clinical care;
- provide explanations and insight for the bereaved relatives; and
- help fulfil the investigative obligation arising under Article 2 of the European Convention on Human Rights ('the right to life') by working together with coroners to ensure as far as possible that the full facts are brought to light and any relevant failing is exposed, any commendable action or practice is identified, and any lessons from the death are made clear.[34]

31 The deaths of individuals other than immigration detainees, as defined under Immigration Act powers at the time of death, will be investigated by the IPCC for England and Wales, the Police Investigations & Review Commissioner in Scotland or the Police Ombudsman for Northern Ireland.

32 The NHS Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations confer responsibility on the NHS Commissioning Board (NHS England) for commissioning health services in prisons and custodial establishments.

33 In the case of fatal incidents in Immigration Removal centres in Scotland or Northern Ireland.

34 The relationship between the Ombudsman and the Coroners' Society is described in a separate Memorandum of Understanding

Clinical issues

The Ombudsman's investigation includes examining the clinical issues relevant to each death. In the case of deaths in prisons, youth detention accommodation, Secure Children's Homes and immigration facilities, the Ombudsman will ask NHS England or, in Wales, the Healthcare Inspectorate Wales (HIW)[35] to review the clinical care provided according to agreed protocols, including whether referrals to secondary healthcare were made appropriately. The clinical reviewer will be independent of the relevant authority's healthcare provision and will have unfettered access to healthcare information. Where appropriate, the reviewer will conduct joint interviews with the Ombudsman's investigator.

Relationship with other investigations

34. The Ombudsman may defer all or part of an investigation, when the police are conducting a criminal investigation in parallel. If at any time the Ombudsman forms the view that a criminal investigation should be undertaken, the Ombudsman will alert the police.[36]

35. In the case of the death of a young person in custody, the Local Safeguarding Children Board in England will conduct a serious case review. In Wales, the Safeguarding Children Board may undertake a child practice review. This will normally take place in parallel to the Ombudsman's investigation. The PPO will seek to work closely with the relevant safeguarding board to maximise the benefit of both exercises.

36. If at any time the Ombudsman forms the view that a relevant authority in remit should undertake a disciplinary investigation, the Ombudsman will alert that authority. If at any time findings emerge from the Ombudsman's investigation that the Ombudsman considers require immediate action by the relevant authority, the Ombudsman will alert the relevant authority to those findings.

Outcome of the Ombudsman's investigations

37. The Ombudsman has the discretion to choose the exact manner in which the findings of investigations are reported but all investigations will result in a written response. The targets will be set out in the Ombudsman's annual business plan.

38. Where a formal report is to be issued the Ombudsman will send a draft and any related documents to:

- the head of the authority in remit and the complainant in the case of a complaint. The Ombudsman may, however, share an advance draft with the authority where there is a concern over the disclosure of security issues; and

35 In the case of fatal incidents in Immigration Removal centres in Scotland or Northern Ireland, the equivalent relevant authority.

36 The relationship between the Police and the Ombudsman is described in a Memorandum of Understanding between the ACPO/APA and the PPO.

- the head of the authority in remit, and the bereaved family, the Coroner, NHS England or HIW[37] in the case of a fatal incident report.

39. The recipient(s) will have an agreed period to draw attention to any factual inaccuracies. The relevant authority may also use this opportunity to respond to any recommendations.

40. If the draft report recommends disciplinary action be taken against an identified member of staff, the Ombudsman will normally disclose an advance copy of the draft, in whole or part, to the relevant authority in order that they, and the staff member(s) subject to criticism, have the opportunity to make representations (unless that requirement has been discharged by other means during the course of the investigation).

41. The Ombudsman will consider any feedback on the draft report, but will exercise his own discretion on what, if any, changes to make, and issue a final report. Final reports into complaints will be issued to the complainant and the relevant authority. Final reports into fatal incidents will be issued to the relevant authority, the bereaved family, the Coroner, the Local Authority, NHS England or HIW.[38] Additional circulation of final reports will be at the Ombudsman's discretion.

42. In the case of a fatal incident investigation, and having considered any views of the recipients of the report, and having complied with the legal obligations in relation to data protection and privacy, the Ombudsman will publish the final report on the Ombudsman's website. All references to individuals other than the deceased will be anonymised.[39]

43. The Ombudsman will consult the Coroner or relevant authority if the report is to be published before the inquest.

44. The Ombudsman may make recommendations to the authorities within remit, the Secretary of State for Justice, the Home Secretary, the Secretary of State for Education, the Secretary of State for Health or to any other body or individual that the Ombudsman considers appropriate given their role, duties and powers.

45. The authorities within remit, the Secretary of State for Justice, the Home Secretary, the Secretary of State for Education or the Secretary of State for Health will provide the Ombudsman with a response within four weeks indicating whether a recommendation is accepted or not (in which case reasons will be provided) and the steps to be taken by that authority within set timeframes to address the Ombudsman's recommendations.

37 In the case of fatal incidents in Immigration Removal centres in Scotland or Northern Ireland, the equivalent relevant authority.

38 In the case of fatal incidents in Immigration Removal centres in Scotland or Northern Ireland, the equivalent relevant authority.

39 In reports of fatal incident investigations of people under the age of 18, the deceased person's details are also anonymised.

Where that response has not been included in the Ombudsman's report, the Ombudsman may, after consulting the authority as to its suitability, append it to the report at any stage. The Ombudsman will advise the complainant of the response to the recommendations.

Disclosure

46. The Ombudsman is subject to the Data Protection Act 1998 and the Freedom of Information Act 2000.

47. In accordance with the practice applying across government departments, the Ombudsman will follow the Government's policy that official information should be made available unless it is clearly not in the public interest to do so.

48. The Ombudsman, HM Inspectorates of Prisons and Probation, and the Independent Monitoring Boards will share relevant information, knowledge and expertise, especially in relation to conditions for prisoners, residents and detainees generally. The Ombudsman may also share information with other relevant specialist advisers, such as the Independent Police Complaints Commission, and investigating bodies, to the extent necessary to fulfil the aims of an investigation. Protocols will be developed in order to describe the Ombudsman's relationship with relevant partners.

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