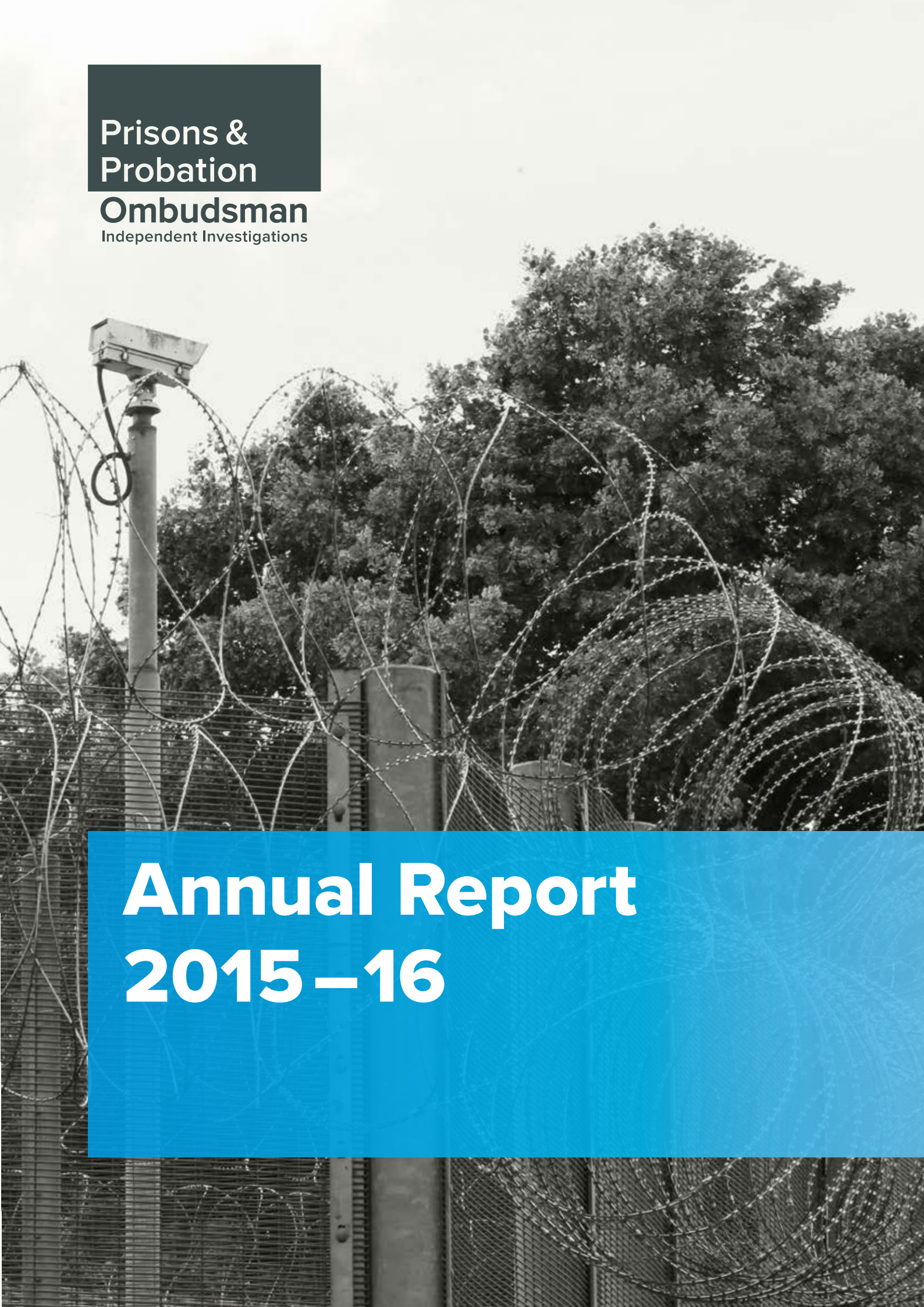
Prisons & Probation Ombudsman
Independent Investigations



Annual Report 2015–16

Prisons & Probation Ombudsman

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[1] The Ombudsman's Terms of Reference, a standard appendix in previous years, are absent from his 2015-16 Annual Report. They have been under review by the Ministry of Justice since 2012, and are currently out-of-date.

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 the National Offender Management Service; 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 Justice Board; 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 his office's Terms of Reference (ToR). The PPO has three main investigative duties:

- complaints made by prisoners, young people in detention, 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.

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

Safety and fairness must underpin prison reform

This is my fifth and final annual report as Prisons and Probation Ombudsman. My tenure has coincided with a difficult period for prisons and probation. One consequence of this has been that demand for independent investigation of deaths and complaints remains unremittingly high. Over the past year, deaths in custody have risen sharply, with a shocking 34% rise in self-inflicted deaths, steadily rising numbers of deaths from natural causes and the highest number of homicides since my office was established. The number of complaints from prisoners also remains very high.

Together with rising levels of violence and disorder, these figures are evidence of the urgent need to improve safety and fairness in prison. Fortunately, there is a beacon of hope among the concerns, as the previous Prime Minister and previous Secretary of State for Justice set out an ambitious programme of prison reform. However, if the new Secretary of State decides to pursue these reforms, progress will be limited unless there is a basic underpinning of safety and fairness on which to build. Despite a recent injection of additional resource, these foundations are in need of considerable reinforcement.

My office has an important part to play in supporting this improvement. I regularly provide route maps towards improved safety and fairness, in my individual investigations and in a growing body of thematic learning. These provide the services I oversee with clear, objective and practical lessons about how to improve.

Unfortunately, I have been saying many of the same things for much of my time in office. While resources and staffing in prisons are undeniably stretched, it is disappointing how often – after invariably accepting my recommendation – prisons struggle to sustain the improvement I call for. Improving safety and fairness is less about identifying new learning and more about implementing the learning already available. Ensuring real and lasting improvement in safety and fairness needs to be a focus of the new prison reform agenda.

“Over the past year, deaths in custody have risen sharply, with a shocking 34% rise in self-inflicted deaths, steadily rising numbers of deaths from natural causes and the highest number of homicides since my office was established.”

Suicide: a rising toll of despair?

It is deeply depressing that suicides in custody have again risen sharply but it is not easy to explain this rising toll of despair. Each death is the tragic culmination of an individual crisis for which there can be a myriad of triggers. Some have argued, perfectly plausibly, that staff reductions and regime restrictions in prison have reduced factors that protect against suicide and self-harm, such as activity, time out of cell and interaction with others, but the evidence for this is inconsistent. Some major themes do emerge from my investigations, for example the pervasiveness of mental ill-health and the destructive impact of an epidemic of new psychoactive substances, but no simple explanation for the rise in suicides suffices.

> “Some major themes do emerge from my investigations, for example the pervasiveness of mental ill-health and the destructive impact of an epidemic of new psychoactive substances...”

> “I have frequently identified gaps in the assessment of risk of suicide and self-harm and poor monitoring of those identified as being at risk.”

In such a complex context, effective and thoughtful efforts at prevention by prison staff are vital. Unfortunately, too often my investigations identify repeated procedural failings, which hamper the prospects for prevention. For example, I have frequently identified gaps in the assessment of risk of suicide and self-harm and poor monitoring of those identified as being at risk. Occasionally, I have identified a fundamental lack of care, but, more often, I have found caring and compassionate efforts by staff to support the suicidal. What is clear, however, is that more can and should be done to improve suicide and self-harm prevention in prison.

More also needs to be done to understand and reverse the troubling increase in prisoner homicides. There were six of these deaths last year, two more than the year before. Distilling learning is slow, as my investigations must wait for the conclusion of the criminal process, but, at the request of the previous Prisons Minister, I am updating my 2013 review of homicides to see if there is any new learning on which the Prison Service needs to act. However, what is already clear is that there is an unacceptable level of violence in prison.

Still no strategy for older prisoners

By contrast, the reason for the steady annual increase in deaths from natural causes is more explicable: it is largely the result of the age related ill-health that attends a rapidly ageing prison population. This demographic shift has been dramatic, driven by increased sentence length and more late in life prosecutions for historic sex offences. As a result, the number of prisoners over 60 has tripled in 15 years and is now the fastest growing segment of the prison population. The projections are all upwards, with more than 15,000 prisoners over 50 predicted by June 2020.

One mournful consequence was that there were 172 deaths from natural causes last year, 42% more than five years ago. The challenge is clear: prisons designed for fit, young men must adjust to the largely unexpected and unplanned roles of care home and even hospice. Increasingly, prison staff are having to manage not just ageing prisoners, but the end of prisoners' lives and death itself.

Unfortunately, there has been little strategic grip of this major change in the prison population. Prisons and their healthcare partners have been left to respond in a piecemeal fashion, resulting in variable end of life care for prisoners and limited support for staff. I have personally seen many examples of humane care for the dying, but it is astonishing that there is still no properly resourced older prisoner strategy, to drive consistent provision across prisons, despite repeated demands from campaigners, Parliamentarians and scrutiny bodies such as mine.

“As a result, the number of prisoners over 60 has tripled in 15 years and is now the fastest growing segment of the prison population. The projections are all upwards, with more than 15,000 prisoners over 50 predicted by June 2020.”

Still plenty to complain about?

In each of my annual reports since appointment, I have listed the raft of challenges facing the prison system, which go some way to explaining the sustained levels of complaints reaching my office. The list is long: the prison population remains proportionately the highest in Western Europe, austerity and recruitment problems have reduced staff numbers, regimes in many prisons remain curtailed and crowding is the norm. Levels of violence (and deaths) have risen and new threats to safety have emerged, such as new psychoactive substances. In short, prisoners may have plenty of reasons to complain.

These strains in the system may also be reflected in the increasing proportion of complaints from prisoners that I uphold because prisons got things wrong, often in contravention of their own or national policies. It is interesting, that five years ago only 26% of complaints were upheld, compared to 40% last year. Yet I do not believe this reflects a more sympathetic approach to prisoners by my investigators, instead I suspect it simply reflects prisons making more mistakes and failing to learn lessons from my previous investigations.

> “…five years ago only 26% of complaints were upheld, compared to 40% last year.”

Avoiding mistakes and ensuring basic fairness, including an appropriate degree of consistency and equity of provision between prisons, will also need to be at the heart of any prison reforms. Greater autonomy for governors may be a more effective way to deliver some desired outcomes than through a centralised bureaucracy, but autonomy from central policy prescription must be balanced by clear statements of minimum entitlements for prisoners. Without clarity as to these minimum standards and how they are to be adhered to, prisoners’ legitimate expectations may be dashed, inappropriate disparity between prisons entrenched, engagement in rehabilitation undermined - and independent dispute resolution mechanisms like my office (as well as the courts) flooded with even more complaints.

> “…autonomy from central policy prescription must be balanced by clear statements of minimum entitlements for prisoners.”

Fairness demands that wrongs are put right or that prisons model the behaviour that they expect of prisoners and offer an apology where one is merited. In some serious cases, staff must be held to account for misbehaviour, which is why I was sometimes obliged to recommend disciplinary action last year. More generally, the ability to complain effectively is integral to a legitimate and civilised prison system. An independent complaint adjudication function, such as my office, is key to this and provides a means for prisoners to ventilate grievances legitimately. It is also essential now that much prisoner access to legal aid has been removed.

That said, the prison complaint process requires improvement. I have tried hard to educate prisoners to use our independent service properly and avoid making so many ineligible complaints, which frustrate them and waste my staff's time. More controversially, I have tried to target my scarce resources more effectively. Unlike five years ago, I now make significant use of my discretion not to investigate minor but eligible complaints. I must exercise care here, as small things mean a lot to prisoners with little, but this proportionality allows resources to be reallocated to more serious cases.

However, the real key to further improvement of the prisoner complaint process is better complaint management in prisons. This too needs to be a focus of the reform programme, so that complaints are properly dealt with at source and do not need to be escalated to my office in the first place.

> “
>
> ...the ability to complain effectively is integral to a legitimate and civilised prison system.”

The lessons are clear

One key commitment that I made on appointment was to introduce a new learning lessons agenda to support improvement in safety and fairness, in custody and in offender supervision, by looking across individual investigations to identify broader themes. There have now been over 30 of these publications since 2011, and this development has been well received by stakeholders and external commentators alike.

In 2015–16, bulletins looked at how to avoid the worrying increase of suicides by prisoners in segregation units, which were not designed for those in crisis; how to address the increase in deaths associated with new psychoactive substances; and how to manage those at risk of suicide and self-harm in the particularly vulnerable early days in custody. There was also a substantial thematic study collating learning from my investigations into deaths in custody, about the pervasive issue of mental ill-health. Finally, a bulletin looked at how prisons should better manage prisoners' legal mail and avoid the many complaints to my office about failures to adhere to policy and the law.

As part of my ongoing efforts to support improved safety and fairness in prisons, and to gain traction for the learning from my investigations among prison staff, last year saw the second series of well-attended learning lessons seminars for operational staff and managers. These seminars were well received and are to be repeated in the autumn of 2016–17.

Still delivering more for less

I pay tribute to my staff who have worked so hard to enable me to deliver the commitments that I made to the Justice Select Committee on my appointment five years ago. These were three-fold: to develop a new programme of learning lessons publications; to improve the quality and timeliness of fatal incident and complaint investigations; and to do more with less.

Despite sadness that I have had so many more fatal incidents to investigate, I am pleased that last year we again surpassed our target and delivered every single one of our initial fatal incident investigation reports on time. By contrast, five years ago we undertook 53% fewer fatal incident investigations, using more resources, but delivered only 14% on time. This is really impressive progress.

Reassuringly, our stakeholder and bereaved family surveys indicate that these investigations were recognised for improved quality, as well as better timeliness. This improvement has real benefits: bereaved families are helped towards a degree of closure in a timely fashion, we assist coroners to expedite the inquest system and we give investigated services speedy, relevant learning.

There has also been significant progress in our complaints investigation performance, where new ways of working and sheer hard work have eradicated a substantial backlog of unallocated cases and improved overall timeliness. Again, stakeholder and complainant surveys suggest increased recognition of both improved timeliness and quality.

> “…new ways of working and sheer hard work have eradicated a substantial backlog of unallocated cases and improved overall timeliness.”

I am immensely proud that we have improved many aspects of the way we work, streamlined our casework processes, sustained our agenda of thematic learning publications and improved efficiency. We will have to do still more for less in 2016–17, because my budget has been reduced while demand continues to rise. I know my staff will rise to the challenge.

Still no statutory reinforcement of independence

Finally, as I have done in each of my previous annual reports, I repeat the need to reinforce my office’s actual and visible independence. Unlike most Ombudsmen, I have no statutory basis for my work. This means that my investigations do not have the force of law and are ultimately dependent on the goodwill of those we investigate. This is not good enough for a robustly independent body, committed to exposing the truth without fear or favour.

While Ministers have reaffirmed their support for placing my office on a statutory footing, no legislative opportunity has yet been found. I repeat my call for this change as I conclude my tenure, particularly now that there is to be a Prison and Courts Reform Bill. However, even without a statutory footing, readers of this annual report will be left in no doubt of my independence of mind or that of my staff and my unwavering commitment to support improved safety and fairness in custody and for offenders being supervised in the community.

Nigel Newcomen CBE
Prisons and Probation Ombudsman

The year in figures

Fatal incidents

- We started investigations into **304 deaths** in 2015–16, **21% more** than the year before. The majority of these deaths were of prisoners (**95%**).
- We were notified of **12 deaths** in approved premises, **up from 8** the previous year.
- We were notified of **3 deaths** in the immigration removal estate, **up from 2** the previous year.
- Compared with 2014–15, we began **10% more investigations** into deaths from natural causes (**172 deaths**).
- The increase in natural cause deaths appears to be a consequence of rising numbers of older prisoners. The average age at death in these cases was **61**.
- We started investigations into **103 self-inflicted deaths**. This was the highest number in a single year since the Ombudsman began investigating deaths in custody, and is a **34% increase** from 2014–15.
- We were notified of **6 apparent homicides**, compared with **4** the previous year. Again, this is the highest number in a single year since we began investigating deaths in custody.
- We were notified of a further **23 deaths**, **11** of which were classified as 'other non-natural' (usually drug related), and **12** of which await classification.
- We issued **284 initial reports** and **261 final reports**, compared with **245 and 253 the previous year**, a reflection of our increased caseload.
- Despite the increased number of deaths we continued to improve our timeliness. **100% of initial reports** were issued on time in 2015–16, compared with **97% the previous year**. There was also a notable improvement in the timeliness of our final reports, **82% of which were on time**, compared with **57%** in 2014–15.
- The average time taken to produce an initial natural cause death report was **18 weeks**, consistent with the previous year. The average time for all other deaths (self-inflicted, other non-natural and homicide) was **24 weeks**, **1 week less** than in 2014–15.
- In the 2015 stakeholder survey, **9 out of 10 stakeholders** who had been involved with a fatal incident investigation agreed that the quality of the investigation was satisfactory or better.

Draft reports issued

284 2015–16

245 2014–15

Draft reports issued on time

100% 2015–16

97% 2014–15

Total deaths

21% increase

304 2015–16

251 2014–15

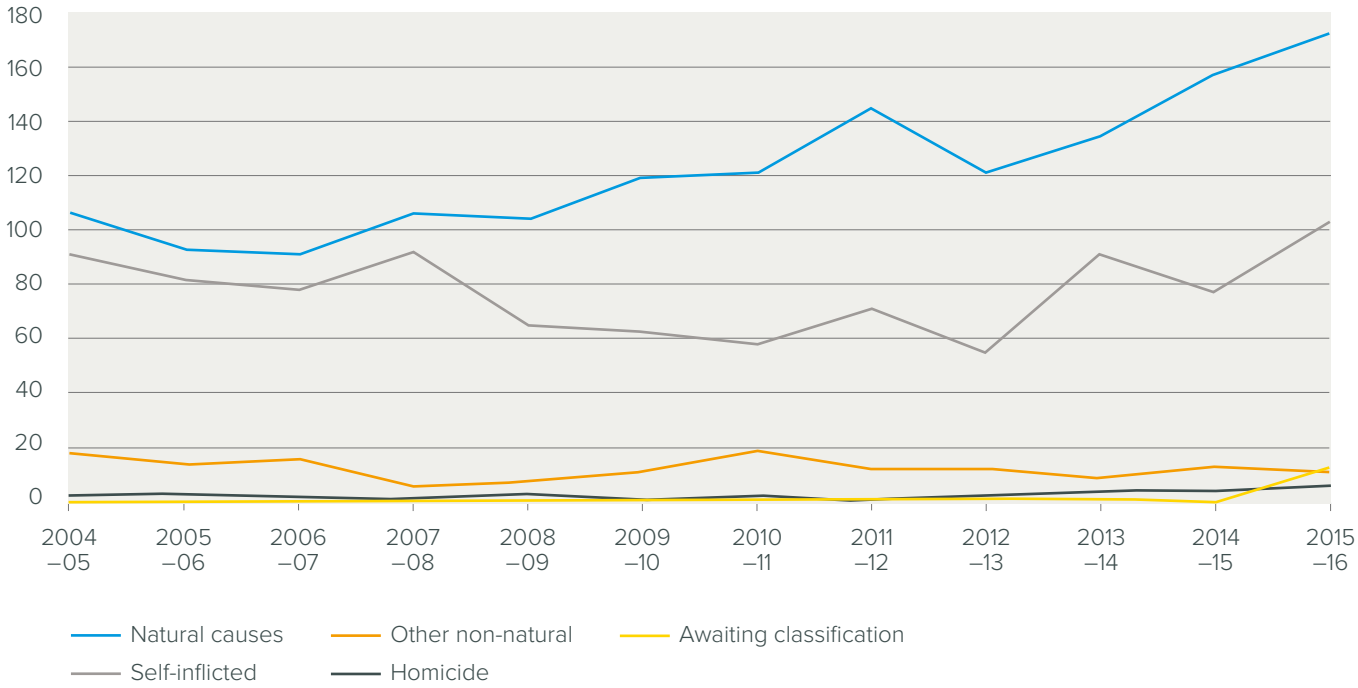
Total self-inflicted deaths

34% increase

103 2015–16

77 2014–15

Fatal incident investigations



Complaints

- We received **4,781 complaints** in 2015–16, a **4% decrease** on the previous year.
- However, we worked on both new complaints and a backlog of historic complaints. As a result, we made **5,020 eligibility assessments** in 2015–16 and the number of complaints accepted for investigation decreased by only **1%** compared with the previous year.
- To ensure that scarce resources are appropriately directed, not all eligible cases are investigated if it is considered that they do not raise a substantive issue, or no worthwhile outcome is likely. In 2015–16, **446 eligible cases** were declined on this basis, compared with **441 cases** the year before.
- A further **49 complaints** accepted for investigation in 2015–16 were later withdrawn, because circumstances changed. The complainant withdrew their complaint in a further **37 cases**.
- In 2015–16, we started **2,357 investigations**, just **23 cases** less than in 2014–15.
- We completed **2,290 investigations**, a **6% increase** on 2014–15.
- This increased productivity helped reduce our backlog. In April 2014, there were **490 cases** that had been waiting over 12 weeks for the investigation to be completed, after the case was allocated to an investigator. This fell to **339 cases** by April 2016.
- As in 2014–15, most (**92%**) of the complaints received were about prisons.
- Complaints from **high security prisons accounted for 30%** of completed investigations, despite high security prisoners making up only **7% of the male prison population**.[2]
- We received **323 complaints** about probation, **5 more** than the previous year, and **58 complaints** about immigration removal centres, **4 less** than the previous year.

[2] Table 1.8, Ministry of Justice (2016) *Offender management statistics quarterly: October to December 2015, Prison population: 31 March 2016*. London: MoJ.

- Complaints about lost, damaged and confiscated property made up **29% of investigations** completed in 2015–16. The next most common complaint categories were issues about administration (**12%**) and adjudications (**7%**).
- We found in favour of the complainant in **40% of the investigations**, compared with **39% the previous year**.
- Complaints from high security prisons were less likely to be upheld: we found in favour of these complainants in **35% of cases**, compared with **43%** in other male prisons.
- Timeliness continued to improve. In 2014–15, only **28% of assessments** were completed within our target of 10 working days of receiving the complaint, but this rose to **50% in 2015–16**. **39% of investigations** were completed within 12 weeks of being allocated to an investigator, compared with **34% the previous year.**
- In our general stakeholder survey, more than **8 out of 10 stakeholders** who had been involved with a complaint investigation in 2015 agreed that the quality of the investigation was satisfactory or better.

Complaints received

4,781 2015–16

4,964 2014–15

Investigations started

2,357 2015–16

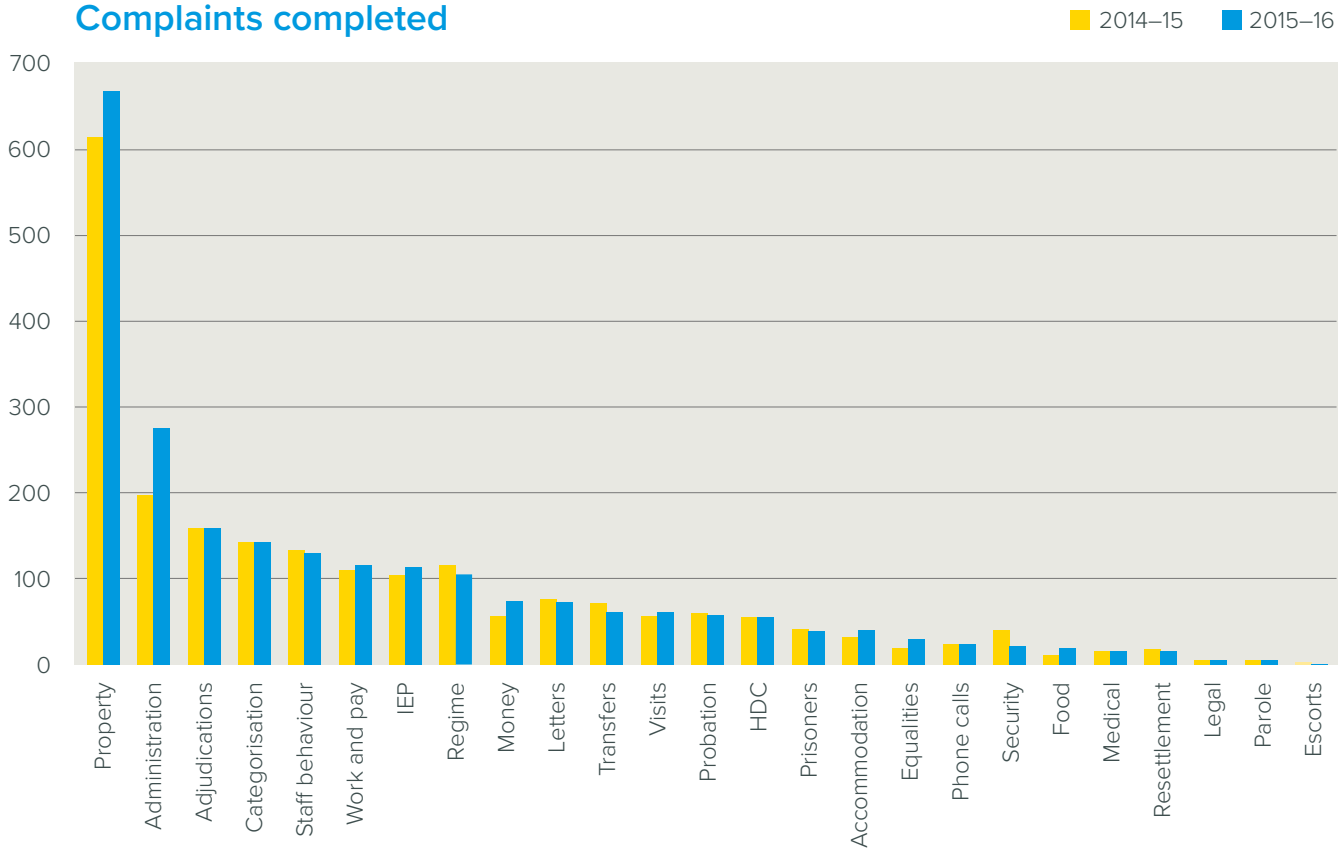
2,380 2014–15

Investigations completed

2,290 2015–16

2,159 2014–15

Complaints completed



Investigating fatal incidents

Self-inflicted deaths

Over the past year, there has been a sharp and troubling rise in deaths in custody, with a 34% rise in self-inflicted deaths, steadily rising numbers of deaths from natural causes and a record number of homicides. There is no simple, well-evidenced explanation for the rise in self-inflicted deaths or homicides. However, our investigations continued to find a number of areas where prisons locally and nationally could and should have done more to identify prisoners at risk of suicide and put in place effective measures to support and protect the most vulnerable.

> “our investigations continued to find a number of areas where prisons locally and nationally could and should have done more to identify prisoners at risk of suicide...”

Risk assessments on arrival

Arriving in prison can be particularly daunting and is a time of heightened risk and vulnerability. We recently published a learning lessons bulletin on this topic[3] which found that in 15% of cases, the death occurred within a prisoner’s first seven days, and in a further 15%, the death occurred within the first month. Despite this, we continue to investigate many deaths where prison reception staff, who assess newly arrived prisoners, are unaware of the risk factors for suicide or, if they are aware of them, discount the risk factors in favour of the prisoner’s presentation or the prisoner’s assurances that they have no thoughts of suicide.

[3] Prisons and Probation Ombudsman (2016) *Early days and weeks in custody*. London: PPO.

Mr A was charged with a serious violent offence against his partner. Five months earlier, he had tried to hang himself and, as a result, suffered a hypoxic brain injury. At court, Mr A's solicitor highlighted his suicide risk. Mr A was remanded to prison and his suicide risk was noted on two separate forms which were handed to prison reception staff. Mr A told reception staff that he was okay and they took his word for it. None of the reception staff knew the full nature of the charges against Mr A so did not consider whether this increased his risk of suicide. No one who saw Mr A in reception began ACCT suicide and self-harm prevention procedures.

Mr A moved to a standard wing in the prison. He did not have any induction or a second health assessment to check how he was settling in. Although his family and his probation officer contacted the prison to warn them about his risk of suicide, no one began suicide and self-harm prevention procedures (known as ACCT procedures). Mr A was found hanged in his cell four days after he arrived at the prison.

Prison Service Instructions require healthcare and discipline staff in reception to interview the prisoner when they arrive, to assess their risk of suicide. Staff are also required to examine all relevant information, including the escort record which arrives with a prisoner and any other available documentation. Unless staff are aware of the charges a prisoner is facing, or of which he has been convicted (and other relevant information), effective risk assessment is not possible.

When a prisoner's risk is not properly assessed in reception and staff do not begin ACCT suicide and self-harm prevention procedures to support them, there may be no further examination of their risk unless the prisoner actively self-harms or otherwise comes to the attention of staff.

Mr B was charged with serious sexual offences against family members. The day before he was due to appear in court, he attempted suicide by overdosing on sleeping tablets and antidepressants. He was detained in hospital under the Mental Health Act. He was discharged five days later and was then remanded to prison. Mr B had never been to prison before. At court, details of Mr B's recent suicide attempt, hospitalisation and suicide risk were noted on a suicide and self-harm warning form, the escort record and the court warrant. However, prison reception staff did not read all of the information that arrived with Mr B and a nurse did not think that Mr B was suicidal.

Despite Mr B's clear risk factors, staff did not begin ACCT procedures in reception and did not refer him for a mental health assessment. As he was not being monitored under ACCT procedures and did not come to staff attention after that, no one reviewed Mr B's risk again. A little under two months after he arrived at the prison, Mr B hanged himself.

ACCT

Assessment Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses to support prisoners identified as at risk of suicide or self-harm. As part of the ACCT process, officers must identify the prisoner's most urgent and pressing needs and draw up a support plan, known as a caremap, to meet those needs. The caremap should set out a small number of realistic goals designed to reduce the prisoner's risk of suicide or self-harm and each goal should be time bound and assigned to named individuals. A case manager should update a prisoner's caremap regularly and all the goals should be achieved before the ACCT procedures are ended.

Although the caremap is central to identifying the prisoner's main concerns and what can be done to help them, too often we find that caremaps are inadequate. Many of the caremaps we examined this year did not effectively identify or address a prisoner's risk factors. Actions recorded to reduce risk were often too general. They did not address issues identified when the prisoner was being assessed as part of ACCT procedure or issues that arose at later reviews. Often staff did not consider a sufficient range of factors and practical action, such as health interventions, peer support, family contact and access to diversionary activities, which might help address the prisoner's issues and reduce their risk.

> "Many of the caremaps we examined this year did not effectively identify or address a prisoner's risk factors."

Four months after he had been recalled to prison, Mr C was moved to a prison some distance from his home. He had a long history of mental health problems and self-harm. He was upset about the move as it meant that his parents, who had health problems, could not visit him. He and his cellmate barricaded their cell and demanded to be moved back. A month after his transfer, Mr C self-harmed and staff began ACCT procedures.

Mr C was still anxious about being away from his parents and the principal caremap action was to reduce his stress by arranging a transfer back to a prison nearer his home. Staff emailed an internal request for him to go back to his previous prison. This was not dealt with, apparently because the member of staff responsible had been given other duties. A few days later, Mr C cut himself again and a manager emailed the officer responsible for transfers about a move. No action was taken. Less than a week later Mr C hanged himself in his cell.

We were very concerned that no one made sure that the main identified caremap action to help reduce Mr C's risk of suicide was implemented. Although family contact was his main concern, no one considered involving Mr C's family in the ACCT process. He did not have enough money to call them but no one considered allowing him phone calls to speak to them. Lack of activity had also been identified as a risk factor. Mr C did not have a job and spent much of his time in his cell. Despite a caremap action to increase his access to activity, he lost access to the gym as part of a disciplinary punishment, which a manager refused to amend.

The case manager should review a prisoner's caremap at each case review to ensure that it is still relevant to a prisoner's current needs and risks. All actions should be addressed before the case manager can close a prisoner's ACCT, if it is safe to do so. Too often, we find this does not happen. In many cases, we find caremap actions which are simply referrals to services with no assessment of whether the referral has been effective at reducing risk before the caremap action is marked as completed.

A reception nurse began ACCT procedures when Mr D said he had recently attempted suicide by taking an overdose. Staff at case reviews did not consider all Mr D's risk factors when assessing his risk of suicide and self-harm and they set caremap actions that were little more than referrals to services: the substance misuse team, the mental health team and housing services. They were marked as completed before there was any meaningful intervention and the mental health referral was never progressed. Because of this, staff ended ACCT monitoring without any firm evidence that Mr D's risk of suicide and self-harm had reduced.

A prisoner's caremap should be fundamental to managing his or her risk of suicide. We have repeatedly found that staff at ACCT case reviews do not complete caremaps properly and do not revisit them at each case review to check that agreed actions have been completed or whether new ones need to be added as result of issues identified since the previous case review. As a result, prisoners do not get the support and interventions they need to help reduce their risk of suicide.

New psychoactive substances

There has been a lot of publicity during the year about the increasing prevalence of new psychoactive substances (NPS) in prisons. These substances are difficult to detect, as they are not identified in current drug screening tests. Many NPS contain synthetic cannabinoids, which can produce experiences similar to cannabis, but are often more potent. NPS are usually made up of dried, shredded plant material with chemical additives and are smoked. They can affect the body in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and causing vomiting.

As well as emerging evidence of dangers to both physical and mental health, including episodes of psychosis, hallucinations, erratic behaviour and paranoia, trading in these substances can lead to debt, violence and intimidation. For some people, it appears that NPS can be a trigger for suicide or self-harm. While it is difficult to establish whether taking NPS was a direct causal factor in self-inflicted deaths, the debt and bullying associated with trading drugs can increase a prisoner's vulnerability and the psychological effects can have a profound influence of mood.

“For some people, it appears that NPS can be a trigger for suicide or self-harm. While it is difficult to establish whether taking NPS was a direct causal factor in self-inflicted deaths, the debt and bullying associated with trading drugs can increase a prisoner's vulnerability and the psychological effects can have a profound influence of mood.”

Mr E was nearly two years into a long sentence when he cut his neck and told officers that he was scared of other prisoners on his wing. Until that point, he had never self-harmed in prison. No one investigated Mr E's fears for his safety, but officers started suicide prevention measures. In the early hours of the next morning, Mr E went to hospital because he had opened the cut on his neck. Two days later, he cut his neck again and the next morning an officer found Mr E had hanged himself in his cell.

The prison did not respond adequately to the rapid deterioration in Mr E's mental state and escalating self-harm. It is possible that this change in behaviour was related to his use of NPS, which he had admitted to staff, but no one referred him to substance misuse services.

We have also investigated apparent deaths from natural causes of prisoners known to be using NPS. In many cases, it is difficult to know what part, if any, the use of NPS played a part in these deaths, but in some cases the links have been established. One prisoner died of a heart attack, which the clinical review suggested was triggered by the use of NPS. In other cases, taking NPS can mask symptoms of serious health conditions and make them hard to detect.

Mr F had complained of stomach pain early in his sentence, but it seemed to resolve itself. Six months into his sentence, Mr F began to act bizarrely and did not appear to eat, drink or sleep. He was often naked in his cell, which was dirty and covered in urine. Nurses were unable to examine him and he would not engage with them.

As Mr F's mental health deteriorated further, some staff considered that he might have used NPS. He told a psychiatrist that he had been smoking 'mamba', a synthetic cannabinoid, which the psychiatrist considered was the most likely explanation for his presentation. Mr F did not mention any physical health problems to the psychiatrist or say that he was in pain.

A few days later, staff noticed blood on Mr F's body and in his cell. They thought he might have harmed himself and moved him to another cell. A nurse could not find any injuries, which might have caused the blood, but noted that it might have come from his mouth. Early the next morning, officers noticed that he had stopped breathing. A post-mortem examination found that Mr F had died from a massive internal haemorrhage and burst duodenal ulcer.

The availability of NPS in prisons remains a serious concern which is why we published a learning lessons bulletin on the subject in July 2015.[4] This made clear that managers should work to reduce the supply of NPS as well as the demand for it, by educating prisoners about the dangers of taking NPS. Prison staff need better information about NPS and managers need to tackle robustly, the associated issues of bullying and debt. All prisoners who are suspected of taking NPS should be referred to substance misuse services, for appropriate monitoring and treatment.

"Prison staff need better information about NPS and managers need to tackle robustly, the associated issues of bullying and debt."

[4] Prisons and Probation Ombudsman (2016) *New Psychoactive Substances*. London: PPO.

Foreign nationals

Approximately 12% of the UK's prison population are foreign nationals, some of whom do not speak or understand English well. This presents difficulties for prisons caring for foreign national prisoners who are at risk of suicide. Foreign nationals represented almost 20% of the self-inflicted deaths we investigated in prisons in 2015–16.

> "Foreign nationals represented almost 20% of the self-inflicted deaths we investigated in prisons in 2015–16."

The Prison Service's policy on foreign national prisoners states that language barriers can exacerbate other existing problems and that staff should not assume that prisoners who appear to comprehend English necessarily understand everything that is said to them. Poor communication can have implications for prisoners' mental and physical wellbeing. Prison Service Instructions explicitly advise staff to consider using professional interpreting services when dealing with prisoners whose first language is not English. This is particularly critical when staff are conducting assessments of risk, and conveying technical or confidential information, such as medical details. Too often, we find that this does not happen.

Mr G was Polish and spoke very little English. He was in prison for the first time and had been convicted of a violent offence against a family member. Both these factors increase the risk of suicide. No one in reception, including a nurse at an initial health screen, used a telephone interpreting service. Staff therefore had little appreciation of the continuing pressures Mr G was under.

Mr G did not attend a scheduled education induction assessment and none of the staff referred him for English classes. However, he shared a cell with another Polish-speaking prisoner who interpreted and translated for him. His cellmate later told us that Mr G found it difficult to cope with being in prison and relied on him a lot.

One morning, Mr G's cellmate was informed that he was being transferred to another prison immediately. Mr G was left alone in his cell and very anxious about the implications for him. None of the staff were aware of this or attempted to speak to him. Later that morning, Mr G hanged himself in his cell.

We were concerned that prison staff did not use professional interpreting services when assessing Mr G, and did not identify all of his risk factors, when he arrived. Mr G relied on his cellmate to interpret for him, but staff did not refer him to English classes, which might have helped to prevent his isolation. Wing staff had had little meaningful contact with Mr G over the six weeks he was in prison and no one considered the impact on him when his cellmate was suddenly transferred.

Mr H was Belarusian and did not speak or understand English well. He was very hard of hearing, which made communication through a speech interpreter very difficult, although he could sign. Mr H also had mental health problems. He had previously attempted suicide.

It was over two weeks after Mr H arrived at the prison before the prison used a British Sign Language (BSL) interpreter to assist him. Some attempts were made to communicate through prisoners who spoke Russian, although Mr H could not speak or understand Russian very well either. Staff advised him how to telephone the Samaritans, but this was of little use as he could not understand English and could not hear well enough to use the phone.

Mr H often seemed isolated and frustrated, which increased his vulnerability. Prison staff found it difficult to engage with him and support him and he said that he intended to kill himself after his impending fiftieth birthday. His mental health deteriorated and he began to show signs of a psychotic illness. A psychiatrist considered he should move to a psychiatric hospital and arranged a move before a bed became available. There was no space in the prison's inpatient unit and Mr H remained on his wing. Three days later, he hanged himself in his cell.

Mr H had an unusual and complex set of communication difficulties, but there was no strategic or coordinated approach to manage these, or to support him. There was no care plan to address his disabilities and the lack of structured support added to his isolation and frustration, with wing staff unsure how to manage him. Although he communicated best with a signing interpreter, little was done to make sure one was available for important appointments and assessments. While there was little to indicate that Mr H's risk of suicide had substantially increased in the days before his death, prison processes did not address his needs properly.

Prisoners serving indeterminate sentences

We continue to investigate a number of self-inflicted deaths of prisoners serving an indeterminate sentence, either a life sentence or an indeterminate sentence of imprisonment for public protection (IPP). Prisoners serving indeterminate sentences have a minimum amount of time they must serve in prison (sometimes known as the 'tariff') before they can be considered for release. Release is then a matter for the Parole Board, if it is satisfied that the prisoner no longer needs to be detained to protect the public. As we noted in a learning lessons bulletin in April 2014,[5] this is an uncertain situation, particularly when indeterminate sentence prisoners serve some time past their minimum term, and see no prospect of release. This can lead to a sense of hopelessness and an increased risk of suicide.

In 2005, Mr I was sentenced, to an indeterminate sentence for a violent offence against his former partner, with a minimum period to serve of just over two years. He had been in prison for 10 years, eight years past his minimum term. Mr I had spent time at a number of prisons and had completed several offending behaviour programmes but the Parole Board had never considered his risk sufficiently reduced to direct his release. He became increasingly frustrated about his lack of progress.

Mr I had a number of risk factors which heightened his risk of suicide, including depression, ADHD (attention deficit hyperactivity disorder), anxiety, a history of drug misuse, being from the Traveller community and his mother's recent death. Soon after his mother died, Mr I was refused parole and found out that his father had cancer. A few months later, the prison began ACCT procedures when Mr I said he felt like killing himself but they stopped monitoring him the same day. Mr I later said he was anxious about parole, felt beaten by the system and did not think he would ever be released.

A manager arranged to transfer Mr I to another prison when Mr I said he felt unsafe at the prison. The evening before his transfer, Mr I cut his wrist and threatened to kill himself. The prison officer who responded contacted the night manager who told him to begin ACCT procedures. This took about 10 minutes and when he went back to Mr I's cell, he found Mr I had hanged himself.

[5] Prisons and Probation Ombudsman (2014) *Risk factors in self-inflicted deaths in prisons.* London: PPO..

It was evident that Mr I had begun to despair of ever being released and his risk was exacerbated by other factors in his life. We found that Mr I did not get the support he needed and suicide and self-harm prevention procedures ended prematurely without dealing with any of the issues identified or considering any of Mr I's risk factors. The prison did not adequately investigate Mr I's concerns about his safety but instead arranged an unsuitable transfer which was likely to prolong his stay in prison, which Mr I began to recognise. We also had serious concerns about the management of Mr I's risk after he initially self-harmed on the night he died.

Common to the deaths of prisoners serving indeterminate sentences we have investigated during the year was a sense of despair about ever being released. The deaths of such prisoners are a sad reminder of the stress and uncertainty they face. In some cases, we found it would have been difficult for staff to spot the extent of this distress, but those serving indeterminate sentences often have substantial records, which can provide vital information about risk factors. When this is the case, assessing risk is often about judging how emerging events may exacerbate existing static risk factors and being watchful for any changes in behaviour, which might indicate increased risk.

“Common to the deaths of prisoners serving indeterminate sentences we have investigated during the year was a sense of despair about ever being released.”

Women prisoners

Women represent only a small percentage of the total prison population. In March 2016, there were 3,894 women in prison, less than 5% of the total prison population. Although levels of self-harm among women prisoners are very high, incidents of self-inflicted deaths are low compared to men. Sadly, this reporting year has seen an increase in self-inflicted deaths of women.

Ms J had a history of self-harm and suicide attempts, mental ill-health and substance misuse. She had never been to prison before when she was sentenced to two years for drug offences. When she arrived in prison, she discovered she was pregnant. Staff began ACCT procedures the day after Ms J arrived at the prison and continued ACCT monitoring for most of the next few months.

Ms J was told that her baby would be taken into local authority care immediately after it was born, which she was very upset about. Staff noted that a trigger for Ms J's suicidal thoughts was the likely removal of her baby. However, a month before the baby was due, staff ended ACCT monitoring. Ms J was discharged from hospital back to the prison two days after her baby was born. For another two days, staff took her to hospital so that she could feed her baby. Two days later, a prison manager decided to stop Ms J's hospital visits without any advance warning. This was not discussed with Ms J, social services or the hospital. Ms J was very upset, but no one considered beginning ACCT procedures again. Five days after giving birth to her baby, Ms J was found hanged in her cell.

Separation at birth from a child who is taken into care is traumatic for any mother, and particularly for a woman in prison. Despite good support before the birth, we found little evidence of multidisciplinary planning to support Ms J during the postnatal period, with ad hoc, uncoordinated care. To compound matters, Ms J' s risk of suicide was not managed well. She was monitored throughout the latter stages of her pregnancy but staff unaccountably decided to end suicide and self-harm monitoring before the birth, even though Ms J' distress about the imminent removal of her baby had been identified as a trigger for potential suicide. No one identified the postnatal risk.

Ms K had borderline personality disorder, substance misuse problems and depression. She had served a number of short prison sentences before she was sentenced to 18 months. Ms K was a prolific self-harmer in prison. In the 185 days she was in prison she harmed herself on 235 occasions. On 215 of these occasions, Ms K tied strips of material tightly enough around her neck to stop her breathing. Staff often found her almost unconscious or convulsing. Six months after Ms K arrived at the prison, she was found unconscious in her cell with a strip of sheet tied tightly around her neck. She did not recover and died in hospital two days later.

Many women in prison have complex needs, which makes effective multidisciplinary planning very important.

> "Many women in prison have complex needs, which makes effective multidisciplinary planning very important."

In both of these cases, we identified individual examples of good support but found failings in their overall management. In Ms J's case, we were concerned that there was poor communication and no coordinated care. In that respect, Ms J's actions could have been anticipated and possibly prevented. Ms K's case was more representative of how difficult it is to manage cases of women who repeatedly self-harm. It is not clear that Ms K intended to kill herself but the nature and frequency of her self-harm, made it extremely difficult for prison staff to prevent her death. However, her care planning lacked coherence and consistency. In both cases, because of their complex needs, we considered that the staff should have used the enhanced ACCT case management process to ensure more senior staff and relevant specialists were involved in multidisciplinary case reviews.

Children and young adult prisoners

Thankfully, there were no self-inflicted deaths of children in 2015–16, although one child died of natural causes. There were six deaths of 18–20 year olds, five of which were self-inflicted. One young man who killed himself was just 18 and had transferred from the young people's estate not long before. Some of the themes that arose from these deaths were reflected in our learning lessons bulletins on child deaths,[6] and the self-inflicted deaths of young adults in prison.[7]

> "...we considered that there needed to be better joint arrangements for children moving to the adult estate, including a management plan for at least the first six months after transfer."

Mr L was 17 years old when he was charged with sexual offences against another child. He was initially held in a young person's unit at a prison but was moved to a secure training centre because he was considered vulnerable to attack. The day after his eighteenth birthday, he was sentenced to four years in prison.

As he was no longer a child, he was held in the adult vulnerable prisoners unit of his original prison. Although the prison received information about Mr L from the youth offending service, they did little with the information and his personal officer knew little about him. Mr L often self-harmed, and was monitored under suicide and self-harm prevention procedures. Mr L had complex needs and his behaviour was difficult to manage but no one began a behavioural plan or referred him for a mental health assessment.

Six months later, Mr L was moved to another prison, due to population pressures. When he arrived at the new prison, he told a reception nurse that he had tied a ligature the previous day as he had not wanted to move, but no one identified him as at risk of suicide. No one checked him during his first night at the prison. An officer found him hanged in his cell the next morning.

6 Prisons and Probation Ombudsman (2013) *Child deaths*. PPO: London.
7 Prisons and Probation Ombudsman (2014) *Young adult prisoners*. PPO: London.

We were concerned that, despite his youth and vulnerability, Mr L's transfer to the new prison seemed to have been arranged to relieve population pressures, rather than in response to his needs. It was worrying that no one at the new prison identified that Mr L might be at risk of suicide, even when he said that he had tied a ligature the previous day because he was unhappy about his transfer.

We found that the management of Mr L's transition from a secure training centre to a vulnerable prisoner unit in an adult prison was poor. There was no effective joint planning about his future and we considered that there needed to be better joint arrangements for children moving to the adult estate, including a management plan for at least the first six months after transfer.

Control and restraint

As a matter of last resort, prison officers can use force to manage violent and non-compliant prisoners when persuasion or other means of managing the situation have not worked. Where the use of force is necessary, only approved control and restraint techniques should be used, unless this is impractical. No more force than necessary should be used and it should be proportionate to the circumstances. Officers using force are required to be trained and to recognise the dangers of using force, such as the risk of positional asphyxia, particularly when a prisoner is in a prone position. Officers should constantly monitor and risk assess the situation when using force to help ensure prisoners' safety.

"Where the use of force is necessary, only approved control and restraint techniques should be used, unless this is impractical. No more force than necessary should be used and it should be proportionate to the circumstances."

Deaths when prisoners are being restrained are relatively rare, but in the investigation into one death this year we were concerned that the national guidance to cover the specific circumstances was inadequate, and we made a national recommendation.

The prison received information that a visitor intended to pass drugs to Mr M. Plans to intercept the visitor before the visit failed, so two officers took Mr M to the search area after he left the visits hall. As they began to search him, Mr M tried to remove something from his clothing. One of the officers said they would restrain him if he did it again or made any sudden movement. When he did, the officers tried to restrain him, but Mr M resisted and the officers and Mr M fell to the floor.

Other officers arrived and saw that Mr M had a package in his hand, which he put in his mouth. He was restrained face down on the floor. The officers told him to spit the package out, and used a pain compliance technique, but he continued to resist. When they tried to stand him up, Mr M went limp. The officers realised that something was seriously wrong and radioed for emergency help.

Mr M had lost consciousness, and officers and nurses were unable to dislodge the package from his throat. Paramedics arrived and removed the package but were unable to revive him. A post-mortem examination concluded that Mr M had died from acute respiratory failure consistent with obstruction of the upper airway.

We considered that officers had reasonable grounds to restrain Mr M when he resisted the search and that they appeared to have used recognised control and restraint techniques. However, we were concerned that Mr M was restrained face down with an object in his mouth and an officer used pain compliance in an effort to persuade him to give it up. We found that the risks in using pain control techniques in these circumstances did not appear to have been fully understood and were not adequately set out in Prison Service policy and guidance. The National Offender Management Service accepted our recommendation about the need for clear guidance and training on the safe use of force, including pain-compliance techniques, when resistant prisoners have items in their mouths, which might compromise their breathing.

> “The National Offender Management Service accepted our recommendation about the need for clear guidance and training on the safe use of force.”

Deaths from natural causes

Investigations into deaths from natural causes continue to make up the majority of fatal incident investigations. In 2015–16, we began investigations into 172 deaths attributed to natural causes, an increase of 10% compared to 2014–15, and up 42% in the last five years. Much of the increase can be attributed to growth in the number of older men in prisons and it is likely that the number of these deaths will continue to rise. In most cases, there is little that can be done to prevent deaths from natural causes but it is important to establish that prisoners and other detained people in state custody have access to appropriate health services and have a standard of care, which reflects that available in the community.

Continuity of care

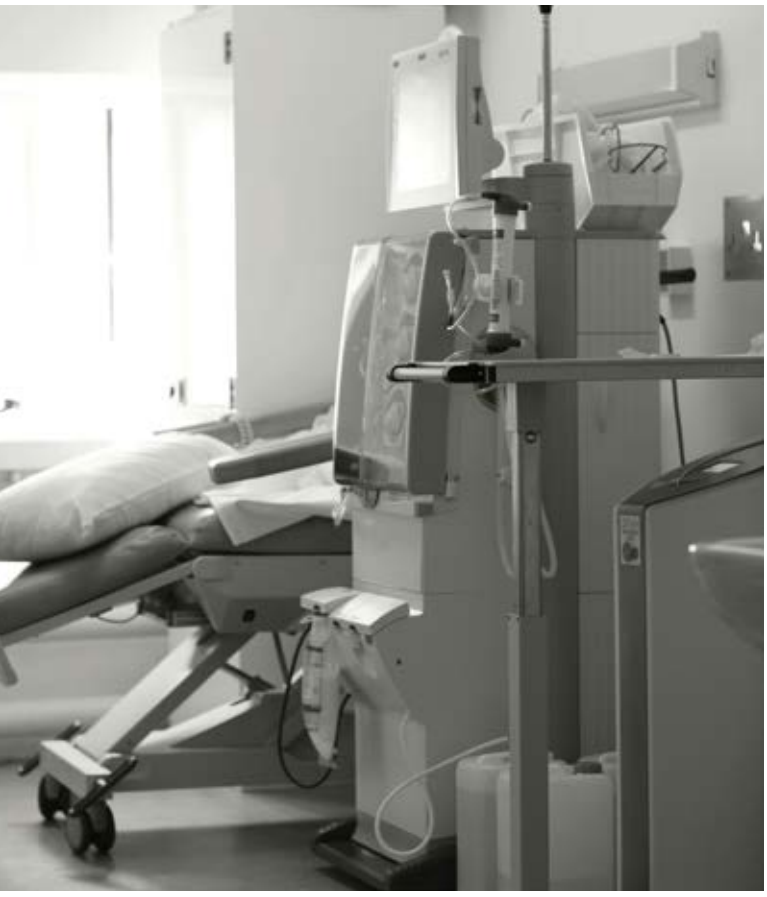
When prisoners with ongoing health issues first arrive in prison, or transfer between establishments, it is essential that there is good communication between community services and prison healthcare staff to ensure appropriate patient care. During the year, we investigated a number of deaths where the transfer of information and continuity of care were poor. Some prisons did not give sufficiently detailed medical information when prisoners transferred, some did not get necessary discharge information from hospitals and some did not request medical histories from community GPs. Usually when prisoners transfer, an up-to-date health summary, the clinical record and an initial supply of medication is sufficient, but more complex cases need more planning and direct communication between the healthcare teams involved.

Mr N was 25 years old and had suffered from unstable, brittle asthma for many years. Healthcare staff treated his asthma with a range of medication and he went to hospital frequently for treatment. When he moved prisons, the transferring prison did not give the new prison enough information about Mr N's recent treatment or medication and did not supply any actual medication. This meant that the new prison did not recognise the extent and seriousness of Mr N's asthma or his heightened risk of having an acute asthma attack. Mr N did not get prescribed the appropriate level of medication at the new prison. He died of an acute asthma attack less than a month after his transfer.

We cannot know whether better continuity of care would have prevented Mr N's death but it would have helped to ensure he received appropriate treatment.

Missed appointments

Prisoners are entirely reliant on prison staff to take them to hospital appointments but, too often, we find that appointments are cancelled. This is particularly concerning when the appointments are for important investigative tests, such as for suspected cancer, when early diagnosis can affect the chances of survival. Most such cancellations occur because of a lack of staff for escorts. Taking prisoners to hospital appointments is an increasing burden on prison resources, particularly as the prison population ages, but governors need to give appropriate priority to appointments for patients with suspected serious illnesses or who have already been diagnosed with life-limiting, complex conditions.



We are also concerned that too many prisons cancel appointments automatically, when a prisoner or their family become aware of the time and date of the appointment, in case the appointment is used as an opportunity to arrange an escape. Prison Service security procedures do not require this to happen automatically but expect that the prisoner's condition and the urgency of the treatment required should be taken into account when making such a decision. If necessary, additional security arrangements should be put in place rather than cancelling appointments. When appointments are cancelled on security grounds, there should be fully justified and recorded reasons.

Mr O began to have problems swallowing. A prison GP suspected cancer and referred him urgently to a specialist under the NHS pathway, which requires patients to be seen within two weeks. However, the prison cancelled the appointment due to a lack of available escort staff. Mr O did not see a specialist until more than a month later, when he was diagnosed with advanced lung cancer. He died a short time later.

> "...governors need to give appropriate priority to appointments for patients with suspected serious illnesses."

While the delay in seeing a specialist does not appear to have affected the outcome for Mr O, as his cancer was very advanced at the time of diagnosis, in other cases such a delay in diagnosis could be critical to survival.

End of life care

End of life care helps those with an advanced, progressive, incurable illness to live as well as possible until they die. It is about the total care of a person with an advanced incurable illness and not just about their medical care. In 2013, we published a thematic report based on a sample of over 200 of our investigation reports into deaths of prisoners where the death was foreseeable. Since then, the number of prisons with specialist end of life facilities has increased and more and more prisons are coming to terms with managing prisoners at the end of their lives. Many prisons have adapted to this new challenge well, but care is still variable and we continue to make recommendations to improve practice.

Mr P was 82 when he was sentenced to eight years in prison for historic sexual offences. He had a number of health problems, including high blood pressure, an irregular heartbeat, and stomach, bladder and bowel problems caused by an unspecified tumour. He refused surgery to remove the tumour. Prison GPs reviewed Mr P frequently. Eight months after his sentence a GP referred him to a specialist urgently for suspected cancer of the bowel. Doctors discovered a large mass in Mr P's pelvis, which was later confirmed as cancer. No active treatment was possible because of Mr P's general poor health.

Mr P had moved to another prison with 24-hour health cover after the mass was discovered. Healthcare staff began appropriate care plans and a GP talked to him about his preferences for end of life care and treatment. The prison held multidisciplinary meetings so that all relevant staff were aware of his needs and he was referred to a community palliative care team to receive the best care possible. A prison family liaison officer helped Mr P re-establish contact with his family who he had not had contact with for some years. Mr P subsequently died peacefully at the prison.

We considered that Mr P received commendably good care with regular multidisciplinary meetings to discuss his ongoing needs. He was helped to reconcile with his family. A named prison GP and other healthcare staff supported him well. His pain was well controlled and there were effective care plans to enable him to have a dignified death.

> “…the number of prisons with specialist end of life facilities has increased and more and more prisons are coming to terms with managing prisoners at the end of their lives.”

Restraints

Despite a High Court judgement in 2007, subsequent Prison Service guidance to prisons, many recommendations from this office and a 2013 learning lessons bulletin on the subject,[8] too many seriously ill and dying prisoners are still restrained by handcuffs and chains in hospital. We recognise that the Prison Service has a fundamental duty to protect the public but it has to balance this by treating prisoners with humanity.

> “…too many seriously ill and dying prisoners are still restrained by handcuffs and chains in hospital.”

The High Court judgement made it clear that prison staff need to take into account a prisoner’s health and mobility, and distinguish between the prisoner’s risk of escape when fit (and therefore the risk to the public) and the same prisoner’s risk when suffering from a serious medical condition. Many staff, including healthcare staff contributing to the risk assessments, are unaware of the legal position and the factors they should be taking into account.

In 2012, Mr Q was sentenced to six years in prison for sexual offences. He was 73 at the time. Some time before he went to prison he had had his right leg amputated because of poor diabetes control. As well as diabetes, he had high blood pressure, heart disease, chronic kidney disease and a blood clot in a vein. In 2014, Mr Q’s left leg was also amputated. Staff had to use a hoist to move him from his bed and a wheelchair to move him.

In November 2015, Mr Q was taken to hospital when he was unwell. An administrative officer from the security department completed the escort risk assessment and recorded that Mr Q’s risk of escape and to the public was ‘medium’. The administration officer also completed the medical section and recorded that there was no information on the medical notes to prevent the use of handcuffs, but highlighted that Mr Q was a double leg amputee. The deputy governor decided that Mr Q should be restrained by double handcuffs and an escort chain (a long chain with handcuffs at each end). Restraints could be removed only in an emergency. Mr Q went to hospital but refused treatment. He returned to prison that evening and died of sepsis the next day.

[8] Prisons and Probation Ombudsman (2013) *Restraints*. PPO: London.

Double handcuffing means that the prisoner's hands are handcuffed in front of them and one wrist is then attached to a prison officer by an additional set of handcuffs. This is usually required for moving category A or category B prisoners in good health. Mr Q was a category C prisoner. When, exceptionally, double cuffs are used for a category C prisoner, the reasons should be recorded in writing but there was no evidence of this. Mr Q was seriously ill when he was taken to hospital, and it was difficult to see how any level of mechanical restraint could have been justified. The deputy governor agreed it should not have happened. We were concerned that Mr Q's risk was not properly assessed and there was no input from healthcare staff. It was not the first time we had criticised the prison for using double handcuffs for an immobile prisoner in a wheelchair.

Despite these examples, some prisons have responded well to our recommendations about restraints. The following case study is an example from a high security prison, which has made effective changes to its risk assessment process to help make appropriate decisions about security for seriously ill prisoners.

Mr R had been in prison since 1974 for sexual offences and murder. He was held in a high security prison and was a category A prisoner (a prisoner whose escape would be highly dangerous to the public or national security). As he became older, he suffered from a number of chronic health problems including kidney disease. In 2010, his condition began to deteriorate significantly and from 2013 his kidneys almost ceased to function. He became very weak and frail.

In February 2014, a prison manager completed a comprehensive and considered risk management plan, which clearly took into account how Mr R's condition affected all his risks, including that of escape. The manager recorded that restraints should not be used for any future visits to hospital because of Mr R's poor health and mobility. Prison managers regularly reviewed the plan. In April 2015, Mr R was taken to hospital and remained there until he died two weeks later. He was not restrained at any time.

We commended the prisons proportionate approach, which was consistent with the legal guidance for the use of restraints for seriously ill prisoners.

Approved premises

There are around 100 approved premises (formerly known as probation and bail hostels) in England and Wales, which provide an enhanced level of residential supervision in the community, mostly for offenders who have just been released from prison. During the year, we investigated 12 deaths of residents in approved premises, five of which were from natural causes. Although these deaths represent only a small proportion of our investigations, there are some specific risks associated with prisoners who have recently been released from prison. Research suggests that, relative to the general population, people discharged from prison are 40 times more likely to die in the first week after discharge and over 90% of those deaths are drug-related.[9] Mainly this is caused by reduced tolerance levels after limited access to drugs in prison, but there is also a risk that the strength and purity of heroin might have increased from that which users had previously been used to.

“Research suggests that, relative to the general population, people discharged from prison are 40 times more likely to die in the first week after discharge and over 90% of those deaths are drug-related.”

[9] Home Office (2003) *Findings 187: Drug-related mortality among newly released offenders.* http://webarchive.nationalarchives.gov.uk/20110218135832/http:/rds.homeoffice.gov.uk/rds/pdfs2/r187.pdf

Mr S had a history of drug and alcohol abuse and when he was released from prison he was required to live in approved premises as part of his licence conditions. He was upset about this, as he had hoped to live with his mother who was ill and needed support.

On his first day at the approved premises Mr S went out twice saying he was going to the shops. When he got back in the early evening, he went to the communal bathroom. Approximately four hours later, staff found him unconscious in the bathroom with evidence that he had taken drugs. His body was obstructing the door and staff did not force it to get to him, in case they injured him. Paramedics tried to resuscitate Mr S when they arrived but a doctor confirmed that he had died. The cause of death was a heroin overdose.

“

…staff supervising residents in approved premises should have specific training in how to respond to a suspected drug overdose, including the use of naloxone”

We considered that when the staff found Mr S collapsed in the bathroom they should have made more active attempts to administer basic life support. We were concerned that, despite the high-risk population, the staff had had little training in how to respond to a drug overdose.

In November 2014, the World Health Organisation launched new guidelines on the community management of heroin overdoses and emergency administration of opiate antagonisers (antidotes), such as naloxone, by people who are not medically trained.[10] Opioid antagonists counteract the effects of opioids and can bring an overdose patient back to consciousness in minutes. In line with these guidelines, we made a national recommendation to the Director of the National Probation Service that staff supervising residents in approved premises should have specific training in how to respond to a suspected drug overdose, including the use of naloxone. The recommendation was accepted.

[10] World Health Organisation (2014) *Community management of opioid overdose* http://www.who.int/substance_abuse/publications/management_opioid_overdose/en/

Immigration removal centres

In 2015–16, we investigated the deaths of three detainees in immigration removal centres (IRCs). Of these, one was natural causes, one was apparently self-inflicted and one is awaiting classification. Deaths in IRCs are relatively rare with few discernable themes, although in one of the cases we were concerned that the family liaison was poorly handled, which we have identified in some other IRC investigations. In another of the cases, the emergency response arrangements were poor. We had previously raised concerns about emergency response arrangements at the same IRC before, in a number of other investigations into deaths in IRCs and in a learning lessons bulletin issued in March 2014.[11]

Mr T was held at an IRC after he arrived at Heathrow Airport and was refused leave to enter the UK which he appealed against. When he arrived at the IRC, he reported no health concerns. Two months later, he told a nurse he had leg pain and the nurse added him to the GP waiting list. Five days later, before he had seen a GP, Mr T suddenly collapsed in his room. Other detainees alerted the unit officer, who radioed an emergency. Nurses arrived and began cardiopulmonary resuscitation but no one called an ambulance until six minutes later. Paramedics arrived and were slightly delayed getting into the centre by a fault with the gate. Mr T did not recover and paramedics pronounced him dead. The cause of death was a heart attack caused by coronary artery arteriosclerosis and thrombosis.

The investigation found that the emergency response was not good enough. A national Detention Services Order, issued in 2014, requires control room staff to call an ambulance as soon as staff radio a medical emergency code. However, the IRC had two confusing and contradictory local policies, neither of which included this requirement. As well as the delay in calling an ambulance, there was a delay in admitting the ambulance once it arrived. Nurses could not assemble the emergency equipment properly, which meant that Mr T was not given oxygen until paramedics arrived. As we had previously expressed concerns about emergency response arrangements at the IRC, and more generally across the immigration detention estate, we considered that this issue needed to be addressed as a matter of urgency.

[11] Prisons and Probation Ombudsman (2014), *Immigration removal centres*. PPO: London.

Investigating complaints

We received almost the same number of eligible complaints in 2015–16 as in the previous year. The majority of complaints were from adult male prisoners and covered a huge variety of subjects, ranging from relatively minor matters to serious allegations of misbehaviour by staff. We upheld 40% of the complaints investigated (compared with 39% in 2014–15). This is a surprisingly high percentage considering all complaints have been through two internal stages before they reach us.

The high uphold rate not only reflects high numbers of cases where prisons simply got things wrong but also indicates poor complaints handling at a local level. For example, complaints being answered by junior staff who lack the confidence or authority to make changes; poor quality replies that do not address the issues adequately; appeals being answered by the same person who answered the first complaint; replies being provided weeks late or not at all. As a result, we see too many complaints that should have been resolved locally, without any need for complaints to be escalated to this office, as the following examples show.

Mr A complained that he had not received his full entitlement of visits because he had transferred from one prison to another. We obtained Mr A's records from the prison and established that he had taken only 20 of the 29 visits he had been entitled to. He was, therefore, 'owed' nine visits. We told the prison this and they agreed to issue Mr A with the additional visiting orders.

Mr B complained about discrepancies in his pay over Christmas. The prison said this was because he was receiving different rates of pay for his different activities (a mix of work and courses) and had received basic pay for the bank holidays. They also said that staff sometimes entered activities on the IT system late, meaning that accumulated pay was sometimes paid in arrears as a lump sum. We could see that this made it difficult for Mr B to know if he was being paid correctly. We, therefore, asked the prison to check Mr B's records. They did so and found that he was owed £2.31, which they agreed to pay him.

In both cases, all the necessary information was available at the prison and the complaints could have been easily resolved locally. This would have been quicker and more satisfactory for the complainant and cheaper for the public purse. However, when this does not happen it is important that prisoners know they have somewhere independent they can turn to when they feel they have been treated unfairly – and that is our role.

> "...it is important that prisoners know they have somewhere independent they can turn to when they feel they have been treated unfairly..."

Property

Property was once again the most frequent subject for complaints, making up 29% of all the complaints we investigated in 2015–16. We have said consistently that many of these complaints could be avoided if prison staff had simply followed the procedures for handling prisoners' property, and that many of the complaints need never reach this office if prisons accepted responsibility when things go wrong[12] (which is also reflected in a remarkably high uphold rate of 60% – a 7% increase on 2014–15).

People in custody often attach a great deal of importance to their personal belongings as a way of maintaining their identity and some freedom of choice. However, although this is an area where we can often make a real difference for individuals, property complaints can be time-consuming to investigate and take up resources that could be better used on more serious complaints.

“People in custody often attach a great deal of importance to their personal belongings as a way of maintaining their identity and some freedom of choice.”

The following cases are typical of the kind of complaints that could – and should – have been resolved locally.

[12] For example, see: Prisons and Probation Ombudsman (2014) *Prisoners' property complaints.* PPO: London.

Mr C complained that three bags of his property had gone missing when he transferred from one prison to another. His previous prison said they had sent the bags to the central storage facility by mistake. Mr C then submitted a number of requests asking for the return of the three bags. When he had still not received a reply after 12 months, he contacted us. We asked the prison to arrange for the bags to be sent to Mr C. He received them four weeks later.

Mr D complained that his mobile phone (which was kept in his stored property) was damaged when he transferred from one prison to another. His previous prison said they would investigate his complaint and respond in due course. Mr D chased on a number of occasions but received no reply. After nine months he contacted us.

We looked at Mr D's property cards. These showed that the phone had not been damaged when it was put into storage at Mr D's previous prison but was damaged when it arrived at his new prison. It was, therefore, clear that the phone had been damaged either in storage or transit while it was the responsibility of the previous prison. We contacted the prison and they agreed to meet the repair costs.

Mr E complained that he was not allowed to have his duvet cover in possession after he transferred to a new prison because it did not have a fire-resistant label. Mr E said that the label had probably fallen off in the wash and that the duvet cover must meet the regulations because he had bought it in prison in the last couple of years and had been allowed it at previous prisons. The prison told him that their decision was 'not open for discussion' and that he would not be allowed the cover.

We obtained Mr E's property cards from the prison. They showed that he had bought the duvet cover in prison from an approved supplier in 2013, two and a half years after the new fire regulations on bedding came into effect in prisons. We therefore concluded that it was reasonable to assume that the cover met the requirements and that the label had become detached through wear and tear. We explained this to the prison and they agreed that Mr E could have his duvet cover back.

Most of the complaints we see about property are genuine, but, of course, this is not always the case. Some are false or involve over-inflated claims.

Mr F complained about a lost DVD player that had been sent to him by his family. He said the item was brand new and worth over £200. Our investigation established that the prison had lost the DVD player and because Mr F could not provide a receipt to support his valuation, we attempted to mediate a settlement for £80 compensation. Mr F rejected this, saying that the item was worth much more.

At this point, Mr F's family sent us a receipt apparently showing that the DVD player had been bought for £400. Mr F said, in the light of this, he was now seeking £1000 in compensation in recognition of the stress he had suffered. However, we had some doubts about the authenticity of the receipt and we, therefore, contacted the retailer who told us that they did not sell DVD players and that the receipt was in fact for a completely different item.

Given this, we could not have any confidence that the DVD player had been brand new or that it was worth what Mr F had said. In addition, it appeared that there had been a fraudulent attempt to deceive the Ombudsman and the Prison Service into awarding more compensation than was justified. We concluded that no compensation should be paid in these circumstances, and we recommended that the prison should inform the police of our findings to consider if any action was warranted against Mr F or his family.

Links with the outside world

Many prisoners place great importance on their contact with family and friends through visits, phone calls and letters, and we continue to receive a steady stream of complaints on this subject. This contact is vital to the wellbeing of both parties, but the maintenance of strong family ties has also been shown to play a positive role in the rehabilitation of offenders. However, these complaints often raise difficult issues about the balance between the benefits of maintaining family ties and the need to ensure security and public safety, as the following examples illustrate.

> “...these complaints often raise difficult issues about the balance between the benefits of maintaining family ties and the need to ensure security and public safety...”

Mr G (a category A prisoner) complained that he was not allowed to stand and embrace family members when they visited him at his current prison, although he had been allowed to do so at other high security prisons.

We found that the relevant Prison Service Instruction is ambiguous. It says that 'reasonable physical contact' should be allowed during visits. It gives no indication of what 'reasonable' might be, but it does say that prisoners should normally be allowed to embrace their visitor at least at the beginning and at the end of the visit. Elsewhere, in an annex, it says that prisoners will normally have to remain seated at all times. We also found that the majority of high security prisons were allowing prisoners to stand and hug visitors at the beginning and end of visits.

Given the ambiguity, we could not say that Mr G's prison was not following the policy correctly. However, we considered that not allowing prisoners to stand and embrace their family members prevented any real contact between them and was likely to have a negative impact on the meaningful maintenance of relationships. We noted that the possible security implications had apparently been managed satisfactorily at other high security prisons. If there were specific security concerns about Mr G, or any other prisoner, special conditions (such as closed visits) could be applied, but we were not persuaded that there were sufficient grounds for not allowing prisoners generally to stand at the beginning and end of their visits to greet and say goodbye to their visitors. We therefore recommended, that the National Offender Management Service issue a revised Prison Service Instruction, making it clear that prisoners will normally be allowed to stand and embrace visitors at the start and end of a visit. Our recommendation was accepted.

Mr H complained that the prison was refusing to let him marry his partner in prison. The governor told us that he had refused because he believed that Mr H posed a real risk to his partner and her child in the light of his index offence.

Sentenced prisoners have a legal right to marry in prison.[13] The governor has the responsibility to determine whether the marriage should take place in prison or in the community but does not have the authority to refuse to allow a prisoner to marry. So, although we understood the Governor's motivation, we upheld Mr H's complaint.

We pointed out, however, that if the governor believed there were public protection issues, he or she must consult with other relevant agencies that are responsible for taking necessary measures to protect those at risk, such as MAPPA and social services. The governor must also consider whether information about the prisoner's offending history and risk of harm should be disclosed to the intended partner. In this case, we understand that Mr H's partner decided not to go ahead with the marriage when Mr H's offending history was disclosed to her.

[13] Marriage Act 1983. PSO 4450 (Marriage of Prisoners) sets out the procedures to be followed when a prisoner applies to marry.

Legally privileged mail

We receive a steady stream of complaints year after year about prisoners' correspondence with their legal advisers (known as Rule 39 mail). Prison Service Instruction 49/2011 provides that letters to and from solicitors and other privileged sources should not be opened or read by staff. If there is any doubt that the letter is from a privileged source, it must only be opened in the presence of the prisoner. If a Rule 39 letter is accidentally opened by prison staff, a record must be made in the prisoner's correspondence log.

As in previous years, we saw many cases where these provisions had not been followed and where clearly marked Rule 39 mail had been opened by staff. It remained the case, however, that we did not find evidence to suggest that this was being done deliberately – although we obviously remain alive to this possibility. Instead, it appeared to be down to poor staff training and poor management.

Apart from securing an apology, there is not much we can do in response to one-off cases. Where, as occasionally happens, we identify a recurrent problem at a particular prison, we generally recommend that the governor commissions a review of mail processing or arranges refresher training for the staff. The following case was rather unusual because it involved a systemic failure to follow the required procedures.

Mr I complained that his prison required prisoners to hand in Rule 39 letters for posting unsealed. When he handed in a sealed letter, it was opened by staff without him being present. The prison told him that staff needed to check all Rule 39 mail to ensure there were no unauthorised articles in the envelopes. They said this was a new policy because the prison was going to be taking a more challenging group of prisoners.

The Prison Service Instruction makes it quite clear that legal correspondence should be handed in already sealed and should not be opened by staff, other than in exceptional circumstances, where there is a good and specific reason – and even then, it should be opened in the presence of the prisoner. We were concerned that this very well-established rule was being breached at the prison and that senior managers were supporting the breach. We upheld Mr I's complaint and recommended that staff be immediately instructed that the provisions of the Prison Service Instruction must be followed.

Employment

Another important issue for many prisoners is employment, which provides them with money to make telephone calls to their families, to rent a television, and to pay for extras such as tobacco, food and clothes. Without this money, prisoners can easily get into debt and come under pressure from other prisoners to get involved in antisocial activities. Employment can also play a key role in equipping prisoners for life in the community after release.

The loss of employment is, therefore, a serious penalty for a prisoner and, as we said in our learning lessons bulletin on the subject,[14] prisons need to follow fair employment practices. Although immediate dismissal will be justified where there has been serious misbehaviour or breaches of trust, in most cases prisoners should receive a warning and have the opportunity to improve before they are dismissed. Unfortunately, we have continued to see too many cases where this has not happened.

A rather different issue was raised by Mr J who was employed by a company in the community on day release from an open prison. He complained that he was not being paid the same as non-prisoner employees doing the same work and was not receiving the national minimum wage (NMW).

Prison Service policy[15] is that the arrangements for prisoners working in the community 'must not give an unfair competitive advantage to those who employ prisoners and that prisoners must not be treated less favourably than other workers in comparable employment'. The policy says explicitly that, after a training period, prisoners who are doing a normal job in the community (as opposed to those on an unpaid voluntary or charitable placement) should be paid the same rate as the company's other employees, at or above the NMW.

At the time of our investigation Mr J had been working for the company for over a year. We found that he was being paid no more than £50 a week by the company (very substantially below the normal rate for the job) and that the prison had deducted £20 a week from this for the first four months of his employment. (The prison described this deduction as an 'administration fee'.)

[14] Prisons and Probation Ombudsman (2013) *Prisoner dismissal from employment.* PPO: London.
[15] PSO 4460 (Prisoners' Pay) and PSI 13/2015 (Release on Temporary Licence, which replaced part of the PSO in March 2015).

The prison told us that Mr J was not entitled to receive higher pay because he was on an unpaid voluntary placement. We were satisfied, however, that, apart from the first four weeks when he was being trained, Mr J had in fact been doing a normal job and that the company should have been paying him the same rate as its non-prisoner employees. We also saw evidence that the prison and the company had jointly agreed to define all the prisoners working for them as 'trainees', and we were told the company had 'insisted' on this.

Prison Service policy makes it clear that, where prisoners are employed by outside companies, it is the governor's responsibility to ensure that prisoners are paid the normal rate for the job. We were concerned that the prison had not only failed to meet that requirement in this case, but had also entered into an agreement with the company that prisoners would be paid very substantially less than they were entitled to. We were also concerned about the prison's deduction of an 'administration fee' from Mr J's wages. There is nothing in the Prison Service Finance Manual that allows for this and there was no audit trail at the prison to show what had happened to this money. It was also not clear whether the company were aware this was being done.

We made a number of recommendations, including that Mr J should receive back pay for wages he had missed out on; that there should be an investigation into what had happened to the 'administration fee'; and that the inappropriate agreement between the prison and Mr J's employers should be discussed with the parent company at a senior level to ensure that Prison Service policy on pay for prisoners doing a 'normal job' is being followed.

"We were concerned that the prison had not only failed to meet that requirement in this case, but had also entered into an agreement with the company that prisoners would be paid very substantially less than they were entitled to."

Adjudications

When we consider complaints about adjudications, our role is not to rehear the evidence but to satisfy ourselves that the adjudicator followed the proper procedures, made sufficient inquiry into the prisoner's defence to ensure a fair hearing, and imposed a proportionate punishment. Some of the procedural failings we identify are relatively minor, but others amount to fatal flaws that compromise the fairness of the adjudication and, in these cases, we recommend that the findings be quashed.

A typical example was that of Mr K who complained about being found guilty on two charges of having unauthorised articles (clothes and CDs) in his possession. Although this should have been a straightforward hearing, the adjudicator did not record the evidence he considered or why he concluded that a finding of guilt was appropriate. As a result, we could not be confident that he had considered the representations submitted by Mr K's legal representatives, and therefore, that he had reached a reasoned decision about the finding or the punishment he awarded.

We, therefore, upheld Mr K's complaint and recommended that the finding of guilt be quashed.

A different issue was raised by Mr L who complained about the delay in processing his appeal. Adjudication appeals are considered by staff at NOMS headquarters. Where a prisoner is serving a punishment of cellular confinement (as Mr L was), the prison should fast track any appeal and fax it for urgent consideration. In this case, Mr L's appeal was not forwarded for six weeks, by which time he had served his cellular confinement. Moreover, when the appeal was considered, the adjudication finding and the punishment were quashed.

We recommended that the prison apologise to Mr L and revise its processes to ensure that the problem did not recur.

Regime

We continue to see cases where prisoners are not receiving their statutory regime requirements, apparently because of staff shortages. This is particularly unacceptable where exercise, time out of cell and time in the open air are concerned.

Mr M complained that he had not had access to the library for 12 weeks. He had been told that access to the library was limited by operational need or staffing availability. This was not correct. All prisoners have a statutory entitlement to have access to the library for at least 30 minutes every week.[16]

This minimum entitlement cannot be overridden by operational need or staffing availability.

We, therefore, upheld Mr M's complaint and recommended that the prison ensure that all prisoners receive their minimum entitlement. Although the prison accepted our recommendation, Mr M continued to contact us for some months to complain that he was still not getting library access. It emerged that there was a particular problem for prisoners employed in Mr M's workshop. We, therefore, continued to raise this with the prison until we were eventually satisfied that the problem had been resolved.

[16] See PSI 02/2015 (Prison Library Service)

Categorisation

Another frequent subject of complaints was security categorisation. Many of these complaints were about being refused category D status (and therefore not being considered suitable for an open prison) or about being re-categorised from D to C (and therefore being returned from an open prison back to a closed prison). Others were from prisoners serving long sentences who had begun to address their offending behaviour and who wanted to progress through the system.

Whatever the circumstances, it is important that prisoners are held in the lowest appropriate security category and that any decisions are transparent and based on evidence. That was not the case in the following example.

> “...it is important that prisoners are held in the lowest appropriate security category and that any decisions are transparent and based on evidence.”

Mr N (a category B prisoner) complained that he was refused category C status at his categorisation review. It is not our role to say what Mr N’s category should be – that is a decision for those who know him best. However, it was not clear to us from the paperwork that the decision had been given sufficient consideration in Mr N’s case.

For example, Mr N had completed two significant offending behaviour courses since his last review, but there was nothing to indicate that the prison had considered whether or not this might have affected his risk, and nothing to explain why the prison had taken the decision it had. The impression given was that this had been a very cursory review that simply went through the motions. We, therefore, recommended that the prison conduct another review and provide Mr N with clear reasons for any decision made.

Incentives and earned privileges (IEP)

Under the IEP arrangements[17] introduced at the end of 2013, prisoners cannot be placed on the Enhanced (highest) privilege level unless they demonstrate commitment to reducing their risk of reoffending and provide evidence of helping others. As there is also a sharper distinction than before between the privileges at the different IEP levels, it not surprising that we received a large number of complaints about IEP levels, especially from prisoners who had been downgraded.

An example is the case of Mr O who complained about being downgraded from Enhanced to Standard. The prison said he had been downgraded because he was not adhering to his sentence plan and not providing evidence of helping others. Mr O complained that this was unfair – he said he could not complete the sex offender treatment programme (SOTP) because he had been wrongfully convicted, and he had applied for numerous roles in the prison to help others but had not been successful.

We concluded that, although Mr O was maintaining his innocence, the completion of the SOTP was still an appropriate sentence plan target. We also found that there was no evidence that Mr O had persisted in applying for roles to help others. We were, therefore, satisfied that Mr O did not meet the criteria for Enhanced status and that the decision to downgrade him had been reasonable.

However, we thought that Mr O's complaint raised an important question about whether there were sufficient opportunities at his prison for prisoners to demonstrate they were helping others. A fundamental principle of any incentives scheme is that everyone must feel they can earn the rewards available. If prisoners cannot achieve Enhanced status because of circumstances beyond their control, there is no motivation for them to keep trying.

We therefore recommended, that the governor should amend the local IEP policy to make it clear that there was a range of ways in which prisoners could help others, and not just by holding one of a prescribed list of roles.

> "...we received a large number of complaints about IEP levels, especially from prisoners who had been downgraded."

[17] PSI 30/2013 (Incentives and Earned Privileges)

Segregation

In July 2015, the Supreme Court[18] found that the Prison Service's long-standing procedures for authorising segregation beyond 72 hours were unlawful.[19] The situation was regularised by new legislation in September 2015, but we have had a number of complaints about the legality of segregation authorised under the old procedures. The Ombudsman's office is not a court and we are not able to determine lawfulness. We have therefore, advised these complainants to bring legal proceedings if they want to challenge this aspect of their segregation and have continued to investigate complaints about other segregation issues.

> "...any decision to segregate must be carefully and comprehensively considered and documented. This does not always happen."

The segregation of any prisoner is a serious matter. It is a further curtailment of his or her remaining liberty and can be mentally and emotionally damaging. For these reasons, any decision to segregate must be carefully and comprehensively considered and documented. This does not always happen.

An example was the case of Mr P who complained that he was segregated at a high security prison for seven weeks without being told why. When we investigated, we could not find a clear and convincing account of why Mr P had been segregated. The reason recorded initially was that weapons found in a workshop were considered 'attributable' to him. There was no security intelligence to support this, however, and later paperwork said that he was segregated because of concerns about his behaviour in the workshop. This was not sufficient to justify segregation for seven weeks.

In addition, we were concerned that the explanations Mr P was given, did not meet the requirement to tell prisoners the reason for their segregation. Mr P was repeatedly told that an investigation was being carried out but we saw no evidence that this was the case. We upheld Mr P's complaint and recommended that the governor remind managers of the importance of providing prisoners with a full written account of the reasons for their segregation and of recording the steps being taken to bring the segregation to an end as soon as possible.

[18] R (oao Bourgass and another) v Secretary of State for Justice [2015] UKSC 54.
[19] New legislation came into effect in September 2015 which regularised the situation and introduced additional safeguards for prisoners.

Equality and diversity

Mr P's case also illustrated our concerns about the inadequate way in which prisons can treat complaints about discrimination. Although Mr P made repeated allegations that he was being victimised because of his faith, he did not receive a considered response to these complaints – he was simply given bland assurances that this was not the case. This was poor, especially in the absence of a proper explanation of why he had been segregated.

This was typical of many of the complaints we received about discrimination. In far too many cases, the prisoner was either simply assured that there had been no discrimination or this aspect of the complaint was ignored altogether. A different equality issue was raised by the following case.

Ms Q (who is in the security category eligible for open conditions) applied to transfer to a prison with an open unit. Her transfer request was refused and Ms Q complained that she had been discriminated against because she is a transgender woman.

Our investigation found that Ms Q had begun her sentence in a male prison (where she had been located in the segregation unit for her own safety), but had then transferred to a female prison where she had settled without problems. She now wanted to transfer to an open prison in the area closest to her resettlement address to aid her rehabilitation and resettlement.

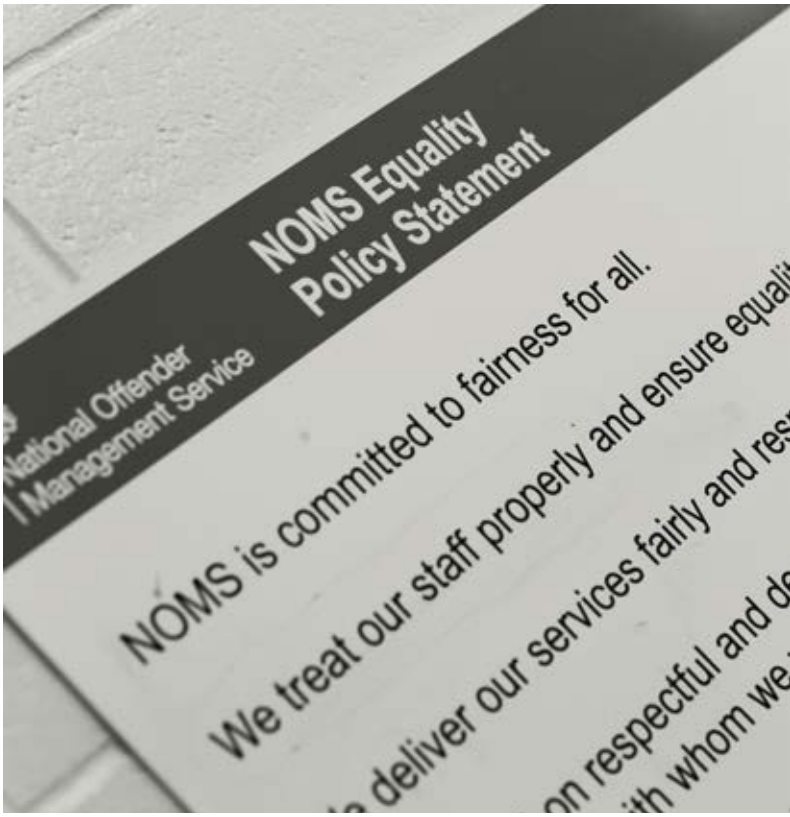
The prison said that, although Ms Q had a gender recognition certificate (GRC), she had not had surgery and her male genitalia were intact. They said that they had a large number of women prisoners who had experienced abuse, that they did not have private shower facilities and that most of their accommodation was unsupervised at night. They said that they had, therefore, rejected Ms Q's application on the grounds of safety and decency, and not because she was transgender.

We recognise that the accommodation of transgender prisoners can raise some difficult issues for the Prison Service to manage. However, the legal position is clear:[20] a person's gender is a legal rather than an anatomical question and the fact that Ms Q had not undergone surgery is irrelevant. She has a GRC and is therefore a woman, under UK law.

This means, among other things, that Ms Q should be offered the same opportunities to transfer to the open estate as other female prisoners. Not to offer her these opportunities on the grounds of her transgender status would be discriminatory in the same way as it would be to refuse her a transfer to the open estate on the grounds of her race or religion.

[20] PSI 07/2011 (The Care and Management of Transsexual Prisoners)

We recommended that the prison should re-assess Ms Q's transfer request against the same criteria that they would use for any other woman. We added that, if Ms Q met the criteria for a transfer, she should be accepted in the usual way. The prison would need to produce a care plan to manage her safely and decently, identifying and managing any risks to and from Ms Q, in the same way as they would with any other prisoner. This might mean, for example, that they would need to make arrangements for Ms Q to shower at a different time or in a different location from other prisoners, or to be accommodated in a single room. The prison accepted our recommendation and a few weeks later Ms Q was accepted for a transfer.



> "In far too many cases, the prisoner was either simply assured that there had been no discrimination or this aspect of the complaint was ignored altogether."

Staff behaviour

Although complaints about staff behaviour made up 6% of our caseload, complaints about alleged physical abuse by staff were thankfully low. We investigated 44 such allegations in 2015–16, compared with 25 the year before. They are, however, among the most serious complaints that we receive. Our investigations help to ensure that staff are held accountable for any misbehaviour – and they can be equally important in providing reassurance in other cases that the use of force by staff was necessary for the preservation of security and safety.

Prisons can be violent places. The use of force must, therefore, always be available to staff as an option. It is crucial, however, that staff use force only when strictly necessary and that any force used is proportionate to the circumstances.[21]

Two years ago we set up a specialist team to investigate serious complaints about staff, including about the use of force on prisoners, children and young people, and immigration detainees. We have also set out the key lessons for establishments from these investigations in two learning lessons bulletins.[22]

Mr R complained that use of force had been used on him unnecessarily. He had no history of violence to staff. He was told he was going to be moved to another wing the next day which he was very worried about because he thought there was a prisoner on that wing who had assaulted him in the past. He expressed his concerns to staff and was told that the wing manager would come and talk to him about it, but this did not happen. Instead a planned removal was arranged as staff thought he would refuse to move.

Later that day, a control and restraint (C&R) team in full personal protection kit came to his cell and told him he was being moved. Mr R said that he would rather go to the segregation unit. At that point, the C&R team entered the cell at speed, without further discussion, pushing Mr R to the back of the cell with a shield. He was then restrained with his arms behind his back and handcuffed. The video footage showed that Mr R offered no resistance and was fully compliant as he was taken to the segregation unit.

[21] Prison service policy on the use of force is set out in PSO 1600. This says that the use of force is justified, and therefore lawful, only if it is reasonable in the circumstances; necessary; if no more force than is necessary is used; and if it is proportionate to the seriousness of the circumstances.

[22] Prisons and Probation Ombudsman (2014) *Use of force;* Prisons and Probation Ombudsman (2016) *Use of force (further lessons).* PPO: London.

We concluded that the supervising officer was far too quick to initiate force, and that this was done without any attempt at persuasion or de-escalation. Mr R was not posing any physical threat and the good order of the establishment was not at risk at that point. The supervising officer did not appear to understand that force should be a last resort and that he had a duty to try to resolve the situation without using force.

We also concluded that the prison should have addressed Mr R's concerns about the move before the planned removal. As it turned out, the prisoner he was worried about had already moved to another wing. If Mr R had been told this, there is every reason to believe he would not have objected to moving wings. We were satisfied that this situation could and should have been resolved without the use of force and we upheld Mr R's complaint.

"The supervising officer did not appear to understand that force should be a last resort and that he had a duty to try to resolve the situation without using force."

Prisoner on prisoner violence

With rising levels of violence in prisons, it is not surprising that we received a number of complaints from prisoners who believed staff had failed to protect them from attack.

A typical case was that of Mr S who was assaulted in his cell by another prisoner. He complained that the assault had occurred because a named member of staff had disclosed his offence to other prisoners. He also complained that the prison had not supported him properly after the assault.

As a result of our investigation, we did not uphold every aspect of Mr S's complaint – for example, we found that he had received a good level of medical attention after the assault and he had been given the opportunity to transfer to a vulnerable prisoner wing (which he declined). However, we were not satisfied that the prison had carried out an adequate investigation into Mr S's serious allegation against the member of staff, or made adequate efforts to take action against Mr S's attacker. In the circumstances, we did not think it was surprising that Mr S felt his complaints had not been taken seriously. We recommended that the prison should introduce systems for following up violent incidents and providing support to victims.

> “We recommended that the prison should introduce systems for following up violent incidents and providing support to victims.”

Complaints from children and young people

As in previous years, we received a disproportionately small number of complaints from under-21s,[23] and only 24 of the 2,290 complaints we investigated were from children and young people. When young people did complain, the most frequent topics were property, adjudications and staff behaviour. Among them were some serious complaints.

For example, Mr T (who was 16) complained that staff in a secure training centre assaulted him on two occasions. His legal representatives also complained that the centre had failed to investigate his complaints adequately.

The first incident occurred after Mr T had been excluded from outdoor activities because of his behaviour earlier in the day. The CCTV footage showed that Mr T tried to go out with the other boys, despite being excluded, and stood in the way of the door. We could see that three staff spent seven minutes trying to persuade Mr T to leave the door. A member of staff then stood between Mr T and the door to let the other boys out. At this point Mr T struck her twice with his arm and pushed another member of staff. Staff then restrained him.

We considered that staff dealt with the situation in a very patient and professional manner. We were satisfied that Mr T was posing a risk to staff and perhaps to other boys, and that the use of force was reasonable in the circumstances. However, we were concerned that a member of staff used an incorrect and potentially dangerous head hold during the restraint. We, therefore, upheld this part of Mr T's complaint and we recommended that the member of staff be given formal advice and guidance.

We were also concerned that, about a minute after the restraint began, staff and Mr T moved onto a stairwell where they were out of sight of the CCTV camera. Mr T said this was when staff assaulted him. We were aware that the Youth Justice Board has a general concern about incidents 'being taken off camera' in STCs and YOIs. However, there was not enough evidence to enable us to conclude that it was done deliberately in this case.

The second incident took place in Mr T's bedroom a few weeks later. Mr T and staff agreed that he was using the phone when he should not have been, that two staff entered the bedroom, that Mr T threw toiletries at them, and that the staff removed the phone and left the room. However, Mr T said that one of the staff grabbed him by the throat, but staff said that there was no physical contact.

[23] Complaints from those under 21 made up 1.5% of all complaints received, yet this age group account for 6.2% of the total prison population (based on Ministry of Justice *Offender Management Statistics Quarterly, Prison Population:* 31 March 2016).

There was no CCTV in the bedroom and this, therefore, came down to Mr T's word against the word of the staff. Without further evidence either way, we could not say, even on the balance of probabilities, that the assault Mr T described took place. We recognised that our inability to reach a conclusion about what happened in the stairwell or in the bedroom was not satisfactory for Mr T or the staff involved, but in the absence of corroborative evidence, it was the only finding we could reach.

With regard to the local investigation, the STC correctly referred Mr T's complaints to the local authority designated officer (LADO) who then supervised and directed an investigation. We had several criticisms of this investigation and, although the LADO is not within our remit, we copied our report to the LADO to highlight our concerns.

We were also critical of the STC's failure to provide Mr T's representatives with a copy of the CCTV footage. It is not the case, as the STC said, that doing so would have contravened the Data Protection Act. They should either have made it available to view at the centre or provided a copy with the faces of the other boys pixellated out.

Another serious complaint involved 17-year-old Mr U whose legal representatives complained that the young offender institution (YOI) had failed to provide him with a lawful regime and had failed to respond to complaints they had submitted on his behalf.

We found that Mr U had a history of assaulting other young people and staff at the YOI, and in a little over a year he had had more than 130 days added to his sentence for serious offences in the YOI. We recognised that the YOI experienced real difficulties in managing his challenging behaviour and the risk he posed to others.

On one occasion, he was segregated for 21 days under Rule 49 for the safety of staff and other young people. Although this was a long time for a 17-year old, we were satisfied that it was justified in Mr U's case. However, we were concerned that it was impossible to establish exactly what regime Mr U had access to when he was not segregated. Because of his behaviour, he was subject to a complex mix of behaviour management plans, single unlock, IEP levels and privilege losses following adjudications. There was no single record that showed how much time he had out of his room each day, what access he had to association and purposeful activity, or what privileges (such as TV and canteen) he enjoyed on any particular day.

As we have said in similar cases in the past, without a clear overall record, it is difficult to be sure that a combination of a restricted regime and other sanctions does not effectively amount to a form of unauthorised and unregulated segregation on occasions. We were also concerned that the YOI had not replied satisfactorily to the complaints submitted on Mr U's behalf.

This office sees too many cases, like this one, where complaints submitted through lawyers have received inadequate and/or very tardy replies and prisoners should not be disadvantaged because their complaint has been submitted by a lawyer. While it is not realistic to expect prisons to respond to complaints from lawyers in the same timescale as they are required to respond to complaints submitted directly by prisoners, we can see no reason why prisons should not be expected to follow the principles set out in Prison Service Instruction 02/2012.

Complaints from female prisoners

We also received a disproportionately small number of complaints from female prisoners. Although women made up 4.5% of the total prison population,[24] they accounted for only 1.8% of all the complaints we received from prisoners.[25] When women did complain, their concerns were generally similar to those of male prisoners, with property being the largest category. In addition to complaints about property, women also raised concerns in their complaints about contact with family and friends. One such case was that of Ms V, which illustrates the difficult issues that can arise over contact with children.

Ms V (who is serving a life sentence) complained that the prison was preventing her having contact with her three children (two minors and one over the age of 18).

We found that there was a court order in place that restricted Ms V's contact with the two youngest children, to six letters or cards a year via social services, which we were satisfied was not a forgery (as Ms V believed).

[24] Ministry of Justice (2016) *Offender Management Statistics Quarterly, Prison Population: 31 March 2016.*

[25] This statistic refers to the number of complaints received from prisoners living in the female estate. It does not include complaints received from male to female transgender prisoners living in the male estate.

We were therefore satisfied, that the prison had acted correctly in not allowing Ms V to have visits or telephone calls with the children, and in stopping her attempts to contact the children via third parties.

We also found that the adult child had telephoned the prison to request no contact with Ms V. We were, therefore, satisfied that the prison had acted correctly in preventing Ms V writing to or telephoning her child. We did not, therefore, uphold Ms V's complaints.

> "Although women made up 4.5% of the total prison population, they accounted for only 1.8% of all the complaints we received from prisoners."

We were concerned, however, that Prison Service policy was unclear on whether or not no contact requests should be made in writing. We also found that the prison was confused about how to deal with child contact cases where restrictions were based on reasons other than the prisoner's offence. Finally, we thought that more could have been done to explain the reasons for the restrictions to Ms V. We made recommendations on all these points.

Complaints from immigration detainees

We investigated 30 complaints from immigration detainees. Most were about property or staff behaviour.

A typical case was that of Mr W who complained that a friend had sent him £100 cash by recorded delivery but that, when he received the letter, the envelope was empty and had clearly been tampered with. The immigration removal centre (IRC) had refused to compensate Mr W as they said the envelope had been opened before it arrived at the centre and that they were not, therefore responsible for any loss. They advised Mr W to complain to Royal Mail.

We investigated the case as a priority as Mr W was due to be deported in a few days. We found that staff at the centre had signed for the letter when it was delivered. They said that they only noticed later that the envelope had been opened and was empty. We had no way of knowing if this was correct or not, although we noted that there had been a recent spate of money going missing from letters sent into the centre.

We took the view that the centre had accepted that the letter was in good condition when they signed for it, and so had prevented Mr W seeking any form of recourse from Royal Mail. Although there was no proof that the envelope had contained £100, there was evidence that Mr W's friends had sent him similar amounts in cash in the past. We, therefore, recommended that the IRC pay Mr W the full sum in compensation before he was deported. We also recommended that the centre carry out an internal investigation into this and other similar cases of missing money, in order to establish whether the problem lay inside or outside the centre.

Complaints from probation supervisees

We received 323 complaints from probation supervisees. Of these only 11% were eligible for investigation (compared with 59% of complaints from prisoners and 55% of complaints from immigration detainees). Although the eligibility rate of complaints from probation supervisees has always been lower than that of other groups, it has dropped to an all time low since the changes to probation and the establishment of the Community Rehabilitation Companies (CRCs). We regularly receive telephone calls from supervisees who want to complain to or about a CRC but do not know how. The case of Mr X illustrates the problem.

> “We regularly receive telephone calls from supervisees who want to complain to or about a CRC but do not know how.”

Mr X (who was being supervised by a CRC) complained about the facilitator on an offending behaviour course he had attended. He said she had treated him unfairly during the course and written inaccurate comments about his behaviour on the course in a report, and had repeated those comments during a family court hearing.

The CRC initially told Mr X that they could not investigate his complaint because it was about the decision of a court. When Mr X appealed against this response, the chief executive of the CRC repeated what had already been said, but added that she had read the course report and watched the DVD of the session Mr X had complained about. She said that not all the conversations were audible on the DVD and so she could neither confirm nor refute some of the comments Mr X was said to have made. However, she said she did not believe Mr X had been unfairly treated by any of the facilitators, or that they had conspired against him in any way. She also said that if Mr X wanted to take the matter further, he should complain to the Ombudsman – which he did.

We considered that Mr X's complaint had been about the facilitator and the contents of her report, not about the decision of the family court, and that the CRC should therefore have investigated it.

> "We were also concerned that the CRC was not following the mandatory requirements for the handling of complaints set out in Probation Instruction 51/2014."

We were also concerned that the CRC was not following the mandatory requirements for the handling of complaints set out in Probation Instruction 51/2014. We did not consider that the chief executive's response met the requirement for a formal investigation. We were also concerned to learn that the chief executive carried out the function of an appeals body for the CRC by herself. We did not consider this met the requirement for an appeal panel, of at least three senior people, to hear complaints appeals.

We recommended that the CRC appoint a suitable person to investigate Mr X's complaint, and that the chief executive should establish an appeal panel, as required by the PI.

Learning lessons from PPO investigations

Our investigations into both fatal incidents and complaints often identify areas for improvement and result in recommendations to the establishment in question. However, there is also much to be learned from collective analysis of our investigations. One of the Ombudsman's key commitments throughout his tenure has been to introduce and develop a learning lessons agenda. The office has a dedicated learning lessons team who collect standardised information about investigations, and identify trends and common themes. This is presented and disseminated through learning lessons publications, which aim to promote safer, fairer custody and offender supervision.

In 2015–16, we published five learning lessons reports. The first, in June 2015, set out learning from investigations into the self-inflicted deaths of prisoners being held in segregation at the time of death. It examined the rules and procedures for segregated prisoners, the use of segregation for extended periods and the suitability of segregation for vulnerable prisoners, particularly those being managed under suicide and self-harm procedures. The bulletin found that challenging prisoners, particularly those suffering from mental health issues, can also have significant vulnerabilities which may be worsened by segregation. It emphasised the importance of prison staff understanding and following mandatory procedures for safeguarding segregated prisoners, and the need for thorough screening and review of the appropriateness of the initial use and any continuation of segregation.

"The bulletin found that challenging prisoners, particularly those suffering from mental health issues, can also have significant vulnerabilities which may be worsened by segregation."

In July 2015, we published a bulletin about New Psychoactive Substances (NPS). The bulletin looked at 19 deaths in prison, between April 2012 and September 2014, where the prisoner was known or strongly suspected, to have been using NPS before their death. It identified risks to physical health from NPS, such as drug toxicity, seizures or heart failure. It also identified risks to mental health, including unpredictable behaviour and psychotic episodes, and potential links to self-harm and suicide. In addition, the bulletin considered issues around debt and bullying which can be associated with NPS use, and which can increase the risk of suicide and self-harm among the vulnerable. The bulletin stressed the importance of effective local strategies for drug supply reduction and violence reduction for tackling NPS use in prisons. It also emphasised the need for prison staff to be provided with information about the possible signs of NPS use, and for prisoners to be educated about the effects and risks of NPS.

> “...the bulletin considered issues around debt and bullying which can be associated with NPS use, and which can increase the risk of suicide and self-harm among the vulnerable.”

Our learning lessons agenda also considered issues raised by our complaint investigations. In September 2015, we published a bulletin looking at legal and confidential letters. Such mail should not be opened by prison staff, unless there are grounds to suspect that it contains illicit items or is not from an organisation whose mail is protected under confidentiality rules. The bulletin found that most instances of mail being wrongly opened were one-off and occasional errors. However, it uncovered a small number of cases where staff training or processes had not been adequate to prevent repeated errors. The bulletin emphasised the importance of correspondence logs being sufficiently detailed, routinely completed and regularly monitored for quality and completeness. It also stressed that staff working with prisoner letters need to fully understand the requirements for handling confidential correspondence and to be clear about which organisations are covered by the rules for legal and confidential mail.

At the beginning 2016, we published a thematic report about prisoner mental health which brought together lessons from investigations of both natural cause and self-inflicted deaths. Mental ill-health is one of the most prevalent and challenging issues in prisons. The report considered the changes that have taken place in recent years regarding mental health provision in prisons, and reviewed the deaths of over 500 prisoners who died in prison custody between 2012 and 2014. It found that some improvement had been made in managing the mental health needs of prisoners, but that there was still a long way to go. The report identified a number of areas for improvement related to both the identification of mental health problems and the provision of care. It stressed the importance of staff training in order to facilitate positive change. Although there is clearly room for improvement, the report recognised that prisoners with mental health needs can sometimes be very difficult to manage, and referenced positive examples where staff had gone to great lengths to ensure that prisoners in crisis received excellent care.

> “Mental ill-health is one of the most prevalent and challenging issues in prisons. The report considered the changes that have taken place in recent years regarding mental health provision in prisons, and reviewed the deaths of over 500 prisoners who died in prison custody between 2012 and 2014.”

The final publication of the year was a bulletin which examined the self-inflicted deaths of prisoners within their first few days and weeks in custody. The initial period of custody is often a difficult time for prisoners, and can be a time when those at risk of suicide are particularly vulnerable. The bulletin identified that too often, staff failed to recognise or act upon indicators of a heightened risk of suicide.

In addition to publications, we have used other avenues to disseminate learning from our investigations. In October 2015, we ran a second annual series of learning lessons seminars for operational staff, which were well attended by representatives from establishments across England and Wales. Feedback from attendees was very positive.

Appendices

Statistical tables

Fatal incident investigations started	Total 2014/15	% of total (14/15)	Total 2015/16	% of total (15/16)	Change 14/15–15/16	% change year on year
Natural	157	63%	172	57%	15	10%
Self-inflicted	77	31%	103	34%	26	34%
Other non-natural**	13	5%	11	4%	-2	*
Homicide	4	2%	6	2%	2	*
Awaiting classification	0	0%	12	4%	12	*
Total	**251**	**100%**	**304**	**100%**	**53**	**21%**

* 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.

Fatal incident investigations started	Total 2014/15	% of total (14/15)	Total 2015/16	% of total (15/16)	Change 14/15–15/16	% change year on year
Male prisoners	225	90%	271	89%	46	20%
Female prisoners**	10	4%	11	4%	1	*
Young offenders	6	2%	7	2%	1	*
Approved premises	8	3%	12	4%	4	*
IRC residents***	2	1%	3	1%	1	*
Total	**251**	**100%**	**304**	**100%**	**53**	**21%**

* 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 death of one transgender prisoner in 2014–15 and two in 2015–16.

*** In 2014–15, one IRC resident was held under immigration powers at the The Verne which was in transition from prison to IRC at the time of death.

Fatal incident investigations started	Male prisoners	Female prisoners**	Young offenders (under 21)***	Approved premises residents	IRC residents	TOTAL
Natural	162	2	2	5	1	172
Self-inflicted	85	9	5	3	1	103
Other non-natural*	7	0	0	4	0	11
Homicide	6	0	0	0	0	6
Awaiting classification	11	0	0	0	1	12
Total	**271**	**11**	**7**	**12**	**3**	**304**

* 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 an investigation into the death of one transgender prisoner in 2014/15 and two in 2015/16.

*** This also includes children under the age of 18. We investigated the death of one child in 2015/16, who died of natural causes.

Fatal incident reports issued	Total 2014/15	% in time*	Total 2015/16	% in time*	Change 14/15–15/16 (volume)	% change year on year (volume)
Draft reports	245	97%	284	100%	39	16%
Final reports	253	57%	261	82%	8	3%
Reports published on website	419**		258		-161	-38%

* In time for draft 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 draft.

** The large number of reports published in 2014–15 can be explained by a number of historic cases being published on the website that year.

Complaints received	Total 2014/15	% of total (14/15)	Total 2015/16	% of total (15/16)	Change 14/15–15/16	% change year on year
Prison	4582	92%	4397	92%	-185	-4%
Probation	318	6%	323	7%	5	2%
Immigration detention	62	1%	58	1%	-4	-6%
Secure training centre	2	<1%	3	<1%	1	*
Total	**4964**	**100%**	**4781**	**100%**	**-183**	**-4%**

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

Complaints accepted for investigation	Total 2014/15	% of total (14/15)	Total 2015/16	% of total (15/16)	Change 14/15–15/16	% change year on year
Prison	2310	97%	2288	97%	-22	-1%
Probation	37	2%	38	2%	1	3%
Immigration detention	32	1%	30	1%	-2	-6%
Secure training centre	1	<1%	1	<1%	0	*
Total	**2380**	**100%**	**2357**	**100%**	**-23**	**-1%**

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

Complaints investigations completed	Total 2014/15	% of total (14/15)	Total 2015/16	% of total (15/16)	Change 14/15–15/16	% change year on year
Prison	2079	96%	2215	97%	136	7%
Probation	51	2%	43	2%	-8	-16%
Immigration detention	29	1%	30	1%	1	3%
Secure training centre	0	0%	2	<1%	2	*
Total	**2159**	**100%**	**2290**	**100%**	**131**	**6%**

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

Prison complainants 2015/16 (completed complaints)	Number of complainants	% of complainants	Number of complaints	% of complaints
Male prison estate	1482	98%	2185	98%
Female prison estate	26	2%	30	2%
Total	**1508**	**100%**	**2215**	**100%**

Complaints completed per prison complainant (2015/16)	Number of complainants	% of complainants	Number of complaints	% of complaints
11+	8	1%	133	6%
6 to 10	26	2%	184	8%
2 to 5	265	18%	689	31%
1	1209	80%	1209	55%
Total	**1508**	**100%**	**2215**	**100%**

Prison fatal incident investigations started in 2015–16

Prisons	Natural	Self-inflicted	Other non-natural*	Homicide	Awaiting classification	Total
Exeter	7	4	0	0	0	11
Isle of Wight	10	0	0	0	0	10
Norwich	8	1	0	0	0	9
Wakefield	8	0	0	0	1	9
Bullingdon	4	3	0	0	0	7
Littlehey	7	0	0	0	0	7
Woodhill	0	6	0	0	1	7
Leeds	2	4	0	0	0	6
Parc	5	1	0	0	0	6
Ranby	0	4	1	1	0	6
Winchester	2	3	0	0	1	6
Frankland	5	0	0	0	0	5
Full Sutton	5	0	0	0	0	5
Guys Marsh	2	3	0	0	0	5
Holme House	3	1	1	0	0	5
Liverpool	4	1	0	0	0	5
Wandsworth	1	3	0	1	0	5
Whatton	5	0	0	0	0	5
Wormwood Scrubs	4	1	0	0	0	5
Birmingham	2	1	1	0	0	4
Doncaster	3	1	0	0	0	4
Elmley (Sheppey)	4	0	0	0	0	4
Humber	2	1	0	0	1	4
Lindholme	3	0	0	0	1	4
Moorland	3	1	0	0	0	4
Northumberland	1	2	0	0	1	4

Prisons	Natural	Self-inflicted	Other non-natural*	Homicide	Awaiting classification	Total
Pentonville	1	3	0	0	0	4
Peterborough (male and female)	2	1	0	1	0	4
Altcourse	3	0	0	0	0	3
Belmarsh	2	1	0	0	0	3
Bristol	1	2	0	0	0	3
Channings Wood	2	1	0	0	0	3
Chelmsford	0	3	0	0	0	3
Dartmoor	1	0	1	1	0	3
Dovegate	2	1	0	0	0	3
Durham	1	2	0	0	0	3
Forest Bank	1	2	0	0	0	3
Foston Hall	0	3	0	0	0	3
Hewell	1	2	0	0	0	3
High Down	1	1	0	0	1	3
Hull	2	1	0	0	0	3
Lewes	2	1	0	0	0	3
Low Newton	1	2	0	0	0	3
Lowdham Grange	1	1	1	0	0	3
Manchester	0	2	0	0	1	3
Nottingham	2	0	0	1	0	3
Preston	3	0	0	0	0	3
Stafford	3	0	0	0	0	3
Stocken	2	1	0	0	0	3
Wayland	2	1	0	0	0	3
Bedford	1	1	0	0	0	2
Buckley Hall	2	0	0	0	0	2

Prisons	Natural	Self-inflicted	Other non-natural*	Homicide	Awaiting classification	Total
Coldingley	2	0	0	0	0	2
Featherstone	1	1	0	0	0	2
Garth	1	1	0	0	0	2
Gartree	1	1	0	0	0	2
Grendon/Springhill	1	1	0	0	0	2
Leyhill	2	0	0	0	0	2
Lincoln	1	1	0	0	0	2
The Mount	0	2	0	0	0	2
Onley	1	1	0	0	0	2
Rye Hill	2	0	0	0	0	2
Stoke Heath	1	1	0	0	0	2
Sudbury	1	0	1	0	0	2
Swaleside (Sheppey)	1	1	0	0	0	2
Whitemoor	2	0	0	0	0	2
Wymott	2	0	0	0	0	2
Ashfield	1	0	0	0	0	1
Brinsford	0	1	0	0	0	1
Brixton	0	0	0	0	1	1
Bronzefield	0	1	0	0	0	1
Bure	1	0	0	0	0	1
Cardiff	0	1	0	0	0	1
Cookham Wood	1	0	0	0	0	1
Erlestoke	0	1	0	0	0	1
Glen Parva	0	1	0	0	0	1
Haverigg	1	0	0	0	0	1
Highpoint (North and South)	1	0	0	0	0	1

Prisons	Natural	Self-inflicted	Other non-natural*	Homicide	Awaiting classification	Total
Hindley	0	1	0	0	0	1
Holloway	0	1	0	0	0	1
Isis	0	0	0	0	1	1
Lancaster Farms	0	0	1	0	0	1
Leicester	0	1	0	0	0	1
Long Lartin	0	0	0	1	0	1
Maidstone	0	1	0	0	0	1
New Hall	0	1	0	0	0	1
North Sea Camp	1	0	0	0	0	1
Oakwood	0	1	0	0	0	1
Risley	1	0	0	0	0	1
Rochester	0	1	0	0	0	1
Swansea	0	1	0	0	0	1
Swinfen Hall	0	1	0	0	0	1
Thameside	0	1	0	0	0	1
Usk/Prescoed	1	0	0	0	0	1
Warren Hill	0	0	0	0	1	1
Wealstun	0	1	0	0	0	1
Total	**166**	**99**	**7**	**6**	**11**	**289**

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

IRC fatal incident investigations started in 2015–16

IRCs	Natural	Self-inflicted	Other non-natural*	Homicide	Awaiting classification	Total
Colnbrook	0	0	0	0	1	1
The Verne	0	1	0	0	0	1
Yarl's Wood	1	0	0	0	0	1
Total	**1**	**1**	**0**	**0**	**1**	**3**

* 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 2015–16

Approved premises	Natural	Self-inflicted	Other non-natural*	Homicide	Awaiting classification	Total
Abingdon Road	1	0	0	0	0	1
Basildon	1	0	0	0	0	1
Cuthbert House	0	0	1	0	0	1
Highfield House	1	1	0	0	0	2
Ozanam House	0	1	0	0	0	1
Southview	1	0	0	0	0	1
St Josephs	0	0	1	0	0	1
Staitheford House	0	0	2	0	0	2
The Grange	1	0	0	0	0	1
Withington Road	0	1	0	0	0	1
Total	**5**	**3**	**4**	**0**	**0**	**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.

Prison complaints completed 2015–16

Prison	Upheld	Not upheld	Total	Uphold rate*	Population**	Upheld complaints per 100 prisoners
Wakefield	37	114	151	25%	724	5.1
Whitemoor	47	76	123	38%	438	10.7
Frankland	32	77	109	29%	792	4.0
Full Sutton	38	66	104	37%	579	6.6
Isle of Wight	23	39	62	37%	1,081	2.1
Lowdham Grange	18	39	57	32%	917	2.0
Highpoint (North and South)	17	36	53	32%	1,303	1.3
Gartree	23	28	51	45%	701	3.3
Woodhill	18	28	46	39%	688	2.6
Long Lartin	19	24	43	44%	535	3.6
Belmarsh	18	23	41	44%	847	2.1
Rye Hill	17	24	41	41%	624	2.7
The Mount	16	25	41	39%	1,014	1.6
Littlehey	18	22	40	45%	1,215	1.5
Parc	12	27	39	31%	1,680	0.7
Ashfield	14	23	37	38%	393	3.6
Swaleside (Sheppey)	22	15	37	59%	1,106	2.0
Moorland	18	16	34	53%	995	1.8
Stocken	14	20	34	41%	704	2.0
Ranby	11	20	31	35%	1,037	1.1
Whatton	12	19	31	39%	833	1.4
Manchester	18	10	28	64%	1,033	1.7
High Down	13	14	27	48%	1,185	1.1
Humber	9	18	27	33%	1,049	0.9
Wandsworth	15	12	27	56%	1,568	1.0

Prison	Upheld	Not upheld	Total	Uphold rate*	Population**	Upheld complaints per 100 prisoners
Nottingham	11	15	26	42%	1,039	1.1
Oakwood	11	15	26	42%	1,583	0.7
Bure	11	14	25	44%	642	1.7
Garth	6	19	25	24%	837	0.7
Lincoln	11	14	25	44%	585	1.9
Rochester	10	15	25	40%	739	1.4
Stafford	9	16	25	36%	747	1.2
Hewell	9	14	23	39%	1,223	0.7
Hull	13	10	23	57%	1,031	1.3
Lindholme	11	12	23	48%	1,000	1.1
Dovegate	9	13	22	41%	1,109	0.8
Elmley (Sheppey)	10	12	22	45%	1,092	0.9
Doncaster	11	10	21	52%	1,033	1.1
Forest Bank	8	13	21	38%	1,450	0.6
Pentonville	17	3	20	85%	1,278	1.3
Grendon/Springhill	4	15	19		529	0.8
Onley	8	10	18		741	1.1
Birmingham	7	10	17		1,451	0.5
Erlestoke	9	8	17		520	1.7
Risley	8	9	17		1,103	0.7
Northumberland	2	14	16		1,334	0.1
Bullingdon	7	8	15		1,102	0.6
Liverpool	8	7	15		1,144	0.7
Coldingley	5	9	14		517	1.0
Guys Marsh	9	5	14		564	1.6
Wayland	7	7	14		980	0.7

Prison	Upheld	Not upheld	Total	Uphold rate*	Population**	Upheld complaints per 100 prisoners
Buckley Hall	4	9	13		451	0.9
Channings Wood	4	9	13		707	0.6
Featherstone	4	9	13		688	0.6
Haverigg	6	7	13		618	1.0
Peterborough (male and female)	5	8	13		1267	0.4
Wormwood Scrubs	7	5	12		1263	0.6
Holme House	4	7	11		1221	0.3
Huntercombe	4	7	11		429	0.9
Dartmoor	5	5	10		634	0.8
Lewes	4	6	10		643	0.6
Wealstun	4	6	10		824	0.5
Leeds	3	6	9		1,129	0.3
Maidstone	7	2	9		598	1.2
Winchester	8	1	9		673	1.2
Wymott	5	4	9		1,152	0.4
Aylesbury	5	3	8		435	1.1
Bedford	5	3	8		489	1.0
Chelmsford	2	6	8		702	0.3
Ford	4	4	8		496	0.8
Leyhill	4	4	8		504	0.8
Norwich	4	4	8		753	0.5
Brixton	4	3	7		803	0.5
Bronzefield	3	4	7		554	0.5
Kirkham	1	6	7		592	0.2
Stoke Heath	5	2	7		756	0.7
Sudbury	3	4	7		480	0.6

Prison	Upheld	Not upheld	Total	Uphold rate*	Population**	Upheld complaints per 100 prisoners
Warren Hill	1	6	7		206	0.5
Altcourse	3	3	6		1,017	0.3
Foston Hall	3	3	6		338	0.9
Leicester	2	4	6		323	0.6
North Sea Camp	3	3	6		359	0.8
Swinfen Hall	2	4	6		601	0.3
Thorn Cross	1	5	6		354	0.3
Bristol	3	2	5		547	0.5
Durham	3	2	5		924	0.3
Exeter	3	2	5		521	0.6
New Hall	1	4	5		404	0.2
Preston	3	2	5		755	0.4
Usk/Prescoed	2	3	5		530	0.4
Feltham	3	1	4		503	0.6
Hollesley Bay	0	4	4		414	0.0
Isis	2	2	4		622	0.3
Kirklevington Grange	1	3	4		253	0.4
Send	2	2	4		276	0.7
Brinsford	3	0	3		332	0.9
Hatfield	0	3	3		324	0.0
Holloway	1	2	3		319	0.3
Standford Hill (Sheppey)	0	3	3		459	0.0
Thameside	1	2	3		1,197	0.1
Cardiff	2	0	2		776	0.3

Prison	Upheld	Not upheld	Total	Uphold rate*	Population**	Upheld complaints per 100 prisoners
Lancaster Farms	0	2	2		548	0.0
Low Newton	2	0	2		313	0.6
Portland	1	1	2		513	0.2
Styal	1	1	2		473	0.2
Swansea	0	2	2		444	0.0
Blantyre House	0	1	1		***	
Glen Parva	1	0	1		524	0.2
Kennet	0	1	1		338	0.0
Werrington	1	0	1		108	0.9
Wetherby	1	0	1		282	0.4
Total	**896**	**1319**	**2215**	**40%**	**85,064**	**1.1**

* Only given when 20 or more complaints were completed.

** Ministry of Justice (2016) Prison Population Bulletin – Monthly, March 2016: https://www.gov.uk/government/statistics/prison-population-figures-2016

*** Blantyre House empty due to temporary closures.

Probation complaints completed 2015–16

Probation	Upheld	Not upheld	Total	Uphold rate*
Surrey and Sussex	9	0	9	
NPS North East	5	2	7	
NPS London	3	0	3	
NPS Midlands	1	2	3	
Essex CRC	2	0	2	
Hampshire	1	1	2	
Lancashire	1	1	2	
NPS South West & South Central	1	1	2	
Staffordshire and West Midlands	2	0	2	
Avon & Somerset	0	1	1	
Cambridgeshire	0	1	1	
Cheshire	1	0	1	
Bristol Gloucestershire Somerset and Wiltshire CRC	1	0	1	
Norfolk & Suffolk CRC	1	0	1	
Staffs & West Midlands CRC	1	0	1	
Humber	1	0	1	
London Probation Area	0	1	1	
Merseyside	0	1	1	
NPS North West	1	0	1	
Wales	0	1	1	
Total	**12**	**31**	**43**	**28%**

* Only given when 20 or more complaints were completed.

IRC complaints completed 2015–16

IRCs	Upheld	Not upheld	Total	Uphold rate*	Population**	Upheld complaints per 100 detainees
Colnbrook	3	4	7		295	1.0
Harmondsworth	3	2	5		545	0.6
Morton Hall	1	4	5		385	0.3
Campsfield House	1	2	3		242	0.4
Brook House	0	2	2		360	0.0
Dover	1	1	2		***	
Heathrow STHF	0	2	2		****	
Yarl's Wood	0	2	2		276	0.0
The Verne	0	2	2		481	0.0
Total	**9**	**21**	**30**	**30%**	**2607**	**0.3**

* Only given when 20 or more complaints were completed.

** Population data for Morton Hall and The Verne taken from Ministry of Justice (2016) Prison Population Bulletin – Monthly, March 2016: https://www.gov.uk/government/statistics/prison-population-figures-2015 / for all other establishments taken from Home Office (2016) Immigration statistics, October to December 2015: https://www.gov.uk/government/publications/immigration-statistics-october-to-december-2015/detention#data-tables

*** Dover IRC has now closed.

**** Heathrow STHF is a non-residential facility.

STC complaints completed 2015–16

STCs	Upheld	Not upheld	Total	Uphold rate*	Population	Upheld complaints per 100 detainees
Oakhill	1	0	1		**	
Rainsbrook	1	0	1		**	
Total	**2**	**0**	**2**		**162*** **	**1.2**

* Only given when 20 or more complaints were completed.

** Data not available at individual establishment level

*** Youth Justice Board (2016) Youth Custody Report: March 2016: https://www.gov.uk/government/statistics/youth-custody-data (provisional figure only)

Categories of complaints completed 2015–16

Complaint category	Upheld	Not upheld	Total	Uphold rate*
Property	401	269	670	60%
Administration	98	177	275	36%
Adjudications	44	114	158	28%
Categorisation	38	103	141	27%
Staff behaviour	51	79	130	39%
Work and pay	35	81	116	30%
IEP	41	71	112	37%
Regime	32	73	105	30%
Money	25	49	74	34%
Letters	32	40	72	44%
Transfers	8	52	60	13%
Visits	21	38	59	36%
Probation	16	41	57	28%
HDC	6	49	55	11%
Prisoners	17	22	39	44%
Accommodation	13	25	38	34%
Equalities	7	21	28	25%
Phone calls	7	17	24	29%
Security	4	18	22	18%
Food	9	8	17	
Medical	7	9	16	
Resettlement	2	13	15	
Legal	4	1	5	
Parole	1	1	2	
Total	919	1371	2290	40%

5-year comparison

* Only given when 20 or more complaints were completed.

Fatal incidents

Fatal incident investigations started	Total 2010/11	% of total (10/11)	Total 2015/16	% of total (15/16)	Change 10/11–15/16	% change
Natural	121	61%	172	57%	51	42%
Self-inflicted	58	29%	103	34%	45	78%
Other non-natural**	19	10%	11	4%	-8	*
Homicide	2	1%	6	2%	4	*
Awaiting classification	0	0%	12	4%	12	*
Total	**200**	**100%**	**304**	**100%**	**104**	**52%**

* 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.

Fatal incident investigations started	Total 2010/11	% of total (10/11)	Total 2015/16	% of total (15/16)	Change 10/11–15/16	% change
Male prisoners	173	87%	271	89%	98	57%
Female prisoners**	9	5%	11	4%	2	*
Young offenders	5	3%	7	2%	2	*
Approved premises residents	11	6%	12	4%	1	*
IRC residents	2	1%	3	1%	1	*
Total	**200**	**100%**	**304**	**100%**	**104**	**52%**

* 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 death of two transgender prisoners in 2015–16.

Fatal incident reports issued	Total 2010/11	% in time*	Total 2015/16	% in time*	Change 10/11–15/16 (volume)	% change (volume)
Draft reports	200	15%	284	100%	84	42%
Final reports	178	45%	261	82%	83	47%
Reports published on website	174		258		84	48%

* In time for draft 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 draft.

Complaints

Cases received	Total 2010/11	% of total	Total 2015/16	% of total (15/16)	Change 10/11–15/16	% change
Prison	4659	88%	4397	92%	-262	-6%
Probation	502	9%	323	7%	-179	-36%
Immigration	130	2%	58	1%	-72	-55%
Secure training centre*	n/a	n/a	3	<1%	3	n/a
Total	**5291**	**100%**	**4781**	**100%**	**-510**	**-10%**

* The remit of the PPO did not encompass complaints regarding secure training centres until 2013.

Complaints accepted for investigation**	Total 2010/11	% of total	Total 2015/16	% of total (15/16)	Change 10/11–15/16	% change
Prison	2,416	94%	2288	97%	-128	-5%
Probation	70	3%	38	2%	-32	-46%
Immigration	75	3%	30	1%	-45	-60%
Secure training centre*	n/a	n/a	1	<1%	1	n/a
Total	**2561**	**100%**	**2357**	**100%**	**-204**	**-8%**

* The remit of the PPO did not encompass complaints regarding secure training centres until 2013.

** The comparison of this data should be treated with caution as the criteria for accepting a complaint for investigation has changed. In 2010–11 all eligible complaints were accepted for investigation. In 2015–16, 446 eligible cases were not investigated as it was considered that they did not raise a substantive issue, or that no worthwhile outcome was likely.

Investigations completed	Total 2010/11	% of total	Total 2015/16	% of total (15/16)	Change 10/11–15/16	% change
Prison	2362	95%	2215	97%	-147	-6%
Probation	67	3%	43	2%	-24	-36%
Immigration	67	3%	30	1%	-37	-55%
Secure training centre*	n/a	n/a	2	<1%	2	n/a
Total	**2496**	**100%**	**2290**	**100%**	**-206**	**-8%**

* The remit of the PPO did not encompass complaints regarding secure training centres until 2013.

Financial data

Finance	2014/15	% of total (14/15)	2015/16	% of total (15/16)	Change 14/15-15/16	% change year on year
Budget allocation	£5,524,000		£5,524,000		£0	0%
Staffing costs	£5,156,991	93%	£5,139,357	95%	-£17,634	0%
Non-staff costs	£376,727	7%	£255,715	5%	-£121,012	-32%
Total Spend	**£5,533,718**	**100%**	**£5,395,072**	**100%**	**-£138,646**	**-3%**

Recommendations

The Ombudsman's vision for the organisation is to contribute to making custody and offender supervision safer and fairer. One of the key ways to fulfil this ambition is by making effective recommendations for improvement.

We make recommendations following both fatal incident and complaint investigations, when the investigation has highlighted that there is room for improvement or the need for action to correct an injustice. Almost all of the recommendations that we make are accepted by the organisations concerned. In the few cases where a recommendation is rejected by the National Offender Management Service, the Chief Executive will write personally to the Ombudsman with the reasons for this.

When recommendations are made as a result of a fatal incident investigation, the organisation they are directed towards is required to provide an action plan. This details the actions that they are going to take in order to comply with the recommendations, and who will be responsible for completing those actions, when. Evidence must then be provided to show that these actions have been completed.

During their inspections, HM Inspectorate of Prisons routinely follow up progress on the implementation of our recommendations about fatal incident investigations. A protocol was this year signed with the National Council of Independent Monitoring Boards to put in place a similar arrangement. Discussions are also underway with HM Inspectorate of Probation to consider opportunities for them to follow up progress of the implementation of our recommendations related to probation.

Individual investigations provide transparency to those affected by a death and a means to obtain redress to complainants. Any recommendations also have the potential to ensure that specific and sometimes national lessons are learned. We record and monitor all of the recommendations that we make, enabling us to identify common areas of concern. This information is fed into our Learning Lessons publications, which we use to disseminate learning across establishments and organisations within our remit.

In 2012, the Ombudsman issued instructions that recommendations should be prescriptive and clear about what is expected. In particular, they should be specific, measurable, realistic and time-bounded, with tangible outcomes. If our recommendations are to lead to impactful change, it is important that they are clear, and that they are achievable.

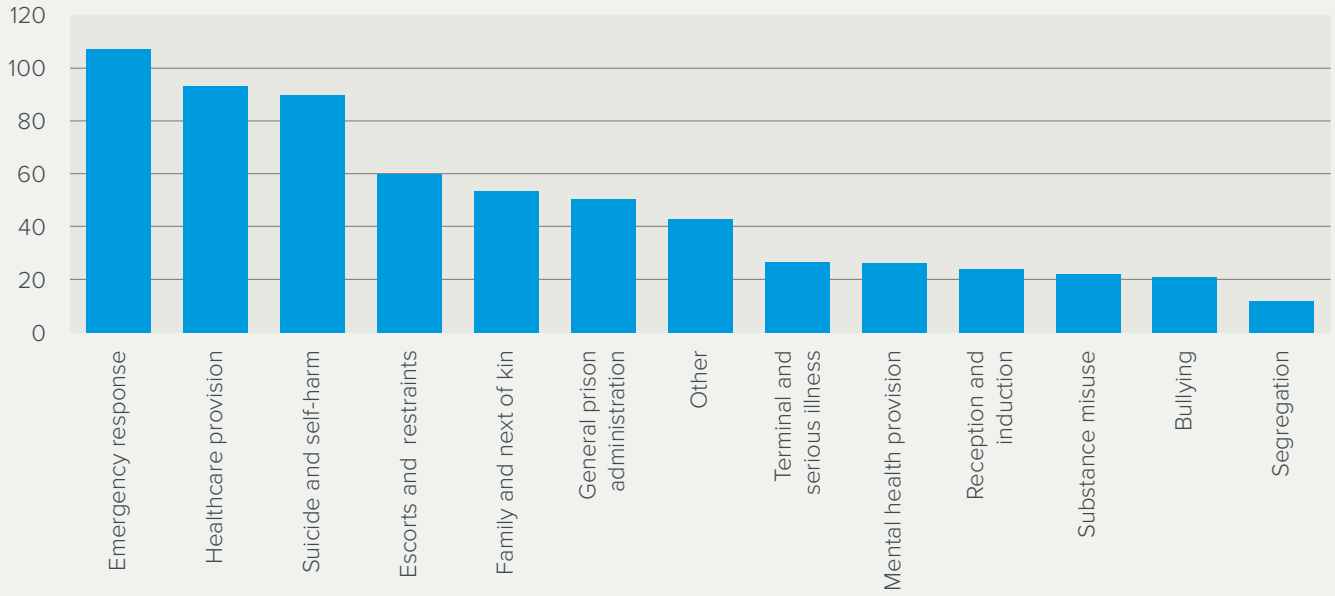
In July 2013, a thematic review, *Making Recommendations*,[26] was published which explored recommendations from a full year, and considered the emerging themes. This exercise is repeated annually and is now included as an annex to the annual report.

[26] Prisons and Probation Ombudsman (2013) *Making Recommendations*. PPO: London.

Fatal incidents

- In 2015–16, we made 629 recommendations following deaths in custody. Every one of these recommendations was accepted.
- There were three main issues that prompted recommendations: emergency response (17%), healthcare provision (15%), and suicide and self-harm prevention (14%).
- Emergency response recommendations largely focused on the importance of staff understanding their responsibilities during a medical emergency, including bringing the relevant equipment to the scene, using the appropriate emergency codes, and ensuring that there are no delays in calling an ambulance when one is required.
- Healthcare recommendations covered a wide range of issues including: care plans, hospital appointments, accurate record keeping, staff training, health screening, and timely diagnosis, referral and treatment.
- Recommendations relating to self-inflicted deaths related particularly to mental health provision, strategies for dealing with bullying and intimidation, accurate record keeping and information sharing, the quality of risk assessments, and, most notably, the adequacy of ACCT monitoring and reviews for prisoners considered to be at risk of suicide and self-harm.
- Recommendations relating to natural cause deaths were primarily related to health provision, care for those with terminal or serious illnesses, and the inappropriate use of restraints for prisoners attending or admitted to hospital.

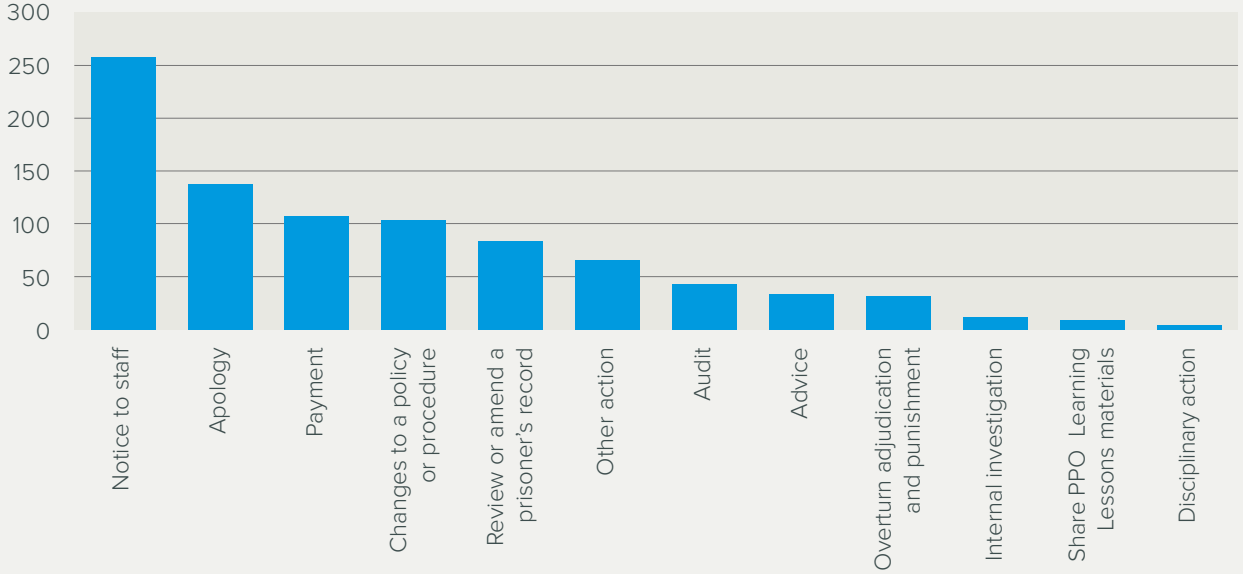
Recommendations following deaths, by issue



Complaints

- During 2015–16, we made 884 recommendations following investigations into complaints. Of these, just seven were rejected (1%), most (801, 91%) were accepted, and we are awaiting a response to the remaining 76 (9%).
- The most frequent recommendation (29%) was that a Governor or Director should issue a notice reminding staff to adhere to policy.
- The second most frequent recommendation (16%) was for an apology to be made to the complainant. Often a written apology was recommended alongside another action intended to ensure that the issue which led to the complaint was not repeated.
- The next most frequently recommended actions were for a compensation payment to be made to the complainant (12%), for a revision to be made to a policy or procedure (12%), or a prisoner's record to be reviewed or amended (10%).
- In one case, a disciplinary investigation about staff behaviour was recommended. At other times – where incidents fell below the threshold for disciplinary action – we recommended that managers issue formal advice and guidance to specific staff members, including sharing our report and discussing our findings.

Recommendations following complaints, by action



Stakeholder feedback

Collecting feedback from stakeholders is crucial to understanding the level of satisfaction with the services that we provide and how we can improve those services. We routinely collect feedback from complainants, bereaved families, staff involved with our investigations, coroners, and a number of other stakeholders. Reports of the findings of our stakeholder surveys can be found on our website.

General stakeholder survey

- In January 2016, we surveyed stakeholders across the prison, probation and immigration removal centre estates, as well as coroners, Independent Monitoring Boards and Inspectorate staff. Stakeholders were asked for their feedback on our performance in the previous year.
- 132 stakeholders responded, compared to 84 the previous year.
- Stakeholders reported better timeliness of both complaints and fatal incident investigations than the previous year: 69% felt complaint investigations were conducted quickly enough or better (compared to 62%), and 74% felt that fatal incident investigations were quick enough or better (compared to 61%).
- PPO publications were widely read, in particular those related to fatal incident investigations. The most seen publication was the thematic report about self-inflicted deaths of prisoners in 2013–14, which was seen by more than five out of six stakeholders. More than three-quarters reported having seen last year's annual report.
- Nine out of 10 stakeholders agreed that the quality of the work and services provided by the PPO was satisfactory or better, and that it had stayed the same or improved since the previous year.
- Independence is central to the PPO's role and, encouragingly, 92% of stakeholders rated the PPO as 'quite' or 'very' independent, compared to 85% the previous year.

Complainants' survey

- Each month questionnaires are sent to a sample of those who have complained to the Ombudsman. The sample is broken down into those whose complaint was ineligible, those whose complaint was eligible and upheld, and those whose complaint was eligible but not upheld. The following data refer to 344 survey responses received between December 2014 and November 2015, a response rate of 38%.
- The PPO has made efforts over the last year to increase awareness of its role among prisoners, and ensure that information posters and leaflets are visible and accessible. Encouragingly, 70% of respondents remembered seeing PPO posters or leaflets, up from 37% the previous year.
- Overall, complainants reported that it was easier to find out about the PPO than it had been previously: 67% said that it was very easy or fairly easy to get information about the PPO, compared with 51% the previous year.

- Among those whose complaint was eligible for investigation, opinions varied considerably based on the outcome of the complaint:
  - 70% of those whose complaint was upheld felt that the PPO investigation had been carried out fairly, compared with 15% for those whose complaint was not upheld.
  - 73% of those whose complaint was upheld felt that the PPO had taken their complaint seriously, compared with 21% of those whose complaint was not upheld.
  - 66% of those whose complaint was upheld reported that they were satisfied or very satisfied with the service they received from the PPO, compared with 16% of those whose complaint was not upheld.
- When a complaint is assessed as ineligible for investigation, we write to the complainant to explain why. 65% of those whose complaint was ineligible reported that we told them quite clearly or very clearly why we did not investigate their complaint, an improvement on 51% the previous year.
- More than half of all complainants said that they would use the PPO again. Results varied depending on whether the complaint was eligible and the outcome of the investigation: 52% of those whose complaint was ineligible said they would use the PPO again, compared to 76% of those whose complaint was upheld and only 37% of those whose complaint was not upheld.

Bereaved families' survey

- At the end of a fatal incident investigation, a survey is sent to the family of the deceased alongside the final report. The response rate to this survey is low, so we analyse the results biennially. The following data refers to the 69 survey responses received between April 2013 and March 2015. Full results are available on our website.
- We asked families to provide feedback on a number of different aspects of their interaction with the PPO. On the whole, responses were positive and similar to previous years.
- 54 families said they received the right amount of contact from the PPO family liaison officer during the investigation, although 12 would have appreciated more.
- 49 families rated the quality of the contact as good, 9 as average and 7 felt it was poor.
- Families were asked if they were satisfied that the PPO's investigation had fulfilled its purpose to establish the circumstances of the death and provide an explanation to the family. Around three-quarters (48 of 65 families answering) said that the PPO's investigation had 'fully' met their expectations in this respect. This was an increase compared to the previous survey period, when just over half (30 out of 55 families) reported feeling this way.

Post-investigation survey

- At the end of a fatal incident investigation, surveys are sent to various stakeholders to collect feedback about that investigation. Surveys are sent to the head of the establishment where the death had occurred, the establishment's PPO liaison officer for that investigation, the head of healthcare and the coroner responsible for any related inquest. Survey questions are tailored to each stakeholder type depending on their involvement in the investigation. The data below refers to 268 survey responses received between March 2014 and February 2015. This is the first year of results for this survey and full results are available on our website.
- Liaison officers reported a very positive experience of their dealings with PPO investigators. Almost all (97%) said the investigation process was explained to them by the investigator, and comments provided suggested that the investigators worked hard to develop positive relationships with them.
- In general, the coverage and quality of the investigation was considered to be of a high standard. For example, 78% of governors (59 of the 75) and 86% of heads of healthcare (24 out of 28) rated the quality of the investigation as good or very good.
- PPO staff strive to be professional and courteous. When asked if the investigator was found to be professional and courteous, nearly all (96%) stakeholders asked agreed that they did.
- Stakeholders were also asked to evaluate the knowledge of the investigator, by considering whether they demonstrated an understanding of the system in which the stakeholder operates. A high proportion of all stakeholders (88%) did find the investigator to be knowledgeable.
- At the end of an investigation, the findings are presented in a report. Governors and heads of healthcare were asked if the report met their expectations, and the majority of both groups agreed that it did (84% of governors and 86% of heads of healthcare).
- The report also aims to support the coronial process, by ensuring that all facts are uncovered, failings exposed, and lessons are identified. Most coroners (31 out of 35) rated the report as good or very good with the remaining four rating it as satisfactory.
- Where relevant to the findings of an investigation, the PPO makes specific and time-bound recommendations intended to provide clear guidance as to how improvements can be made. When asked about recommendations directed towards their establishment, 95% of heads of establishment felt that the recommendations were fair or very fair, and 97% found them to be clear or very clear.

Performance against business plan 2015–16

Objective 1: Maintain and reinforce our reputation for absolute independence

Key deliverable	Measure of success	Progress
1. Work with the Ministry of Justice to secure a statutory footing for the PPO at the next legislative opportunity	Consideration in the next relevant Bill with resultant change in law	**Not achieved** While Ministerial commitments remain to place the Ombudsman on a statutory footing there was no legislative opportunity this financial year.
2. Secure a review of the PPO's ToR that enhances our independence and clarifies our remit and operational scope by end March 2015	Agreed ToR [as endorsed by Ministers and the PPO]	**Ongoing** Subject to delay by MOJ Sponsors, who did not consult stakeholders until June 2015 and send responses to the PPO until April 2016. Discussions are ongoing.
3. Ensure an appropriately funded extension of the PPO's remit to include the investigation of: ■ serious self-harm incidents in prison custody ■ deaths of transferred prisoners to secure mental health facilities	Agreed additions to ToR [as endorsed by Ministers and the PPO]	**Ongoing** NOMS deferred discussions about serious self harm incidents to 2016/17.
4. Increase stakeholders' confidence in the office's independence	Improved response to independence question in annual stakeholder survey to be conducted November 2015	**Achieved** 58% of respondents recorded finding the PPO to be 'very' independent in 2015, an increase from 52% in 2014 and 50% in 2013.

Objective 2: Improve the quality and timeliness of our investigations and resulting reports ensuring a robust and proportionate approach.

Key deliverable	Measure of success	Progress
1. Apply a continuous improvement approach to PPO investigation methodology and report production in order to deliver against target by end March 2015	Delivered to time and quality [as measured by the project plan for the redesign process and endorsed by the PPO]	**Ongoing** We are continuing to work with Lean methods to improve the delivery of our complaint investigations and support functions.
2. Improve the quality and consistency of investigation reports through the development of report templates, better knowledge management and other innovations by end March 2016	Delivered to time and quality [as measured by the project plan for the redesign process and improved feedback through the surveys from stakeholders]	**Achieved** New templates were introduced in September 2015 and new approaches to knowledge management are being trialled.
Complaints investigations		
3. Determine the eligibility of complaints within 10 working days of receipt of necessary paperwork	At least 80% delivered to time and quality [as indicated by management information and endorsed by the PPO]	**Not achieved** 50% of eligibility assessments were completed to time in 2015-16. However, performance improved in year. In April 2015, only 43% of assessments were completed on time, but this had increased to 81% by March 2016.
4. Provide a draft response to "serious complaints" (usually allegations of assault) within 20 weeks of accepting the complaint as eligible.	At least 70% delivered to time and quality [as indicated by management information and endorsed by the PPO]	**Not measured** Lack of research resource in year
5. Provide a substantive reply to new complaints not identified as serious complaints within 12 weeks of accepting the complaint as eligible	At least 60% delivered to time and quality [as indicated by management information and endorsed by the PPO]	**Not achieved** 39% of non-serious cases were completed within 12 weeks of assessing the case as eligible for investigation, although an improvement on 34% last year.
6. Ensure that 100% of the cases in the backlog "queue" (i.e. allocated backlog cases) have their investigations completed before end March 2016	Delivered to time and quality [as indicated by management information and endorsed by the PPO]	**Not Achieved** Only 8 cases still outstanding, of which all but 3 had been issued in draft by the end of the year.

Key deliverable	Measure of success	Progress
Fatal incident investigations		
7. Complete the investigation into a self-inflicted death and distribute the draft report for consultation within 26 weeks of initial notification	At least 70% delivered to time and quality [as indicated by management information and endorsed by the PPO]	**Achieved** 100% of draft reports were completed on time
8. Complete the investigation into deaths due to natural causes and distribute the draft report for consultation within 20 weeks of initial notification	At least 70% delivered to time and quality [as indicated by management information and endorsed by the PPO]	**Achieved** 100% of draft reports were completed on time
9. Finalise all fatal incident investigation reports within 12 weeks of issue of the draft report	At least 70% delivered to time and quality [as indicated by management information and endorsed by the PPO]	**Achieved** 82% of final reports were issued on time

Objective 3: Improve our influence through the identification and sharing of lessons learned from our investigations.

Key deliverable	Measure of success	Progress
1. Improve the impact of investigation recommendations by challenging rejected recommendations and following up progress	High acceptance of PPO recommendations, with preparation of appropriate action plans by the investigated bodies; PPO challenge and, where appropriate, escalation of all rejected recommendations; high implementation of PPO recommendations as measured by HMI Prisons on the Ombudsman's behalf during their inspections; and high implementation of PPO recommendations as evidenced during PPO thematic fieldwork	**Not currently measured** Lack of research resource in year.

Key deliverable	Measure of success	Progress
2. Hold three Learning Lessons seminars for operational staff from services in remit by end March 2016 focused on sharing the learning from investigations of: ■ Self-inflicted deaths ■ Natural causes deaths ■ Complaints	Delivered to time and quality [as endorsed by the PPO and participant feedback]	**Achieved** Seminars took place on: 4 November – self inflicted deaths 5 November – natural cause deaths 6 November – use of force and property complaints Feedback from the attendees proved the seminars were well received and the format will be repeated for 2016-17.
3. Promote timely learning from individual investigations through the publication of themed Learning Lessons publications for both fatal incidents and complaints investigations on: ■ Complainant feedback ■ Stakeholder feedback ■ Staff background survey ■ Post-investigation feedback ■ Segregation ■ New psychoactive substances ■ Bereaved families feedback ■ Early days in custody ■ Mental health issues in deaths ■ Ineligible complaints ■ Complaint process in prisons (with HMI Prisons) ■ Assaults ■ Rule 39 complaints ■ Comparison of complaints in public and private prisons	Delivered to time and quality [as measured by the agreed publication timelines and the PPO's endorsement]	**Revised** Due to resource shortages in the Learning Lessons team, the number of publications had to be reduced. Publications were released on the following topics: ■ Segregation ■ New psychoactive substances ■ Post-investigation feedback ■ Bereaved families feedback ■ Legal mail: Rule 39 ■ Prisoner Mental Health ■ Early days and weeks in custody

Key deliverable	Measure of success	Progress
4. Conduct full joint thematic with HMI Prisons on redress by end March 2016	Delivered to time and quality [as measured by the respective project plan timelines and the PPO's and HMCIP's endorsement]	**Ongoing** Thematic deferred
5. Respond to relevant Government and operational policy consultations by March 2016, including: ■ NOMS review of the implementation of suicide prevention procedures; ■ The Harris Review	Delivered to time and quality [as endorsed by the PPO]	**Achieved** Responded to eighteen consultations during 2015-16, including the two consultations specified. These were published on the PPO website.
6. Identify topics for learning lessons analysis 2016-17 through internal and external consultation on themes by January 2016	Delivered to time and quality [as endorsed by the PPO]	**Achieved** List of topics agreed and published in the PPO Business Plan 2016-17.
7. Improve rates of positive feedback on the PPO's performance through post-investigation and annual surveys of complainants and other stakeholders. Publish the feedback findings and related actions on the PPO website by March 2016	Delivered to time and quality [as defined by the stakeholder management action plan, supported by stakeholder feedback and endorsed by the PPO]	**Achieved** Findings set out in an annex to this Annual Report. In the 2015 general stakeholder survey, 93% of respondents found the work of the PPO to be satisfactory or better compared to 91% in the 2014.
8. Produce an annual report for April 2014 to March 2015 for publication in September 2015	Delivered to time and quality [as defined by the publication timelines and endorsed by the PPO]	**Achieved** Annual Report 2014-15 published on 10 September 2015.

Objective 4: Use our resources efficiently and effectively.

Key deliverable	Measure of success	Progress
1. Hold three full staff meetings in order to promote training and development and share learning across the office	Delivered to time and quality [as measured by positive feedback on staff evaluation forms]	**Revised** Two full staff meetings were held during the year. A third was postponed due to Ministry of Justice spending controls.
2. Conduct a staff engagement survey by November 2015	Delivered to time and quality [as measured by the level of response to the survey]	**Achieved** Staff survey was completed in November 2016 with an improved response rate and a more positive response overall.
3. Devise an action plan in response to concerns raised in the staff engagement survey by March 2016	Delivered to time and quality [as measured by the level of response to the survey]	**Achieved** The Staff Engagement Action Group devised and took forward the action plan.
4. Deliver the PPO's equality and diversity action plan (see annex)	Delivered to time and quality [as measured through quarterly monitoring by the Equality and Diversity Group]	**Achieved** The Equality and Diversity Group, chaired by the Ombudsman, delivered the equality and diversity action plan.
5. Deliver the PPO's learning and development action plan (see annex)	Delivered to time and quality [as measured through improved response to the staff survey on development opportunities]	**Achieved** Bespoke investigator training, equality and diversity training and Plain English training delivered. Mandatory e-learning specified. Individual learning and development needs are discussed with line managers.
6. Negotiate appropriate budget allocations based on real and anticipated changes to workload by March 2016	Delivered to time and quality [as endorsed by the PPO]	**Achieved** Budget delegation notified.
7. Deliver a replacement case management system which supports an efficient and effective investigation process	Delivered to time and quality [as endorsed by the PPO]	**Ongoing** Funding approved as part of the Spending Review 2016.

Key deliverable	Measure of success	Progress
8. Produce a business plan for the PPO 2016-17 by March 2016	Delivered to time and quality [as endorsed by the PPO]	**Achieved** Plan drafted, consulted on and published.
9. Review Memoranda of Understanding for all key stakeholders to promote effective joint working by end March 2016	Delivered to time and quality [as endorsed by the PPO]	**Ongoing** MoUs agreed and published on the PPO website or awaiting sign off.
10. Devise a methodology to assess the affordability and deliverability of objectives by end March 2016	Delivered to time and quality [as endorsed by the PPO]	**Revised** Spending Review exercise.

Staff list

Ombudsman
Nigel Newcomen CBE

Deputy Ombudsmen
Kimberley Bingham
(started 17 Septemeber 2015)
Louise Falshaw (left 12 July 2015)
Michael Loughlin
Elizabeth Moody

Policy Officer and Secretary to Executive Committee
Caroline Parkes

Personal Secretary
Janet Jenkins (left 25 September 2015)
Hazel Lansdale (started 19 October 2015. Left 31 December 2015)

Assistant Ombudsmen
Emma Attwell (left 31 July 2015)
Karen Cracknell
John Cullinane (left 8 March 2016)
Michael Dunkley
Susannah Eagle
Kate Eves (career break since 31 January 2015)
Karen Johnson
Wendy Martin
Caroline Mills (started 8 February 2016)
Olivia Morrison-Lyons (left 8 March 2016)
Simon Stanley (started 29 March 2016)
Lee Quinn
Nick Woodhead

Strategic Support Team
Durdana Ahmed
Ermelinda Bajrami (started 23 April 2015)
Mark Chawner (left 25 September 2015)
Catherine Costello
Dan Crockford
Rowena De Waas
Henry Lee
Esther Magaron
Tony Soroye
Ibrahim Suma
Jade Swietochowska
(started 1 September 2015)

Learning Lessons Team
Olly Barnes
Sue Gauge
John Maggi
Grace Scott (seconded from 3 August 2015 to 29 January 2016)
Helen Stacey (left 23 August 2015)
Christine Stuart

Complaints Assessment Team
Susan Ager
Veronica Beccles
Agatha Eze
David Gire-Mooring (left 1 May 2015)
Siobhan Green (started 4 January 2016)
Helena Hanson
John Howard (started 1 December 2015)
Christine Kavanagh (left 23 August 2015)
Leoni Larbi (started 4 January 2016)
Emma Marshall (left 1 October 2015)
Parvez Miah (started 8 June 2015)
Chris Nkwo
Alison Parkes (started 14 August 2015)
David Watson (started 14 August 2015)

Family Liaison Officers

Narinder Dale
Abbe Dixon
Laura Spargo
Seema Vishram (left 24 July 2015)

Senior Investigators and Investigators

Sharon Adonri
Amanda Anglish
Nana Acquah
Martha Archibald (started 11 January 2016)
Terry Ashley
Liam Askins (left 14 February 2016)
Georgina Beesley
Rachael Biggs
Diane Blyth
Tracey Booker
Nicola Bredin (started 27 July 2015)
Nicole Briggs
Simon Buckley
David Cameron
Karen Chin
Althea Clarke-Ramsey
Debbie Clarkson
Akile Clinton (career break from 5 August 2015)
Vicki Cole
Paul Cotton
James Crean
Lorenzo Delgaudio (left 4 September 2015)
Rob Del-Greco
Peter Dixon
Nick Doodney
Angie Dunn
Juan Diego Garzon
Kevin Gilzean
Maria Gray
Christina Greer
Rachel Gyford
Joanne Howells (left 1 July 2015)
Joanna Hurst
Lindsay Jones (started 1 September 2015)
Mark Judd
Razna Khatun
Madeleine Kuevi
Lisa Lambert
Karl Lane
Anne Lund
Steve Lusted
Steve McKenzie
Beverly McKenzie-Gayle
John McVeigh (started 1 September 2015)
Catriona MacIvor (started 30 November 2015)
Sonja Marsh
Kirsty Masterton
Ruby Moshenska (left 7 January 2016)
Anita Mulinder
Nicola Murray-Smith (left 7 March 2016)
Tamara Nelson
Claire Parkin
Katherine Pellatt
James Peters
Jade Philippou
(career break from 15 February 2016)
Amy Powell (left 14 August 2015)
Mark Price
Rachel Rodrigues

Jessica Rule (left 30 August 2015)
Martina Ryan (started 12 October 2015)
Rebecca Sanders
Andrea Selch
Kai Sinor (started 22 March 2016)
Anna Siraut
Katherine Solomon
Sarah Stolworthy
Rick Sturgeon
Tina Sullivan
Paul Televantou
Daniel Thomas
Stephen Thompson (started 1 September 2015)
Jonathan Tickner
John Unwin
Charlotte Walton (started 7 September 2015)
Erica Webb (started 17 August 2015)
Alix Westwood
Karl Williamson
Jane Willmott


Drug Testing Suite
GYM II
WEIGHTS ROOM
AND
CARDIO SUITE
A & B WINGS
C WING
CHAPEL
CSU
KITCHEN

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