PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

PRISONS AND PROBATION OMBUDSMAN ANNUAL REPORT 2012 – 2013

Prisons and Probation Ombudsman

Annual Report 2012–2013

Presented to Parliament
by the Lord Chancellor and Secretary of State for Justice
by Command of Her Majesty

September 2013

Cm 8702

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Printed on paper containing 75% recycled fibre content minimum.

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Vision

To be a leading, independent investigatory body, a model to others, that makes a significant contribution to safer, fairer custody and offender supervision.

Values

- We are independent, impartial, fair and honest in all our dealings, internally and externally.
- We take pride in delivering both quality and value for money.
- We have respect for, listen to and respond to each other, the users of our service and wider stakeholders.
- We celebrate diversity, both internally and externally, so that everyone can give their best.
- We approach our work with determination, dedication and integrity.
- We are committed to improvement through learning lessons internally and influencing how lessons are learned externally.

CHALLENGING TIMES

The past year has been a challenging one for all those involved with custody or probation. The prison population has stabilised but remains proportionately higher than anywhere else in Western Europe and it is also rapidly ageing. As resources have shrunk, so have regimes and staffing levels. Meanwhile, Ministers are understandably concerned that more needs to be done to rehabilitate prisoners and reduce future crime. They have put in place an extensive programme to 'transform rehabilitation', with rationalisation of the prison estate, more competitive tendering and various reforms to ensure offenders are 'properly punished and incentivised to turn away from crime'.

These are indeed challenging times.

With the services I investigate under pressure, it is unsurprising that demand for my office's services remains high. In some ways, the cases reaching my desk are an indication of the strains in the system – and, I would argue, evidence of the need for a robustly independent mechanism to offer redress to those in custody or on probation with legitimate complaints, as well as the need to ensure impartial analysis of how to avoid future fatal incidents in custody.

These strains are perhaps also reflected in the increasing proportion of complaints where we found fault in the services under investigation. Last year there was a substantial rise in the proportion of complaints upheld (from 23% to 31%) and in the number of recommendations for improvement. I have sought to ensure that there is absolute clarity about the remedial action required, so recommendations are now more prescriptive, time-bounded and outcome focused. This adds to expectations on prison, probation and immigration services, so it is commendable that they continue to accept almost all our recommendations, put in place improvement plans and – usually – learn appropriate lessons.

Of course, I recognise that there can be a cost to implementing recommendations, but not always: an apology is free. Moreover, it can be even more costly not to learn lessons (and some important joint work is underway with the National Audit Office to explore this point).

"In such a challenging context, it is pleasing to look back on my first full year in post and see some significant improvements in my office's performance."

In such a challenging context, it is pleasing to look back on my first full year in post and see some significant improvements in my office's performance. Despite the inevitable need for year on year savings[1] and some intractable recruitment difficulties, there has been progress on many of the key commitments I made on appointment, notably: better timeliness in the production of fatal incident reports, improved and more proportionate complaint handling and development of a substantial learning lessons agenda, as well as putting in place some necessary internal reforms.

Quicker and better information to bereaved families and coroners

Loss of a loved one in the closed and hidden world of custody is perhaps harder to bear than in any other circumstance. Little information is readily available and confidence in the adequacy and accuracy of that information can be limited. A major role of my office is to shine a light into this secretive, hidden world and provide an impartial explanation of what actually happened in a fatal incident, so that lessons can be identified and preventable deaths avoided in future.

Unfortunately, my office has had a poor recent record in producing timely investigation reports into deaths in custody. This has added to families' distress and contributed to the excessively slow coronial system. In 2010–11, only 16% of draft fatal incident reports met our time targets. This figure rose slightly in 2011–12 to 21%. But in the past year, given a clear strategic focus on timeliness and sheer hard work by my staff, the figure jumped to 55%. This is an important move in the right direction.

This progress was aided by close working with Primary Care Trusts to improve and expedite the reviews of clinical care required in all our fatal incident investigations. While most clinical reviews still miss our targets, their overall timeliness and quality have improved. We have now put in place arrangements with NHS England to build on this progress.

"A major role of my office is to shine a light into this secretive, hidden world and provide an impartial explanation of what actually happened in a fatal incident, so that lessons can be identified and preventable deaths avoided in future."

So a start has been made but, with shrinking resources, we have also had to be more proportionate. This has meant targeting efforts on fatal incident investigations where there may be most to learn – such as last year's three tragic child deaths – while introducing a more standardised approach where a death from natural causes was reasonably foreseeable. However, every death in custody must be independently investigated[2] and lessons can be learned even where death is entirely predictable. It is depressing, for example, how frequently I have had to criticise the inappropriate use of restraints on elderly, infirm and dying detainees.

[1] The Prisons and Probation Ombudsman's budget will fall 14% between 2010–11 and 2014-15.

[2] Article 2 of the Human Rights Act

> "Ultimately, however, my fatal incident investigations are of limited merit if they do not help bereaved families come to terms with their loss. It is therefore gratifying to have improved our levels of positive feedback in recent surveys of families."

Ultimately, however, my fatal incident investigations are of limited merit if they do not help bereaved families come to terms with their loss. It is therefore gratifying to have improved our levels of positive feedback in recent surveys of families.[3]

Improving our handling of complaints

There has been no let up in demand for my office's other main activity: the independent investigation of complaints. The overall number of complaints increased by 2% last year and, after a concerted communication campaign, the proportion of eligible complaints increased from 51% to 59%. This is important as it is frustrating to complain to my office only to be told that the complaint is ineligible because, for example, the internal complaint mechanism of the prison, immigration removal centre or probation trust concerned has not been exhausted.

However, increasing eligibility also increases demand. Once again, proportionality is key. Scarce resources must be targeted on the most serious cases, such as allegations of assault, bullying and racism. These can be complex investigations in which we have to interview the complainant, other detainees and staff. We need to get these cases right as detainee safety, as well as staff careers, may be at stake. It is a key part of my office's function to ensure that independent investigation helps to eradicate abuse in custody[4] and later in this report there are some troubling examples of poor staff behaviour where, after thorough and robust investigation, we have had to recommend disciplinary action.

But if resources are targeted at serious cases, less remain for other complaints. While small issues can mean a lot to detainees with very little, not all eligible cases merit investigation and one size of investigation does not fit all. Accordingly, we have had to decline to investigate complaints where no worthwhile outcome is likely and to withdraw cases which are no longer relevant. We have also introduced an unreasonable complainant policy to ensure offensive or threatening behaviour to my staff is not tolerated and scarce resources are not inappropriately consumed by prolific complainants.

None of this, however, should suggest a stepping back from insistence on improvement in custody or probation trusts where this is necessary. Such rigour and robustness is clearly evidenced by the increased proportion of complaints upheld and the greater number of recommendations to right wrongs or make improvements – but this is now being done in a more targeted and proportionate way.

Nor are the challenges likely to reduce.

[3] Prisons and Probation Ombudsman Bereaved Family Survey 2011–13

[4] Article 3 of the Human Rights Act

"It is a key part of my office's function to ensure that independent investigation helps to eradicate abuse in custody."

Changes in other parts of the criminal justice system may impact on my office. For example, there have been cases where the new, streamlined Prison Service internal complaints system appears to be leading to us receiving poorly investigated complaints – and we will have no hesitation in sending such cases back to be dealt with properly. I am also carefully monitoring the uncertain implications of the prospective changes to legal aid for prisoners.

There is a long way to go. While our assessment of the eligibility of complaints has quickened, the timeliness of investigations has slipped. While more complaints are being upheld, perceptions of my office amongst complainants are too closely tied to whether they succeed. More needs to be done to convince them that, even if their complaint has not been upheld, they have had a fair hearing. In a pressurised context, we may even get some cases wrong and where this happens we must apologise, learn lessons and improve.

My office must do more for less but in doing so my staff and I will always be guided by an unwavering commitment to supporting fairer custody and offender supervision.

"There is a long way to go."

Learning lessons

A key part of the new vision for my office is to identify and disseminate lessons from investigations. Our primary job is to investigate individual cases, but if we are to contribute more generally to improving safety and fairness, we must encourage services to learn the lessons that can avoid the next complaint and help avoid the next preventable death. To this end, the past year has seen the creation of a significant agenda of learning lessons materials.[5]

The first of this year's two thematic studies (which look at large samples of investigations) explored the many complaints we receive about the prison disciplinary system. In around a fifth (21%) of cases, we found the adjudication unsafe and called for it to be quashed. This reflects poor practice. Many cases should have been resolved by the Prison Service without coming to my office at all and there is a general learning point about the need for better adjudication training for prison staff.

The second thematic study looked at investigations into end of life care for the growing numbers of mainly elderly prisoners known to have a terminal illness, whose final days are spent in custody. The study suggested prisons are making some headway in adjusting to the growing challenge of providing decent care for the terminally ill, but care remains variable and occasionally unacceptable. While learning for improvement is identified, a question must remain as to whether prison can ever be the best place for those reaching the last days and hours of their life.

[5] See appendices for a full list of publications 2012–13.

A new series of learning lessons bulletins now offer expeditious, topical guides based on small numbers of cases. The first two bulletins focused on probation issues. One identified the need for probation trusts to manage their internal complaint process better, including avoiding 'buck passing' between prisons and probation. The other looked, for the first time, at deaths in probation approved premises, and identified the need for better awareness of methadone and mixed drug toxicity and improved management of prescribed medication.

> "A key part of the new vision for my office is to identify and disseminate lessons from investigations."

A subsequent bulletin focused on learning from the tragic sequence of self-inflicted child deaths in custody in 2011–12. Three deaths occurred within a few months and, to varying degrees, each investigation found that more needed to be done to ensure an appropriately holistic, child-centred approach to managing the risks presented by the most vulnerable children in custody. This included the ability of authorities to allocate to settings equipped to keep children safe – something with which busy young offender institutions with essentially adult-orientated processes can struggle. The bulletin was provided to Ministers to inform their review of the juvenile secure estate. I am also pleased that the National Offender Management Service (NOMS) and the Youth Justice Board have set up a working group to review suicide and self-harm prevention arrangements for juveniles in light of our findings.

Further bulletins have looked at the growing number of complaints about religious issues and another at sexual abuse in prison. A further bulletin flagged up the failure of too many prisons to ensure an appropriate balance between security and humanity in the use of physical restraints on elderly, infirm and dying detainees. Finally, a bulletin explored links between suicide and Incentives and Earned Privileges (IEP) levels, finding that fatal incidents disproportionately occurred among prisoners on the basic level of privileges and emphasising the need for prisons to balance the management of challenging behaviour and vulnerabilities. This bulletin was also sent to Ministers to help inform their review of the IEP scheme.

So, the year has seen a much greater emphasis on learning lessons. The task now is to ensure services act on our findings. My staff will continue to refine these publications to ensure they can really contribute to improvement.

Enhancing independence

I concluded the introduction to last year's annual report by regretting that, despite various attempts over the years, my office had still not been put on a statutory footing. This damages my actual and perceived independence. While I am pleased that Ministers have repeated their commitment to this change, no legislative opportunity has yet been found. I will continue to press for my independence to be reinforced. It would buttress the commitment of my office to contribute robustly and impartially to safer and fairer custody and probation supervision – a commitment that is reflected throughout this annual report.

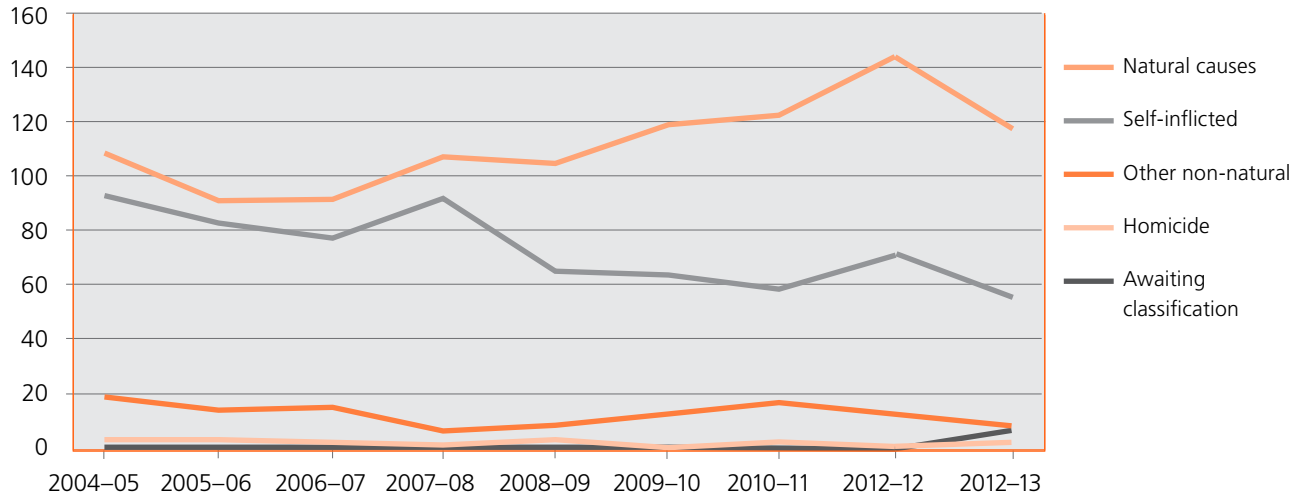
Nigel Newcomen

THE YEAR IN FIGURES

Fatal incidents

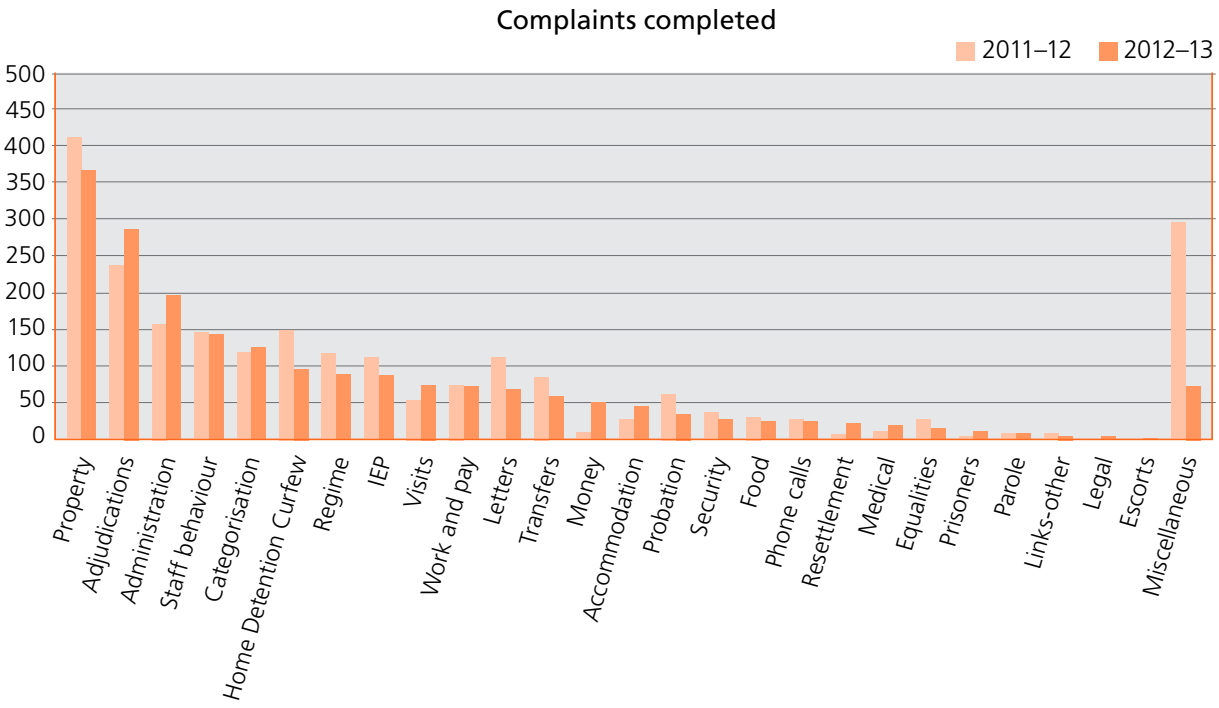
- We were notified of **201** deaths in 2012–13 (9 of which were not investigated as they were outside our remit) and we started **192** investigations, 37 (16%) fewer than last year.
- There were **118** deaths from natural causes and **55** which were apparently self-inflicted.
- We were notified of **2** murders, compared to 1 last year.
- **9** cases were classified as 'other non-natural' and a further **8** await classification (last year there were six such cases, all of which were subsequently classified as either natural causes or other non-natural).
- Output increased significantly, with **247** draft reports and **242** final reports issued in 2012–13, compared to 212 and 196 last year.
- Timeliness improved dramatically, with **60%** of natural cause reports and **47%** of self-inflicted reports issued on time, compared to only 22% and 19% last year.
- The average time taken to produce a natural cause draft report was **28 weeks**, 6 weeks shorter than last year. The average time for self-inflicted cases was **40 weeks**, three weeks shorter than last year.
- Completed investigations included some very high profile and complex ones, including the first **3** self-inflicted child deaths in nearly five years.
- Our annual stakeholder survey indicated some improved satisfaction with timeliness. Bereaved families also rated their experience more highly, with **85%** stating it was 'above average' compared to 77% in 2009.

Fatal incident investigations



Complaints

- **5,374** complaints were received this year, 80 more than last year. Of these **4,894** (91%) were about the Prison Service, **369** (7%) were about the Probation Service and **111** (2%) were about immigration detention.
- The eligibility rate for complaints rose to **59%** this year from **51%** in 2011–12.
- Overall, **2,815** investigations were started, a **6%** increase on last year.
- Although more investigations were started, **298** (**13%**) fewer were completed compared to last year. A total of **2,062** investigations were completed: **1,986** about prisons, **38** about immigration removal centres and 38 about probation, reflecting (as in previous years) the lower eligibility of probation cases.
- Greater proportionality was introduced, with more cases (**376**) not investigated because there was no substantial issue or worthwhile outcome. A further **303** cases were withdrawn, for example because the complainant had been released.
- Timeliness of assessments improved significantly this year, with **64%** completed within the 10-working day target compared to **40%** last year. On average assessments took **11 working days** to complete, an improvement from **15 days** in 2011–12.
- Timeliness of investigations fell this year (with **33%** completed within 12 weeks, compared to **53%** last year) and on average, investigations increased from **14 weeks** in 2011–12 to **19 weeks** this year.



- Overall, **31%** of cases were upheld, a marked increase on last year when **23%** were upheld. Over **half** of property cases investigated were upheld, compared to **42%** last year. Adjudications saw the biggest increase in uphold rate, rising from **17%** to **38%** this year.
- Of the 4,894 prison cases received, **1,164** (24%) were from high security prisons. The uphold rate (**26%**) for completed cases was lower than the **33%** average for other prisons.
- Complaints covered a wide range of subjects, with property being the largest single category, making up **18%** of all complaints and **24%** of immigration detention complaints.
- Like last year, **39** people (less than 3% of the total number who complained) each made more than seven complaints accepted for investigation in the year. These accounted for 523 cases, **19%** of the PPO's caseload.
- In our annual stakeholder survey, **63%** of respondents felt investigations were completed in a reasonable time (or better). Data from the new complainant survey suggest satisfaction levels vary sharply depending on whether the complaint was upheld or not.

INVESTIGATING FATAL INCIDENTS

Learning lessons about fatal incidents

As part of our continued commitment to ensuring that investigations contribute to wider learning, we produced a thematic review and five Learning Lessons bulletins on fatal incidents this year drawing out common themes from across investigations.[6]

Perhaps the most poignant of these was the bulletin reviewing the apparently self-inflicted deaths of three children in custody, the first such deaths in nearly five years. The bulletin was produced much earlier than would have been the case in the past to ensure that any lessons could be drawn to the attention of the authorities and quickly learned, with the earnest hope that such tragedies can be averted in future.

A number of learning points emerged about the need to improve the safeguarding of vulnerable children in custody. Some have been identified in the past, including poor sharing of information within and between agencies and the need to manage bullying better. Others proved particularly topical, for example the need to ensure an appropriate custodial location for the most vulnerable children, an issue that was fed into the Government's review of the juvenile secure estate. The bulletin also found the need for more child-centred processes to manage effectively the risk of suicide and self-harm among children. It is positive that the National Offender Management Service (NOMS) and the Youth Justice Board have established a working group to address this issue.

With an increasingly ageing prison population, and a number of younger prisoners with serious health conditions, caring for those coming to the end of their life is a growing responsibility for the Prison Service. We therefore published a thematic review of the

[6] See appendices for the full list of publications.

"A number of learning points emerged about the need to improve the safeguarding of vulnerable children in custody."

end of life care for 214 prisoners who died of terminal illness between 2007 and 2012. While end of life care was found to have improved in recent years, weaknesses remained. Thus, our clinicians assessed the medical care received by most prisoners as equivalent to that they might have expected in the community, but provision was still patchy. Learning points included the need for: comprehensive palliative care planning, greater involvement of families, earlier application for release on temporary licence or compassionate grounds, and more appropriate use of restraints.

"Unfortunately, the inappropriate use of restraints on seriously ill and dying prisoners is an issue that has arisen in too many investigations this year."

Unfortunately, the inappropriate use of restraints on seriously ill and dying prisoners is an issue that has arisen in too many investigations this year. It was, therefore, the subject of a dedicated learning lessons

bulletin, which stressed the need to balance security with humanity when assessing the use of restraints on very ill, often low risk and frail prisoners. This is an issue that needs to be addressed, whether by better guidance, improved training or simply the application of humane common sense.

Individual investigations

The overall number of deaths in custody notified to this office last year fell 16% from the record number in 2011–12. As previously, around two-thirds of these deaths were from natural causes and around a third were apparently self-inflicted. There were slightly fewer 'other non-natural' cases (usually drug related) and an increase in the small but troubling number of homicides.

At a time of diminishing resources, it is particularly pleasing to note that there was a dramatic improvement in the timeliness of our investigations and in production of reports. This is important as it assists in the learning of urgent lessons, avoids contributing to delays in the inquest system and, above all, provides a better service to bereaved families.

> "As previously, around two-thirds of these deaths were from natural causes and around a third were apparently self-inflicted."

Our fatal incident investigations reflect a broad range of issues which are explored in the following pages. Some are familiar themes, including the need to improve health screening, safety checks and emergency responses. Other issues reflect the range of challenges facing the services we investigate, including the difficulties in managing the personality disordered, those who refuse food and the growing numbers of diabetes sufferers, as well as some emerging themes from a number of complex investigations into homicides.

Reception health screening

Prison Service Instruction (PSI) 74/2011 sets out clearly the expectations for the reception of prisoners, as well as first night and induction into custody. It also covers the expectations in relation to reception health screening.

All newly arrived prisoners should be assessed by a qualified member of the healthcare team or a competent healthcare assistant to determine whether they have any short- or long-term physical or mental health needs, including disability, drugs or alcohol issues and whether there are any immediate needs. Any health records transferred with the prisoner must be examined as part of the assessment.

Follow-up action should be taken, including ensuring that anyone who needs to know about the individual's on-going healthcare requirements is informed, appropriate referrals are made (such as to the substance misuse team or GP) and the assessment and any action taken is recorded in the healthcare record.

Healthcare staff carrying out reception health screening should be ACCT trained (assessment, care in custody and teamwork) and if a prisoner is identified as being at risk of suicide or self-harm an ACCT must be opened or an existing ACCT followed up.

We continue to investigate deaths where reception health screening has been poor. In many cases, previous records are not examined, either because they have not arrived with the prisoner or are simply not taken into account. SystmOne (the computerised prison healthcare record) should have overcome this, but too often little or no consideration is given to the historical record, the summary page has not been completed, or health concerns have not been flagged. Community health records are often not requested, so a full picture of a prisoner's clinical history is not available. There is too much reliance on information from the prisoner, rather than information contained in previous records of any conditions and treatment.

> "We continue to investigate deaths where reception health screening has been poor."

We have also seen some disturbing cases, where there has been a failure to follow up significant findings in the reception screening, putting the prisoner at risk of serious complications.

Ms A arrived in prison directly from court. She did not speak English, but was clearly distressed. The nurse carrying out the reception health screen used a telephone interpretation service and completed and recorded a thorough reception health screen. Ms A's blood pressure was recorded as dangerously high. However, the nurse did not call a GP and did not make any arrangements for any further monitoring of Ms A. Apart from recording the blood pressure reading, the nurse did not flag up the issue for follow-up or evaluation.

The following day, Ms A was seen by the GP as part of the routine assessment. He did not read Ms A's medical record and did not use a telephone interpretation service to assist with his consultation. As a result, he did not notice the high blood pressure reading, and concluded that Ms A was fit and well. Three days later, Ms A was rushed to hospital and found to have malignant hypertension resulting in aortic dissection. This means she had severely high blood pressure leading to irreversible damage to her heart, where blood is forced between layers of the aorta forcing the layers apart. The condition was inoperable and Ms A died four days later. The clinical reviewer concluded that, had Ms A been taken to hospital immediately her high blood pressure was noted, there might have been a better outcome.

> "In at least 10 of our investigations in the last year we found that officers failed to get a response from a prisoner when they unlocked their cell."

We made recommendations about the use of tools to identify and quickly address indicators of serious concerns about blood pressure at a health screen and to flag these up for other clinicians in the prisoner's medical record. We also recommended that healthcare professionals use a telephone translation service when assessing prisoners who do not speak and understand English well.

Checking prisoners at unlock

Prison Service guidance requires that officers check the wellbeing of prisoners when they unlock their cells. Nevertheless, in at least 10 of our investigations in the last year we found that officers failed to get a response from a prisoner when they unlocked their cell, usually in the morning. In some cases, the prisoner was dead when the cell was unlocked, but the officer made no check and failed to notice. In others, the prisoner was seriously unwell, but again the failure to elicit any response from the prisoner at unlock meant this went unnoticed and led to delays in the prisoner receiving treatment.

Mr B was found dead in his cell by another prisoner who was concerned that he had not seen him that morning. The prisoner then raised the alarm. The officer who had unlocked Mr B's cell could not recall if he had even seen him when he unlocked the cell. Had staff carried out their duties properly, the prisoner who found him would not have been put in this distressing situation.

In many of our investigations, officers told us that there was no requirement to get a response from a prisoner when unlocking their cell. However, officers are trained to get a positive response from a prisoner when they unlock a cell. The purpose of this check is to confirm that the prisoner has not escaped, and is not ill or dead. In each of the cases we investigated where this did not happen, we recommended that Governors ensure that officers understood their duty to check prisoners' wellbeing when they unlock their cells.

Emergency response

Life-threatening medical emergencies can occur in prisons whether as a consequence of natural causes, self-harm or other reasons. However, an emergency in a custodial setting presents particular challenges. Speed of response is always critical to the chances of survival but this can be hampered by prison security, such as arrangements for entering a cell at night, calling an ambulance or unlocking several wing gates to reach a prisoner.

During the period covered by this report, we made a total of 143 recommendations about emergency response (six related to deaths in immigration removal centres). Many of these repeated concerns that were identified in our 2012 thematic study, *Deaths from circulatory diseases*. These included recurring recommendations for quicker identification of symptoms and the nature of the emergency, better delivery of emergency first aid and automatic summoning of an ambulance in life-threatening emergencies.

Mr C told his cellmate that he had severe pains in his chest, at around 9.45pm, but did not think he needed the intervention of staff. Forty-five minutes later, his cellmate summoned staff as he was concerned Mr C might be in a coma. The officer who attended instructed Mr C's cellmate to try to rouse him by shaking him and dripping water on his face. The officer believed Mr C was breathing as he saw his torso moving in and out. As there was no response to the attempts at stimulation, he called the senior officer in charge of the prison that night.

The senior officer and three officers went to the cell but two of the officers refused to enter as there was a strong smell. The senior officer said he felt a pulse as well as signs of breathing and assumed Mr C had had an epileptic fit. He decided to let him 'sleep it off'. He cancelled the request for emergency assistance that had been made a few minutes earlier and asked an officer to keep an eye on him. About once an hour throughout the night, the officer checked Mr C, by looking through the observation hatch of the cell with his torch. He noticed that he remained lying in the same position all night. At around 6.20am the following morning, Mr C's cellmate found him unresponsive, cold and stiff. He had been dead for some hours.

> "When seeking help for an unconscious person, every second counts and we are concerned that we have investigated many cases where prison staff have been reluctant to open and enter a cell in an emergency."

The post-mortem report stated that, if Mr C had been taken to hospital immediately after his collapse, 'his prognosis would have been markedly improved' and there was '…no fundamental reason why he would not have survived had he been taken to hospital'. We concluded that the staff involved had failed in their duty of care to Mr C.

When seeking help for an unconscious person, every second counts and we are concerned that we have investigated many cases where prison staff have been reluctant to open and enter a cell in an emergency. Even a few minutes delay can compromise the chances of survival.

A fellow prisoner found Mr D collapsed in his cell 'making gurgling noises and waving his arms about'. He sought help from staff and two officers went to Mr D's cell. It was early evening and there were no healthcare staff on duty. The officers could not find a pulse and noticed Mr D was not breathing. Both officers concluded that he had died and neither considered attempting resuscitation. One of them called the senior officer in charge of the prison, who radioed all staff that there was an emergency where a prisoner was not breathing and asked the control room to call an ambulance. Another senior officer joined him at the cell. Neither examined Mr D, but both accepted the officers' view that he had died without any further enquiry.

> "As with the general population, there is an increasing number of people with diabetes in prison."

The senior officer in charge did not specifically request staff trained in cardiopulmonary resuscitation (CPR) to attend. He did not look for the list of such staff, find out if one of the prisoners had such training or get a defibrillator from the wing office. Neither did the senior officers remain at the cell to coordinate the emergency response. A paramedic arrived at Mr D's cell and, after attaching a defibrillator, concluded that too much time had elapsed without intervention for CPR to stand any chance of success. He therefore confirmed that Mr D had died.

Diabetes care

Diabetes is a chronic condition that affects the body's ability to process sugar or glucose which can have serious health consequences. Left untreated, diabetes can lead to heart disease, stroke, nerve damage and blindness. However, if managed effectively, people with diabetes can reduce the risk of complications and reduce the day-to-day symptoms.

As with the general population, there is an increasing number of people with diabetes in prison, possibly reflecting the rise in the number of older prisoners. We have been concerned to have seen a number of cases where the management of diabetes has been poor, in terms of medication management, day-to-day monitoring of blood glucose levels and the long-term management of the disease. In particular, in the cases we have investigated, few prisoners had received the important HbA1c test (an average plasma glucose test carried out once every three to six months) as part of their diabetic care. When investigating deaths in custody, we look to see that the healthcare provided is equivalent to what might be expected in the community. In respect of diabetes care, too often we have found this has not been the case.

The National Institute of Clinical Excellence (NICE) publishes guidelines for the care and management of diabetes and we consider this to be a cornerstone of good practice for prisons and other places of detention.

Mr E was 38 years old when he died. The post-mortem report showed he died of diabetic ketoacidosis (usually caused by a lack of insulin where the body switches to burning fatty acids and produces ketones, which are harmful) secondary to an infection caused by norovirus. Mr E was a type 1 insulin-dependent diabetic.

When Mr E first arrived at the prison his blood glucose levels were not checked. Two months later an HbA1c test showed a higher than desirable blood glucose level. Mr E was also found to have raised albumin/creatinine levels (which could indicate kidney damage). Both of these results could have indicated that Mr E was at risk of complications from his diabetes, yet there was no diabetic follow-up. Mr E developed diarrhoea and vomiting during an outbreak of norovirus at the prison. The prison concentrated on managing the containment of the outbreak rather than ensuring the needs of individual prisoners were met.

Mr E's diabetes was not appropriately assessed during this time and his deteriorating condition was not noticed. He had various symptoms that indicated raised ketones, including vomiting, abdominal pain and mental confusion. We considered that healthcare staff should have been particularly alert to the possible affects of the virus on a diabetic patient and the risk of raised ketones and subsequently ketoacidosis.

We made a number of recommendations about the management of diabetic prisoners, the use of NICE guidelines and the management of prisoners with existing health conditions during an outbreak of a communicable disease.

Mr F died unexpectedly and a post-mortem showed heart disease caused by diabetes. He was diagnosed with type 2 diabetes in January 2012, but it is likely that he had been diabetic for some time. Mr F had been in prison since 2010 and had spent time in three different prisons in the 12 months before his death. There was no urine dip-testing as part of routine health screens at any of the prisons.

In November 2011, Mr F complained of deteriorating eyesight and was referred to an optician, who found changes in Mr F's retina consistent with diabetes. Blood tests were not taken until the end of December, the results of which showed raised blood glucose. Type 2 diabetes was diagnosed in January. Once diagnosed, the care planning and monitoring of Mr F's diabetes was poor across the three prisons he spent time in. He did not have an HbA1c test and there was no on-going care plan. We could find no evidence that Mr F was initially referred to a diabetic clinic, however this did happen in his final prison.

We found that Mr F's diabetes was poorly controlled. We were critical that there was no urine dip-testing as part of routine health screens at any of the prisons, which would have indicated Mr F's diabetes much earlier and allowed treatment to begin. Left untreated, high blood glucose levels can cause hardening of the arteries and raise the risk of heart disease. Doctors made changes to his medication, but his on-going diabetic

care was not equivalent to the care he might have expected in the community. We made a recommendation about appropriate screening for diabetes and the need for diabetic prisoners to be managed in line with NICE guidelines.

Food refusal

In England and Wales, deaths of prisoners who make a conscious decision to stop eating are fortunately rare. In the first five years that the Ombudsman's office was responsible for investigating deaths in custody, we reported on only one death directly attributed to food refusal. More recently, we have investigated two such deaths. Cases where prisoners refuse to eat are challenging and distressing for those involved in caring for them. Staff have to ensure that the individual understands the seriousness of refusing food and later refusing life-supporting treatment, but the starting assumption must always be that the prisoner has the capacity to make such a decision. In the cases we investigated, we were satisfied that appropriate efforts had been made to establish that the prisoner did not lack this capacity.

When considering the earlier death, we noted the 'professionalism and sensitivity demonstrated by staff and management' at the prison. Nevertheless, we recommended that NOMS and the Department of Health should prepare a briefing about care for a prisoner who is determined to die through food refusal. The Department of Health published guidelines for managing such cases from a healthcare perspective, in January 2010.[7]

Mr G began refusing food shortly after moving prisons. The prison immediately opened an ACCT form, setting out the support and monitoring that could be provided for him. He was assessed daily and staff frequently attempted to persuade him to reconsider his decision. Despite their best efforts, Mr G continued to fast and drew up an advance directive with his solicitor, refusing further medical treatment. All staff and carers who had contact with Mr G were made aware of the terms of the directive and what it allowed them to do for him.

Mr G's condition gradually worsened, and he was admitted to hospital where he reaffirmed to hospital staff that he did not want to be resuscitated. Two days after he was admitted, some four months after he first refused food, Mr G died in his sleep.

No recommendations were made as a result of this investigation as we found that Mr G had been cared for both professionally and compassionately. However, we endorsed a recommendation from the clinical reviewer that more prison staff should be trained to provide end of life care.

[7] Department of Health (2010) *Guidelines for the clinical management of people refusing food in immigration removal centres and prisons.*

Mr H returned to prison from a secure mental health hospital. He told staff when he arrived that he had been refusing food for two months, after he had learned that he would be returned to prison.

Mr H also inflicted wounds on his arms, which he refused to let staff treat. Staff made several attempts to encourage him to eat and accept treatment, but he continued to refuse and was assessed as having capacity to do so. He was eventually taken to hospital after his physical health deteriorated and died of abscesses, which were probably a result of the lack of treatment for his wounds.

In this case, we again thought that staff at the prison had given Mr H appropriate care and advice about managing his decision to refuse food while he was in prison. However, we made two recommendations about care arrangements for prisoners with mental health issues when they return from secure psychiatric hospitals and about wound management.

Enhanced case reviews

Under Prison Service procedures to manage prisoners regarded as at risk of suicide and self-harm, prisons have the discretion to manage the most severely disruptive, volatile and difficult to manage prisoners under an enhanced case review process. In some cases it is mandatory. Enhanced case reviews are designed to allow staff to respond more effectively to prisoner's individual needs and provide a flexible but consistent approach to changing the prisoner's behaviour and managing their risk. We do not see much evidence of enhanced case reviews being used and in five of our investigations into self-inflicted deaths reported on in the last year we found that enhanced case reviews might have improved the outcome. All of the prisoners involved were 21 or under.

"We do not see much evidence of enhanced case reviews being used and in five of our investigations into self-inflicted deaths reported on in the last year we found that enhanced case reviews might have improved the outcome."

Mr I, who was 21, struggled to cope with the restrictions of prison life and a clear trigger to his volatile and impulsive behaviour was being unable to speak to his girlfriend or family. He frequently threatened serious self-harm. He was sometimes threatening and abusive towards staff and was often accused of misusing his cell bell. The responsibility for dealing with Mr I's challenging behaviour fell largely on wing officers and there was no formal strategy setting out how Mr I's behaviour should best be managed. There was little evidence of a robust and consistent approach being taken or of more than sporadic attempts being made to encourage Mr I to reflect on or address his behaviour. His conduct deteriorated.

Membership of an enhanced case review should include 'more specialists and a higher level of operational management' than a typical suicide and self-harm case review. The guidance suggests that a representative of the mental health team, the residential manager, the personal officer, a psychologist, a member of the chaplaincy team, the offender supervisor and any other specialists working with the prisoner should be invited, as well as the prisoner. With such diverse and senior representation, the review should be able to establish a full picture of the individual's needs and tailor the support measures accordingly.

For a significant proportion of Ms J's time in custody she was subject to suicide prevention monitoring, because she self-harmed by cutting and tied several ligatures around her neck. At the same time, she was described as disruptive, and was managed on the basic regime. Ms J's self-harm was managed using standard suicide prevention procedures. Behaviour that was classified as 'disruptive' was managed separately under the behaviour management scheme and, in reaction to her more aggressive behaviour, she was given periods of cellular confinement as a punishment for disciplinary offences, despite her identified risk of self-harm.

The risks of self-harm and disruptive behaviour were managed separately in both of these cases. There was no holistic consideration at a multi-disciplinary forum of the range of behaviour and what it might mean. It is easy to label prisoners as disruptive, but once given this label it can be very difficult to remove. Often it is the behaviour itself that then becomes the focus of staff's attention. The possible root causes of a prisoner's behaviour are often overlooked. Enhanced case reviews should be used more frequently to manage prisoners whose needs cannot be easily categorised according to existing prison procedures, particularly for young people and young adults under 21.

Personality disorders

Many prisoners suffer from mental health problems. Not all of these are mental illnesses which are superimposed on a person's usual personality and may be treatable with interventions such as medication or counselling. Personality disorders, on the other hand, result in extreme behaviour that tends to last throughout the person's life. They are difficult to treat and treatment often includes helping the person to manage their disorder rather than attempting to 'cure' it. The following examples demonstrate the difficulties prison staff face in managing prisoners with challenging behaviour, and also the need to ensure that mental health problems are not ignored because there is no easily diagnosed and treatable illness. However the manifestation of mental health problems is defined, these are still people exhibiting real symptoms of distress and there is a need to ensure appropriate care.

Ms K often failed to collect food and medication, suffered from incontinence, and did not dispose of the pads she was given to help her. She also had mobility issues, although some members of staff thought that she sometimes displayed better mobility than she told them. Ms K's physical health was poor and led to her death but she had mental health and behavioural issues which were not addressed and resulted in some of her basic care needs not being given appropriate priority.

In Ms K's case, healthcare staff were unable to find a medical reason for the incontinence and advised prison staff to use the discipline system to try and change her behaviour. In the meantime, her health began to deteriorate. While our clinical reviewer did not think the care provided to her contributed to her death, he noted that a caring approach to her basic nursing and social care needs was lacking. Although it was clear that she was difficult to manage because of her behavioural problems, more should have been done to examine possible underlying health, mental health or behavioural problems before resorting to the use of disciplinary measures. We considered that there should have been more communication between healthcare and wing staff to ensure that her multiple care needs were adequately met in a holistic way and concluded that not enough was done to get a proper understanding of her mental health and behavioural issues.

Mr L had been in prison for most of the previous five years when he died. During this time, his behaviour was extremely challenging. He flooded his cell, and covered it in urine and faeces. Staff often reported seeing him eat paper plates and other non-edible objects. He occasionally had periods of lucid behaviour, and some of the doctors and psychiatrists he saw thought that he was feigning his symptoms, although these symptoms were sustained for some years.

Mr L was found dead one morning in his cell. A post-mortem examination concluded that the most likely cause of death was the result of him blocking his airway by swallowing some cardboard from an orange juice carton.

As Mr L had a propensity to eat a range of materials, eating cardboard was not unusual behaviour and it did not appear to have been an act of deliberate self-harm. We found that staff had made considerable efforts to care for him, and had taken a multi-disciplinary approach involving healthcare, wing and mental health staff. Although there was no confirmed diagnosis that he had a mental illness or a personality disorder, he continued to receive support from mental health teams. We made no recommendations about his care.

Emerging themes from homicide investigations

Thankfully, homicides in English and Welsh prisons are not common but this year we completed investigations into three homicides and were notified of two new cases, which we will investigate once police enquiries and court proceedings are over. While care must be taken in extrapolating themes from such a small number of deaths, our investigations identified some common issues.

There were examples of Cell Sharing Risk Assessments (CSRAs) being at odds with evidence about the person's risk. On occasion, prisoners were assessed as medium or even low risk to others despite a history of seriously injuring others in custody. It was not always clear whether these apparently illogical assessments were a result of staff not following the process correctly, or key evidence not being available to the staff carrying out the assessment, or a combination of both.

There were also some examples when information about risk was not effectively communicated between prisons, meaning that highly dangerous behaviour in one prison did not result in appropriate risk assessment and management in another. There were also communication breakdowns within establishments and instances where warnings about potential risks where not acted on quickly or effectively. We welcome the recent publication of the NOMS Quick-Time Learning Bulletin to clarify appropriate use of CSRAs, which reminds staff that the assessment is an essential tool to enable identification of prisoners who pose a risk of serious assault or murder to another prisoner in any unsupervised shared space. However, effective risk assessment relies on staff having all the necessary information and we found a worrying lack of awareness among some wing staff about the dangerousness of some prisoners, even when this had previously manifested itself in prison. Effective staff training and robust management checks will be needed to ensure that the learning that has been identified brings about real improvements.

Our investigations into these deaths highlighted the particular challenges faced by prisons in managing individuals who are separated from the main population. Prisoners are usually given 'vulnerable prisoner' status for their own protection as a result of their offence, however some prisoners are granted this status because their behaviour in custody has put them at risk from other prisoners, for example by accumulating debts they cannot pay. In most prisons, vulnerable prisoners live together on a wing, regardless of the reasons for their vulnerability. This inevitably presents challenges over how the risks between prisoners are managed. Our investigations into these cases suggest that there remain lessons to be learned, not least in respect of sharing information effectively and ensuring that this is appropriately used to inform risk assessments and management. We have recommended that in high security prisons, where this is a particular issue, there should be regular reviews of vulnerable prisoner status and that a strategy is developed to manage prisoners in vulnerable prisoner units who themselves are a risk to other vulnerable prisoners.

Mr M was killed in a cell by a fellow prisoner, Mr N, on the vulnerable prisoner wing of a high security prison. Mr N had been moved from another high security prison following the attempted murder of a prisoner. This attack also took place on a vulnerable prisoner wing. Despite Mr N's history, on arrival at the receiving prison, his cell sharing risk assessment made no reference to the attempted murder and he was subsequently judged to present a low risk to fellow prisoners. Senior managers at the prison were also unaware of Mr N's recent violence and so did not factor this into their management of him when new intelligence about his risk to others came to light. Mr N was able to lock himself and Mr M into a cell because, at the time, the practice at the prison meant that the cell bolt could be secured from the inside.

Each of the three homicides we investigated in this period took place in cells, although not between cellmates. In two of the cases, the perpetrators were able to lock themselves in a cell with their victim. In one case, this prevented staff from entering the cell. In the other, two members of staff were unaware of what was happening behind the locked door. Our investigations raised concerns about differing practices across the prison estate in relation to how cell doors are secured to prevent this.

Family liaison

A fundamental aspect of our investigations is the involvement of families and friends of deceased persons. At the outset, our trained family liaison officers seek their views on matters we should consider during the investigation and they are further consulted at key stages.

During the course of the year, we made 23 recommendations regarding family contact covering issues such as proper recording of family contact details, sufficiently early contact with a terminally ill prisoner's family and appropriate contributions to funeral expenses.

As part of the initial reception procedures on their arrival at prison, staff should ask prisoners to give contact details for their next of kin and someone to be contacted in the event of an emergency. Staff should then enter this in the person's record. Not all prisoners choose to nominate someone to be contacted, but sometimes it is not apparent that they have been asked.

Mr O had been in prison for eight months, when he was found hanging in his cell at 3.50pm and taken to hospital. Over two and a half hours after he was found, the prison appointed a family liaison officer to liaise with the hospital and Mr O's family. No family contact details had been recorded so they had to interrogate the prisoner telephone system to identify a family member that he had regularly telephoned and then obtain that person's address from the visitor records. This obviously took some time and his family was not contacted until 10.50pm that night. Mr O died four days later.

We have found many examples where details have not been recorded or are out of date when needed. This information is essential in an emergency and it is helpful if prisoners are reminded that they can provide them or update them at any time, and are given an opportunity to do so, particularly if they are serving a long sentence. Where no details are given, it is best practice for staff to annotate the records to indicate the reason why.

In line with the Prison Rules, NOMS guidance advises prisons to engage immediately with the prisoner's next of kin or another nominated person in the event of a terminal illness, unpredicted or rapid deterioration in physical health and as soon as possible after sudden death. This can include meeting the prisoner's family to provide information on the security arrangements for hospital supervision.

> "During the course of the year, we made 23 recommendations regarding family contact."

Mr P had a cancerous tumour removed and, following the spread of the cancer, he started chemotherapy six months later. He died 26 months after the removal of the tumour. Throughout his time in prison, Mr P had been in contact with a family member, who had often visited him. Eighteen months before his death, an entry in his medical records suggested that a family liaison officer should be appointed, but this was not done until just before Mr P's death. In the early hours of the morning of the day he died, a hospital doctor requested the details of his next of kin. The hospital subsequently agreed that it could wait until the morning. Staff at the prison could not find any contact details as they had not been entered in Mr P's records. At around 9.30am, the prison appointed a family liaison officer and Mr P died an hour later. The family liaison officer left telephone messages for Mr P's next of kin, unaware that he was abroad. By this time Mr P's family had learned of his death through other prisoners.

We concluded that, if the prison had established contact with Mr P's family at an earlier stage of Mr P's illness, in line with Prison Service guidance, the difficulty about contacting his family would have been avoided. It is best practice to appoint a properly trained person, who can act as a consistent and central point of contact for families at an early stage when a prisoner is seriously unwell.

Prison Service instructions require prisons to offer to pay reasonable funeral expenses when there is a death in custody. There are guidelines about what reasonable costs might include, such as the funeral director's fees, a hearse and coffin, but not a headstone, flowers or clothes for mourners.

Mr Q died from cancer two months after his diagnosis. The prison had not appointed a family liaison officer during his illness but made a commendable effort to notify Mr Q's family of his death in person, even though the prison was a long way from the family home. However, the prison paid only a portion of reasonable funeral costs.

The Governor indicated that he had taken into account the balance of Mr Q's private prison account as well as money for the family collected by prisoners on his wing even though the Prison Service instruction expressly says: 'A deceased prisoner's monies must not be used to meet the cost of their funeral'. We made a recommendation about the need to ensure that all reasonable funeral costs are met, up to the threshold indicated. Although NOMS accepted the recommendation, the prison has so far not recompensed Mr Q's family. This is an unacceptable response to a recommendation that has been accepted and unfair on Mr Q's family who have not been treated similarly to others.

Although our investigations necessarily tend to focus on areas for improvement, we also report on good practice. Prison Service guidance makes it a mandatory requirement that prisons have arrangements 'for an appropriate member of staff to engage with the next of kin or nominated person of prisoners who are either terminally or seriously ill'.

As noted, not all prisons adhere to this requirement but a number now appoint trained family liaison officers at a sufficiently early stage to ensure that families are well supported, consulted and receive prompt information about the progression of the prisoner's illness. Sometimes, prisons use a designated member of the healthcare team to fulfil this function. In either case, we welcome families having a named person to contact for information.

Following hospital investigations, a doctor informed Mr R that he had cancer and gave a life expectancy of weeks or months. Owing to the circumstances of his offences, Mr R had been estranged from members of his family. A week after receiving the prognosis, the prison arranged a special visit between him, his family and certain key members of healthcare and prison staff in a quiet area of the prison. After the visit, Mr R decided to tell his family that his illness was terminal and the lead nurse asked him to compile a list of family members who it would be appropriate for her to contact as his condition worsened. Soon after, the nurse telephoned the primary family contact to introduce herself as Mr R's key worker and to discuss his condition and outstanding medical appointments. She subsequently consulted them about his wish not to be resuscitated in the event of a cardiac arrest. She kept in contact with them with regular updates as his health declined. When his death was imminent she gave them the opportunity to bring forward a planned visit. She established with them how they wished to be informed of Mr R's death. After his death, a family liaison officer was appointed, who telephoned various family members as agreed and kept in touch as needed.

This was a good example of very effective family liaison.

INVESTIGATING COMPLAINTS

Learning lessons about complaints

Our individual investigations address the specific issues affecting complainants and seek to support improvement in the particular establishments concerned. However, having completed over 2,000 investigations in 2012–13, it is also important to identify general lessons which should be learned across the system.

A fair and effective disciplinary system is essential to a safe and controlled prison environment. Punishments can have a significant effect on prisoners, so it is no surprise that complaints about adjudications are our second most common type of complaint, behind those about property. However, it is worrying that last year the proportion of complaints about adjudications which were upheld, usually with a recommendation to quash the finding, rose from 17% to 38%. This suggests a marked deterioration in quality. So in March 2013, it was timely that we should publish a thematic report on trends in complaints about adjudications over the last three years, with an in-depth analysis of our cases in the first six months of 2012.

The report identified a number of lessons which reinforce guidance already laid out in detailed Prison Service Instructions. The learning is clear: if this guidance was more closely followed, the quality of adjudications would be improved and the need for recourse to the PPO would be reduced.

Two brief learning lessons bulletins were also published about complaint investigations last year. The first looked at complaints from offenders under probation supervision. Such complaints made up only 7% of all the complaints we received in the year, but they raised important issues not least about the process of complaining. The bulletin concluded that prisons and probation trusts needed to avoid the 'buck passing' of complaints when they come from serving prisoners yet relate to issues which occurred in the community.

"It is worrying that last year the proportion of complaints about adjudications which were upheld, usually with a recommendation to quash the finding, rose from 17% to 38%."

The second bulletin looked at the challenges that custody places on an individual's ability to practise their religion. In general, prisons tried hard to accommodate the religious needs of prisoners but lessons were identified in relation to how Prison Service Instructions are interpreted and applied so that an appropriate balance is struck between security considerations and religious observance.

The first cross office learning lessons bulletin focused on sexual abuse in prisons. It looked at a range of issues including homophobia, transgender issues, relationships in prison and allegations of sexual assault during searches. Lessons were identified regarding strip searching, conformity with the Equalities Act 2010, addressing abusive intimate relationships and facilitating police and internal prison investigations.

Individual complaints

As in previous years, the majority (91%) of the complaints we received came from prisoners. This means that changes to the complaints process in prisons can have a significant impact on our workload. We have, therefore, taken a keen interest in the change to the Prison Service's internal complaints procedure this year, switching from a three-stage process to a two-stage process. We support this change in principle as it should enable prisoners' complaints to be resolved more quickly in prisons. However, we have been concerned by the poor quality of some of the responses by prison staff to complaints that could and should have been resolved without the prisoner ever needing to approach the Ombudsman. This is frustrating and very unsatisfactory for prisoners and a waste of our limited resources. The problem often seems to be that complaints are being answered by junior staff who do not feel they have the authority to offer a solution. We are increasingly sending these complaints back to the prison to resolve. For example:

Mr A complained that his property had gone missing when he was transferred from one prison to another. Both prisons acknowledged that the property was missing but took no further action and simply referred Mr A to the Ombudsman.

We told the prisons that they needed to resolve the complaint themselves and offer Mr A a suitable sum of compensation. We told Mr A that he should contact us again if the complaint was not resolved satisfactorily.

We have also continued to decline to investigate cases that do not raise a substantial issue or where there is nothing more an investigation by the Ombudsman could achieve. For example:

Mr B complained about the noise made by other detainees playing pool and watching TV in the communal area outside his room in an immigration removal centre. The centre offered to move Mr B to another, quieter room, but he refused to move and said that he wanted the pool table and TV moved instead.

We told Mr B that we would not investigate his complaint because we considered that the centre had already offered him an appropriate solution.

We are also taking steps to ensure that the unreasonable behaviour of a few individuals does not take up a disproportionate share of our resources to the detriment of other complainants.

"However, we have been concerned by the poor quality of some of the responses by prison staff to complaints that could and should have been resolved without the prisoner ever needing to approach the Ombudsman."

Mr C, for example, has raised a number of complaints with us – we have declined to investigate some, have investigated and not upheld some, and are still investigating others. Mr C was unhappy with the decisions we had made so, in line with our normal policy, the decisions were reviewed by a senior manager. Following those reviews the outcomes remained the same and we, therefore, told Mr C that we regarded these cases as closed. However, Mr C continued to send us frequent lengthy letters referring to both the closed complaints and to complaints we are still investigating. It was difficult and very time consuming for our staff to work out which complaints were being referred to and we, therefore, had to tell Mr C that we would no longer reply to letters that refer to closed cases or to more than one complaint at a time. We are continuing to investigate his outstanding cases.

All of these measures are necessary to enable us to target our resources on the complaints where this office has a real contribution to make, and especially on the most serious complaints.

Serious complaints

Among the most serious complaints we receive are allegations of assaults by staff, and we have investigated a number of these this year, including some worrying cases involving juveniles and young offenders.

Frequently, these complaints arise in the context of staff using control and restraint (C and R) techniques. The issue we need to address in our investigations, therefore, is not whether force was used – since there is no dispute about that – but whether the use of force was justified (that is, was it reasonable, necessary and proportionate in the circumstances). Our task is considerably more difficult where there is no CCTV or video evidence (for example, where force is used spontaneously in a cell). In these cases we may have nothing to go on apart from the, often very different, accounts given by the complainant and staff, at the time and in our interviews. As a result, it is not always possible for us to reach a conclusion about what happened. In a number of cases, however, we have recommended that disciplinary action be initiated against the staff involved, such as in the case below:

Mr D complained that his wrist was broken in the course of a use of force incident when he was 16 years old. The two officers involved said that Mr D refused an order to go into his room and stood in the doorway being verbally abusive and threatening them with a broom. They said that force was only used after they tried to persuade Mr D to release the broom for 'a good few minutes'. When one of the officers tried to push Mr D into the room, the pair overbalanced and Mr D (who is slightly built and weighed just over 8 stone) fell to the floor with the officer (who is about 6 foot 5 inches tall and weighed about 19 stone) on top of him. Mr D's wrists were then put in back hammers while he was lying face down before being placed in his room. The prison told us that Mr D's wrist had been weakened by a childhood accident and had been injured in the gym a couple of days earlier.

We viewed the CCTV of the incident and interviewed Mr D and the two officers. It was clear to us that Mr D's behaviour was often difficult to manage and that he had been verbally aggressive to the officers immediately prior to the use of force. However, Mr D had only touched the broom for a fraction of a second and was no longer doing so when force was initiated. The CCTV evidence did not support the officers' accounts that they had made a genuine attempt to de-escalate the situation before force was used. On the contrary, the CCTV showed one of the officers standing very close to Mr D, arguing with him and apparently trying to push him into the room. In our view, this use of force was not justified by Mr D's behaviour and was particularly unwise given the difference in their weights. Other staff should have been summoned to place Mr D in his room in a controlled manner. Our investigation found that the officer who initiated force was subject to poor performance procedures at the time of the incident as a result of concerns about his aggressive behaviour and poor communication skills. We concluded that, although it was impossible to be sure whether Mr D's wrist was actually broken during this incident, there was no doubt that it was seriously injured as a result of the use of force – either when he fell to the floor or when his wrist was placed in a back hammer – and required immediate hospital treatment.

We were critical of the fact that the officer had used a back hammer after he heard Mr D scream when he hit the floor, and that he continued to apply it after Mr D screamed that his wrist was broken. We were also very concerned that back hammers were used at all while Mr D was lying face down, since this could have led to breathing difficulties.

We found that the use of force was not reasonable, necessary or proportionate and recommended that a disciplinary investigation be initiated. We were also critical of the prison's internal investigation which we considered insufficiently robust, and we were un-persuaded by the conclusions of a review commissioned by the Deputy Director of Custody.

Another serious complaint we investigated this year at a young offender institution (YOI) involved Mr E.

Six officers restrained 19-year-old Mr E in his cell in the segregation unit one night. Mr E complained that one of the officers had punched him in the face. The officers said that they entered Mr E's cell to try to persuade him to stop setting off the fire alarm and that Mr E had to be restrained after he jumped up and lunged at one of them while they tried to reason with him.

Our investigation found that a number of young offenders had been setting off fire alarms and repeatedly ringing their cell bells in the segregation unit that night (as they had on previous nights). Although Mr E had not set off the fire alarm, he had rung his cell bell four times in the 20 minutes before the officers went into his cell. Mr E accepted that he had jumped up while the officers were in the cell and, in the absence of CCTV evidence, we were unable to say that the restraint in the cell was not justified or that Mr E had been punched in the face. However, it is very unusual for staff to enter a cell during the night patrol state – this would only normally happen if a prisoner were ill or injured. We considered that it had been unnecessary and unwise for the officers to go into Mr E's cell

and that the officers' behaviour amounted to deliberate provocation contrary to the Prison Rules. We were also concerned that the statements the officers completed after the restraint lacked the necessary detail, that Mr E was not debriefed afterwards (as he should have been) and that the YOI's own investigation into Mr E's complaint had been wholly inadequate. We recommended, among other things, that the Governor of the YOI commission a disciplinary investigation into the actions of four of the officers and apologise to Mr E for the unsatisfactory way in which his complaint was investigated.

Not all serious complaints are about the use of force. For example:

Ms F complained that a male officer had submitted negative reports about her behaviour after she rejected his sexual advances. Our investigation did not find any evidence to support the specific details of Ms F's complaint and we did not uphold it. However, in the course of our investigation, another prisoner, Ms G, told us that she had had a sexual relationship with the same officer in return for him bringing items into the prison for her, and that she had submitted an internal complaint about him after transferring to another prison. It also emerged that other prisoners had made similar allegations about this officer over a number of years.

This did not necessarily mean that the allegations about this officer were true, but we were concerned that the prison's internal investigation into Ms F's complaint had not taken the previous allegations into account. We recommended that the prison should commission a disciplinary investigation into Ms F's allegations and that this should take account of the previous allegations about the officer.

The failure to conduct a robust internal investigation is one theme that emerges from a number of these serious complaints. Another concern is that relevant CCTV footage of the events before and after a restraint is not always retained even after a complaint has been made. This was an issue, for example, in this case:

Mr H complained that he was physically and sexually assaulted by staff during the course of a restraint. The restraint took place in a cell and there was, therefore, no CCTV coverage. Our investigation did not provide evidence to support Mr H's complaints and we did not uphold it. However, we were concerned that the CCTV footage that showed Mr H being taken into the cell had been destroyed as a matter of routine after nine days, despite the fact that Mr H had submitted complaints to the prison. Although the CCTV footage did not cover the restraint, it would have provided useful evidence of Mr H's behaviour which staff said had made the restraint necessary.

"The failure to conduct a robust internal investigation is one theme that emerges from a number of these serious complaints."

As the destruction of CCTV footage had arisen in other cases, we made a national recommendation to the Prison Service that any CCTV of a use of force, and of the period before and after, should be retained as evidence for a period of three months if a prisoner makes a complaint about the use of force.

Mr H also complained about being strip-searched unnecessarily after the restraint and this was another theme to emerge from complaints about the use of force during the year. A strip search is one of the most intrusive actions that can be taken against a prisoner and for this reason Prison Service policy,[8] rightly requires that such searches should only take place where there are high risks, serious concerns and good reasons to suspect that a prisoner has secreted items.

Our concerns are illustrated in the following case:

Mr I was strip-searched by force following a restraint in a high security prison. Our investigation found no evidence that a risk assessment was conducted to consider whether it was necessary to do a strip search and we concluded that it was most likely that it was done as a matter of routine. We also found no evidence that a risk assessment was conducted to consider whether it was necessary to strip search Mr I by force, or that any attempt was made to secure his compliance first, and we concluded that it was most likely that this was also done as a matter of routine. Staff did not appear to recognise that a decision to strip search and a decision to strip search by force were two separate decisions and that both needed to be justified and the reasons recorded.

We recommended that the Governor carry out an investigation into the appropriateness of these decisions. We also made a national recommendation during the year that the Prison Service should amend PSO 1700 at the next available opportunity to make it mandatory to record strip searches and the reasons for them.

We have also dealt with complaints from prisoners who feel they have not been protected from assaults by other prisoners.

Mr J complained that he had been subjected to homophobic abuse, threats and an actual assault by another prisoner and that prison staff had failed to protect him. Our investigation found that the relationship between the two prisoners was more complicated than Mr J had suggested, and that there was some evidence that the other prisoner had been responding to taunts by Mr J. We also found that the other prisoner had been challenged by staff about homophobic comments on at least one occasion, and had been placed on report following the assault. In addition, the prison had taken steps to separate Mr J and the other prisoner.

“Any CCTV of a use of force, and of the period before and after, should be retained as evidence for a period of three months if a prisoner makes a complaint about the use of force.”

[8] Prison Service Order 1700 (which refers to strip searches as “full searches”)

However, we were concerned that most of the incidents between the two prisoners had not been recorded and that it had taken the prison four months to provide Mr J with a response to his concerns. We recommended that the prison improve the way they record and respond to complaints of this kind.

Links with the outside world

Keeping prisoners and detainees safe is a fundamental requirement, but other issues may also be very important to those who have lost their liberty. One is the ability to maintain relationships with the people they care about in the community. Some of the complaints we receive about this subject are straightforward ones (for example, about delays in approving the telephone numbers of relatives), but others are more complex and involve a balance of competing needs.

Mr K complained about the prison's decision to stop his 11-year-old daughter visiting him. Our investigation found that Mr K was serving a sentence for a sexual offence against a 16-year-old girl and that the visits had been stopped after staff had expressed concern about what they considered inappropriate behaviour by Mr K when his daughter sat on his lap during a visit. Mr K strongly refuted the suggestion that there had been any inappropriate behaviour.

We were in no doubt that the prison had been absolutely correct to take the concerns expressed by staff very seriously and to investigate them. There is no question that the need to protect Mr K's daughter should take precedence over Mr K's right to a family life. However, stopping contact between a parent and a child will have a significant impact on the child as well as the parent, and is not a decision that should be taken lightly. We were, therefore, surprised to find that the investigation in this case had apparently been carried out as a paper exercise only, without interviews with the staff or Mr K, and that there was no record of what evidence had been considered or what decisions had been taken. We recommended that a fresh risk assessment should be carried out within three months.

Mr L complained that he had been refused permission to attend his father's funeral under escort. Mr L said that he had been told that the police and probation services objected to his attendance, but he knew this was not the case. The death of a parent is a very distressing event and it was natural that Mr L should have wanted to attend the funeral. However, he had been convicted of a serious sexual offence against the daughter of his former partner and it was, therefore, necessary for a thorough risk assessment to be carried out to determine whether his request could be approved.

Our investigation found that the risk assessment showed that the police and probation services did not oppose Mr L's attendance; that he was not considered to be an escape risk; that his victim and her mother now lived over a hundred miles away and would not be present at the funeral; and that Mr L's family had undertaken to ensure that no other children would be present. We concluded that, motivated by the need for a quick decision, the decision maker had failed to read the risk assessment reports properly, and that the refusal was, therefore, based on incorrect reasoning. We upheld Mr L's complaint and recommended that the Governor apologise to him. We were pleased to note that, although Mr L had not been

able to attend the funeral, the prison had nevertheless acted with sensitivity and had offered him support at the time of the funeral and the opportunity to visit his father's grave at a later date.

We receive frequent complaints from prisoners that their legally privileged mail has been opened by staff in contravention of Prison Rule 39. Prisons may not open or read mail from a prisoner's legal adviser or certain other bodies (such as courts), unless they have reasonable cause to believe that it contains an illicit enclosure or is not from a body covered by Rule 39. Where such mail is opened, it must only be done in the presence of the prisoner and must be recorded in the correspondence log.

Mr M complained that his letters from courts and solicitors were being opened routinely. We found that there was evidence that some of Mr M's letters had been opened by mailroom staff despite being clearly marked 'Rule 39'. There was nothing on the envelopes to identify the senders, and it was, therefore, reasonable for staff to have questioned whether they were genuinely from a body covered by Rule 39. However, if there were doubts, the letters should have been opened in Mr M's presence and not in the mailroom. We also found that, although it would have been obvious to staff once the letters had been opened that the contents were legally privileged, the error had not always been recorded in the correspondence log. We did not find any evidence that Mr M's Rule 39 mail was being deliberately or systematically opened, and we concluded the problem had arisen as a result of poor management and training.

We recommended that the Governor apologise to Mr M for the errors in opening his mail. We also recommended that the Governor conduct a formal review of the prison's mail handling arrangements and arrange retraining for all the staff involved.

Property

Complaints about lost and missing property have continued to make up the largest single part of our complaints work (18% of all complaints investigated in 2012–13). The sums of money are usually small, but most prisoners have few possessions and those they do have may be an important source of personal identity.

We uphold a higher percentage of property complaints than many other types of complaints (53%), and we continue to be concerned about the cavalier and unhelpful manner in which these complaints are too often treated by prison staff (as the case of Mr A above illustrates).

"We uphold a higher percentage of property complaints than many other types of complaints (53%)."

Mr N complained that his property was stolen from his cell while he was in hospital after being assaulted by other prisoners. The prison told Mr N that staff had locked his cell when he was taken to hospital, but that other prisoners had broken in and stolen his belongings. They told Mr N that his property was held at his own risk and that the prison was not responsible for its loss. They did, however, offer him £50 in full and final settlement. Mr N complained to the Ombudsman that this was significantly less than the value of the stolen items.

We were disappointed that the prison had told Mr N that he was responsible for his own property since, when he was taken to hospital, he was no longer able to take care of it and responsibility passed to the prison who should have taken steps to secure the property and to record it. We were also surprised that the prison had not conducted an investigation into how other prisoners had been able to break into a locked cell. Our investigation suggested that the prison had underestimated the value of Mr N's property and we mediated a more appropriate settlement.

Of course, not all the complaints we receive about property are upheld.

Mr O complained that £200 in cash sent to him by his partner, had not been credited to his prison account. Our investigation established that that Mr O had received £20 in cash in a card from his partner, and that the prison had endorsed the envelope to record that it had contained £20 and had credited the money to Mr O's account. We examined the letters and envelopes that Mr O provided to support his complaint. We concluded that Mr O had made amendments to a letter to make it appear that it had contained £200, and that he had altered the prison's endorsement on the original envelope from £20 to £200.

We did not uphold Mr O's complaint.

Adjudications

Adjudications give rise to a significant number of complaints each year. The Ombudsman's role in considering these complaints is not to rehear the evidence, but to decide whether, based on the evidence heard at the hearing, it was established beyond reasonable doubt that the prisoner did what he was charged with doing, that the correct procedures were followed, and that a fair and just decision has been reached. We have seen some poorly conducted adjudications this year, and in about 38% of the adjudication complaints we investigated we concluded that the finding of guilt was unsafe – usually because the adjudicator failed to call witnesses without good reason, or failed to enquire fully into the prisoner's defence, or failed to provide reasons for the decisions made. Poorly conducted adjudications are a concern, not least because they can result in prisoners being punished unfairly or in guilty prisoners going unpunished.

Eighteen-year-old Mr P complained about being found guilty of assaulting an officer. The details of the charge were that, during an association period, an officer had been seen emerging from Mr P's cell in a confused state with a cut to his lip. When asked what had happened, the officer said that Mr P had pushed him. Mr P denied that he had assaulted the officer.

Our investigation established that neither the alleged victim, nor the officer who had found him, were present at the adjudication hearing and that statements from them were read out instead. Mr P did not, therefore, have an opportunity to question the evidence against him. This is contrary both to Prison Service policy and to natural justice. The adjudicator did not seek any further evidence to establish that the alleged victim had suffered any injuries consistent with his account or that Mr P had been in the cell at the time. He relied solely on the disputed hearsay evidence to find Mr P guilty.

We considered that the finding was unsafe and recommended that it be quashed. We did so with great reluctance. Mr P had been charged with a serious and wholly unwarranted attack on an officer carrying out his duties. If that is what happened, the alleged victim had a right to expect that the perpetrator would be punished. We would normally have expected that a charge of this seriousness would be referred to an independent adjudicator (a judge) and no explanation was provided for why that had not happened in this case. Assuming that there was a good reason, the onus was on the adjudicating Governor to take pains to ensure that the adjudication was procedurally correct. Unfortunately, he failed to do so. We recommended that he receive refresher training in the conduct of adjudications.

The following case raised a different issue:

Mr Q complained that he had not been given long enough to obtain legal advice when he was charged with using homophobic language towards an officer when asked to comply with a strip search. Our investigation found that the hearing was adjourned for a little over 48 hours to allow Mr Q to obtain legal advice. When the hearing resumed, Mr Q asked for further time. The adjudicator refused, saying that Mr Q had already had sufficient time to obtain legal advice. He proceeded to find Mr Q guilty and imposed a punishment of cellular confinement and loss of canteen, association, television and gym.

Prison Service Instruction (PSI) 47/2011 on discipline procedures says that prisoners who request legal advice must be given 'sufficient time' to consult a legal adviser, and that it is for the adjudicator to decide how long to allow 'but two weeks will normally be enough'. We did not consider that 48 hours was sufficient time for Mr Q to obtain legal advice and we, therefore, recommended that the guilty finding be quashed as unsafe. The Governor disagreed, saying that prisoners were not routinely locked up during working hours and that Mr Q would, therefore, have been able to telephone his solicitor. Most unusually, the Chief Executive of NOMS did not accept our recommendation to quash the finding.

We do not consider that prisoners should be able to string adjudications out unreasonably, and we do not consider that prisoners should always be given two weeks to obtain legal advice. However, it remains our view that 48 hours will not normally be sufficient time for a person who is detained and has limited access to the telephone, and none to fax or email,

to obtain advice from a solicitor who has not seen the papers and who will need to sort out funding issues. It is simply unrealistic to expect that prisoners will be able to obtain instant legal advice over the phone in the majority of cases.

Religious issues

We have continued to receive complaints about religious issues. One of the most significant was that of Mr R.

Mr R complained that the Prison Service did not recognise Rastafarianism as a religion. The Prison Service told us that they were bound by a 30- or 40-year-old Ministerial decision that Rastafarianism should not be recognised as a religion, but that they did nevertheless support the religious and cultural needs of Rastafarian prisoners. They also recognised that the current policy was out of date, as the Equality Act 2010, which recognises Rastafarianism as a religion, overrides any previous Ministerial decision.

We found that the Prison Service's policy on Rastafarianism contravened the Equality Act, and we recommended that the Prison Service should issue guidance to all Governors reminding them of the need to comply with the Equality Act.

Mr S complained that celebrations for the Muslim festival of Eid had been cancelled at his prison.

Our investigation found that the Eid celebrations had not been cancelled. Prayers would take place in the prison's chapel and sweets and snacks would be distributed there. However, because the prison chapel was not equipped for dining, it had been decided that celebratory meals for all religious and cultural meals (including Eid) would in future be served on the wing and not in the chapel. The meals would be made available to all prisoners in order to encourage an understanding of other faiths. As there were very few Muslims on Mr S's wing, they would be allowed to join Muslim prisoners on another wing for the meal. The local imam had confirmed that this arrangement met the religious requirements. We were satisfied that the arrangements had been made after appropriate consultation and with the support of the imam, and we considered that they were entirely reasonable. We did not, therefore, uphold Mr S's complaint.

Categorisation

Being able to progress through their sentence towards release is, understandably, important to prisoners and we, therefore, receive a number of complaints from those who believe they have unfairly been refused re-categorisation to a lower security category.

Mr T complained that he had been refused re-categorisation to category D (which would have allowed him to transfer to an open prison) on the grounds that he was suspected of involvement in the supply of drugs and mobile phones in the prison. Mr T denied this and said that, although he had once been caught with a mobile phone in his possession, he had never had a positive drugs test and had never been found in possession of drugs.

Our investigation found that Mr T's custodial behaviour had been good throughout the previous two years. However, he had twice been caught with a mobile phone, and there had been 25 security intelligence reports (mostly from reliable sources) linking him

> "As in previous years, a disproportionately small number of the investigations we completed were into complaints from female prisoners and young offenders."

to the supply of drugs and mobile phones. Although this was not hard evidence of his involvement, we considered that the prison had legitimate grounds for concern and that, given the importance of trust in open prisons, the decision to refuse Mr T category D status had not been unreasonable. We did not uphold his complaint.

Early release

Prisoners serving determinate sentences for non-violent crimes may spend a proportion of their sentence in the community under Home Detention Curfew (HDC) – commonly known as 'tagging'. Where a prisoner complains that he or she has been refused HDC, our role is to consider whether the Governor's decision was a reasonable one and made in accordance with the rules.

Mr U complained that he had been refused HDC on the grounds that he presented a high risk of re-offending and was a potential threat to public safety. Mr U said that this was his first time in prison and that he had learnt his lesson and had no intention of re-offending.

Our investigation found that Mr U was serving a sentence for dangerous driving while under the influence of alcohol, and that he had a history of drink driving offences. He also had three previous convictions for driving while disqualified on bail, a breach of a conditional discharge and a breach of a court order. Given Mr U's offending history and his convictions for breaches of trust, we did not consider that the Governor's decision to refuse HDC was unreasonable and we did not uphold Mr U's complaint.

Women and young offenders

As in previous years, a disproportionately small number of the investigations we completed were into complaints from female prisoners and young offenders. Only 2.3% of complainants were female, although they make up 5% of the prison population. Meanwhile, only 1.8% of cases were from young offenders (under 21), who make up 9% of the prison population. These complaints tend to be different in nature from those brought by adult male prisoners. The most common complaint from women was about staff behaviour, although this was only seven out of 47 cases. Over a quarter of complaints from young offenders were about adjudications, compared to 14% of all complaints, but the numbers are too small to draw firm conclusions.

The small number of women's prisons means that women are often located a long way from their home, and this can make the maintenance of family ties more difficult, illustrated in the case below.

Miss V, a life sentence prisoner, complained about the decision to end family days for lifers at her prison. She said that she no longer received visits as a result. Our investigation found that Miss V's only regular visitors were her elderly and disabled parents who lived a very long distance from the prison. They found the journey difficult and, in order to visit Miss V, they had to stay overnight near the prison. This was expensive as their income put them just above the threshold for financial assistance with visits. They had been willing to make the long journey and stay overnight when they could spend a whole day with Miss V but, although they still wanted to visit her, they found it too tiring and expensive now that they could only spend an hour or two with her.

The prison told us that they had had to end family lifer days because they could no longer afford the staffing costs of supervising them (although we found that two other prisons holding female life sentence prisoners were still running them). The Prison Service has an obligation under Prison Rule 4 to actively encourage prisoners to maintain outside contacts and meaningful family ties, and we did not consider that it was meeting this obligation in Miss V's case. We recommended that the prison either reinstate lifer family days or allow visits over both days of a weekend for prisoners in Miss V's position. They opted for the latter.

> "Only 1.8% of cases were from young offenders (under 21), who make up 9% of the prison population."

We have investigated a number of complaints from young offenders this year about the use of force, and the cases of Mr D and Mr E above are examples of this. Another issue that has arisen is the need to ensure that young offenders are properly supported at adjudications.

For example, 18-year-old Mr W complained that his request for legal advice on a charge of assaulting another young offender had been refused. He said that he had asked staff the night before if he could have legal advice or representation and had been told it would be sorted out at the hearing.

We were satisfied that, whatever he might have said to staff beforehand, Mr W had not asked for legal assistance at the hearing. However, we considered that, given Mr W's age, significant learning disabilities and lack of experience of adjudications, and the seriousness of the charge, the adjudicator should have encouraged him to seek help from an advocate. We also considered that the adjudicator should have done more to inquire into Mr W's defence that he had acted in self-defence (which Mr W was clearly incapable of articulating himself). In the circumstances, we considered the finding of guilt against Mr W was unsafe and recommended that it be quashed.

Immigration detention

We investigated 38 complaints from immigration detainees this year. Many, such as the complaint from Mr B, were similar to those from prisoners. Twenty-four per cent concerned property. However, some had distinctive features related to the complainants' immigration status.

After serving a prison sentence for a violent offence, Mr X had been transferred to an immigration removal centre (IRC) pending deportation. He complained that he had been dismissed from his employment in the kitchen at the IRC on the grounds that he was not cooperating with the immigration process. Mr X said that this was unfair as he was cooperating.

Our investigation found that the UK Border Agency (UKBA) had repeatedly told the IRC that Mr X had failed to provide information about his identity and home address to enable deportation to be effected, and was, therefore, considered non-compliant. We were satisfied that UKBA's policy of denying employment opportunities to detainees who fail to cooperate was not unreasonable. However, we found no evidence that this was the reason for Mr X's dismissal from the kitchen – although it was the reason why he had been unable to secure alternative employment.

The IRC could not provide any record of when or why Mr X was dismissed: it may have been because staff had belatedly realised that he should never have been employed there in the first place because of his history of violent offending, or because he was suspected of stealing food to make 'hooch', or because of his poor time-keeping. Any of these might have constituted reasonable grounds for dismissal, but the lack of record keeping meant that we could not be sure what the reason was. Although employment in an IRC is a privilege and not a right, it is nevertheless an important privilege for someone like Mr X who has no other income. A record should, therefore, have been kept and Mr X should have been told the reason and given a right of appeal. Although we could not say that the IRC had acted unreasonably in removing Mr X from the kitchen given his offending history, we considered that his dismissal had been badly handled, and recommended that the IRC should apologise to Mr X for this.

Probation

We completed 38 investigations about probation. These complaints were very different in nature from complaints about prison. Nearly a quarter of complaints (24%) were about the complainant's offender manager and one in five (21%) were about reports that had been written and assessments within these reports.

Mr Y complained that he had received a longer sentence than would otherwise have been the case because the pre-sentence report (PSR) prepared by his offender manager had contained 'blatant lies' – specifically that the PSR referred to him having been convicted of 16 sexual offences (rather than 13), included a reference to him having been convicted of 'rape of a child under 13', and misrepresented his personal circumstances in respect of his employment, finances and relationships.

Our investigation found that Mr Y had been convicted of 13 sexual offences against the daughter of his former partner, including 'attempted rape of a child under 13', and had been sentenced to a total of 12 years' imprisonment. The Probation Trust had already investigated Mr Y's complaint and had accepted that the number of convictions and the reference to 'rape of a child under 13' were incorrect. They had apologised to Mr Y and agreed to amend his records, but maintained that the offender manager had written the PSR in good faith and that the errors would not have affected the court sentencing outcome or the assessment of the risk he posed.

We were satisfied that the Trust had investigated Mr Y's complaint properly and corrected the errors. We found that Mr Y's convictions had been incorrectly recorded on the court record sheet supplied to the offender manager, who had then repeated the information in the PSR in good faith. We did not consider that the errors would have made any difference to the sentencing outcome, because the court was fully aware of the offences before it, and had already expressed a firm indication of a lengthy custodial sentence. We noted that Mr Y had received a sentence of 12 years' imprisonment for the offence of 'attempted rape of a child under 13' alone. We were not able to establish whether the details of Mr Y's personal circumstances were correct or not at the time the PSR was written, but we did not consider that the offender manager had deliberately misled the court, and we were satisfied this information was highly unlikely to have affected the decision on sentence. We did not uphold the complaint.

APPENDICES

Statistical tables

Fatal incident investigations started	Total 2011/12	% of total (11/12)	Total 2012/13	% of total (12/13)	Change 11/12–12/13	% change year on year
Natural causes	144	63%	118	61%	-26	-18%
Self-inflicted	71	31%	55	29%	-16	-23%
Other non-natural**	13	6%	9	4%	-4	-31%
Homicide	1	0%	2	1%	1	*
Awaiting classification	0	0%	8	4%	8	*
Total	**229**	**100%**	**192**	**100%**	**-37**	**-16%**

* The % changes in small numbers are not meaningful.
** Other non-natural includes investigations where post-mortem and toxicology tests have been unable to establish cause of death.

Fatal incident investigations started	Total 2011/12	% of total (11/12)	Total 2012/13	% of total (12/13)	Change 11/12–12/13	% change year on year
Male prisoners	198	86%	173	90%	-25	-13%
Female prisoners	4	2%	6	3%	2	*
Young offenders (under 21)**	8	3%	2	1%	-6	*
Approved premises residents**	15	7%	9	5%	-6	-40%
IRC residents	4	2%	2	1%	-2	*
Total	**229**	**100%**	**192**	**100%**	**-37**	**-16%**

* The % changes in small numbers are not meaningful.
** In 2011/12 one female resident and one approved premises resident were under 21. In 2012/13 one approved premises resident was female.

Fatal incident investigations started 2012/13	Male prisons	Female prisons	Young offender (under 21)	Approved premises residents*	IRC residents	Total
Natural causes	109	4	0	4	1	118
Self-inflicted	48	2	2	3	0	55
Other non-natural**	7	0	0	2	0	9
Homicide	2	0	0	0	0	2
Awaiting classification	7	0	0	0	1	8
Total	**173**	**6**	**2**	**9**	**2**	**192**

* In 2012/13 one approved premises resident was female.
** Other non-natural includes investigations where post-mortem and toxicology tests have been unable to establish cause of death.

Fatal incident reports issued	Total 2011/12	% in time*	Total 2012/13	% in time*	Change 11/12–12/13	% change year on year
Draft reports	212	21%	247	55%	35	17%
Final reports	196	39%	242	33%	46	23%
Anonymised reports	143		132		-11	-8%

* 'In time' for draft reports is 20 weeks for natural causes deaths and 26 weeks for all others. 'In time' for final reports is 12 weeks following the draft. This is based on their classification at the start of the investigation.

Complaints received	Total 2011/12	% of total (11/12)	Total 2012/13	% of total (12/13)	Change 11/12–12/13	% change year on year
Prison	4,726	89%	4,894	91%	168	4%
Probation	433	8%	369	7%	-64	-15%
Immigration detention	135	3%	111	2%	-24	-18%
Total	**5,294**	**100%**	**5,374**	**100%**	**80**	**2%**

Complaints investigations started	Total 2011/12	% of total (11/12)	Total 2012/13	% of total (12/13)	Change 11/12–12/13	% change year on year
Prison	2,533	95%	2,704	96%	171	7%
Probation	58	2%	47	2%	-11	-19%
Immigration detention	76	3%	64	2%	-12	-16%
Total	**2,667**	**100%**	**2,815**	**100%**	**148**	**6%**

Complaints investigations completed	Total 2011/12	% of total (11/12)	Total 2012/13	% of total (12/13)	Change 11/12–12/13	% change year on year
Prison	2,248	95%	1,986	96%	-262	-12%
Probation	67	3%	38	2%	-29	-43%
Immigration detention	45	2%	38	2%	-7	-16%
Total	**2,360**	**100%**	**2,062**	**100%**	**-298**	**-13%**

Prisons fatal incident investigations started in 2012/13

Prisons	Natural	Self-inflicted	Other non-natural**	Homicide	Awaiting classification	Total
Isle of Wight	8	1	0	0	0	9
Parc	7	0	1	0	1	9
Lewes	2	3	0	0	1	6
Cardiff	1	4	0	0	0	5
Channings Wood	5	0	0	0	0	5
Holme House	3	2	0	0	0	5
Risley	4	1	0	0	0	5
Wakefield	4	0	0	0	1	5
Altcourse	2	2	0	0	0	4
Durham	0	4	0	0	0	4
Elmley	1	3	0	0	0	4
Frankland	4	0	0	0	0	4
Full Sutton	3	1	0	0	0	4
Lincoln	1	3	0	0	0	4
Liverpool	2	2	0	0	0	4
Norwich	2	2	0	0	0	4
Whatton	4	0	0	0	0	4
Winchester	3	1	0	0	0	4
Wymott	4	0	0	0	0	4
Bullingdon	2	0	1	0	0	3
Chelmsford	1	2	0	0	0	3
Dovegate	2	1	0	0	0	3
Littlehey	2	1	0	0	0	3
North Sea Camp	3	0	0	0	0	3
Pentonville	2	1	0	0	0	3
Peterborough*	2	1	0	0	0	3
Preston	2	1	0	0	0	3
Wormwood Scrubs	1	1	0	0	1	3
Birmingham	1	1	0	0	0	2
Bristol	1	1	0	0	0	2
Bronzefield	2	0	0	0	0	2
Forest Bank	2	0	0	0	0	2
Gartree	1	1	0	0	0	2
Gloucester	0	2	0	0	0	2
Hewell	0	1	0	1	0	2
Highpoint	1	0	0	0	1	2
Hull	1	0	1	0	0	2
Leeds	2	0	0	0	0	2
Long Lartin	0	0	1	1	0	2

Prisons	Natural	Self-inflicted	Other non-natural**	Homicide	Awaiting classification	Total
Maidstone	2	0	0	0	0	2
Manchester	1	1	0	0	0	2
Northumberland	1	1	0	0	0	2
Standford Hill	2	0	0	0	0	2
Bedford	1	0	0	0	0	1
Belmarsh	0	0	0	0	1	1
Dartmoor	1	0	0	0	0	1
Dorchester	1	0	0	0	0	1
Downview	1	0	0	0	0	1
Exeter	0	0	1	0	0	1
Featherstone	1	0	0	0	0	1
Ford	0	0	1	0	0	1
Foston Hall	0	1	0	0	0	1
Garth	0	1	0	0	0	1
Guys Marsh	1	0	0	0	0	1
High Down	1	0	0	0	0	1
Kingston	1	0	0	0	0	1
Leicester	1	0	0	0	0	1
Leyhill	1	0	0	0	0	1
New Hall	1	0	0	0	0	1
Northallerton	0	1	0	0	0	1
Oakwood	1	0	0	0	0	1
Onley	1	0	0	0	0	1
Rye Hill	0	0	1	0	0	1
Shrewsbury	1	0	0	0	0	1
Stocken	0	0	0	0	1	1
Stoke Heath	0	1	0	0	0	1
Swaleside	0	1	0	0	0	1
Swansea	0	1	0	0	0	1
Thameside	1	0	0	0	0	1
The Mount	1	0	0	0	0	1
Wandsworth	1	0	0	0	0	1
Wayland	1	0	0	0	0	1
Whitemoor	0	1	0	0	0	1
Woodhill	1	0	0	0	0	1

* Peterborough total for male and female prisoners.
** Other non-natural includes investigations where post-mortem and toxicology tests have been unable to establish cause of death.

IRC fatal incident investigations started in 2012/13

IRCs	Natural	Self-inflicted	Other non-natural	Homicide	Awaiting classification	Total
Harmondsworth IRC	1	0	0	0	1	2

Approved premises' fatal incident investigations started in 2012/13

Approved premises	Natural	Self-inflicted	Other non-natural	Homicide	Awaiting classification	Total
Bowling Green	0	1	0	0	0	1
Burdett Lodge	0	0	1	0	0	1
Edith Rigby House	1	0	0	0	0	1
Mandeville House	0	1	0	0	0	1
Nelson House	0	0	1	0	0	1
Ozanam House	1	0	0	0	0	1
St Leonards	0	1	0	0	0	1
Trent House	1	0	0	0	0	1
Wilton Place	1	0	0	0	0	1

Prisons complaints completed from 1 April 2012 to 31 March 2013

Prisons	Upheld	Not upheld	Total	Uphold rate (only given when 20 or more completed)	Population (Ministry of Justice stats, Q4 2012/13)	Upheld complaints per 100 prisoners
Frankland	39	120	159	**25%**	771	5.1
Wakefield	28	73	101	**28%**	741	3.8
Full Sutton	23	78	101	**23%**	597	3.9
Long Lartin	28	56	84	**33%**	610	4.6
Isle of Wight	32	44	76	**42%**	1,084	3.0
Woodhill	17	54	71	**24%**	764	2.2
Swaleside	21	35	56	**38%**	1,092	1.9
Gartree	17	37	54	**31%**	704	2.4
Lowdham Grange	14	40	54	**26%**	882	1.6
Garth	16	28	44	**36%**	793	2.0
Lindholme	10	30	40	**25%**	874	1.1
Rye Hill	17	21	38	**45%**	621	2.7
Whitemoor	8	28	36	**22%**	450	1.8
Highpoint North and South	12	21	33	**36%**	1,265	0.9
Ranby	7	25	32	**22%**	1,074	0.7
Dovegate	13	18	31	**42%**	1,021	1.3
Onley	12	16	28	**43%**	676	1.8
Wayland	11	17	28	**39%**	996	1.1
Erlestoke House	10	18	28	**36%**	486	2.1
Belmarsh	9	19	28	**32%**	755	1.2
High Down	7	19	26	**27%**	1,037	0.7
The Mount	9	16	25	**36%**	765	1.2
Bure	3	20	23	**13%**	518	0.6
Brixton	9	13	22	**41%**	742	1.2
Bullingdon	7	15	22	**32%**	1,073	0.7
Stocken	6	16	22	**27%**	833	0.7
Whatton	6	16	22	**27%**	833	0.7
Maidstone	9	12	21	**43%**	592	1.5
Wandsworth	11	9	20	**55%**	1,204	0.9
Huntercombe	5	15	20	**25%**	429	1.2
Manchester	5	15	20	**25%**	1,090	0.5
Littlehey	8	10	18		1,104	0.7
Featherstone	0	18	18		675	0.0
Holme House	8	9	17		1,141	0.7

Prisons	Upheld	Not upheld	Total	Uphold rate (only given when 20 or more completed)	Population (Ministry of Justice stats, Q4 2012/13)	Upheld complaints per 100 prisoners
Liverpool	5	12	17		1,159	0.4
Risley	5	11	16		1,086	0.5
Channings Wood	4	12	16		714	0.6
Parc	8	7	15		1,408	0.6
Lincoln	7	8	15		661	1.1
Wolds	1	14	15		352	0.3
Coldingley	5	9	14		507	1.0
Northumberland	2	12	14		1,321	0.2
Wealstun	6	7	13		814	0.7
Sudbury	3	10	13		574	0.5
Altcourse	2	11	13		1,031	0.2
Dartmoor	2	11	13		642	0.3
Blundeston	7	5	12		516	1.4
Wymott	6	6	12		1,104	0.5
Buckley Hall	3	9	12		435	0.7
Leeds	1	11	12		1,157	0.1
Wellingborough*	4	7	11		584	0.7
Hull	4	7	11		711	0.6
Elmley	3	8	11		1,195	0.3
Nottingham	3	7	10		991	0.3
The Verne	3	6	9		589	0.5
Guys Marsh	1	8	9		558	0.2
Pentonville	1	8	9		1,238	0.1
North Sea Camp	0	9	9		407	0.0
Peterborough**	1	7	8		788	0.1
Shepton Mallet*	3	5	8		188	1.6
Leyhill	4	4	8		522	0.8
Wormwood Scrubs	4	4	8		1,183	0.3
Holloway	3	5	8		462	0.6
Norwich	3	5	8		712	0.4
Hewell	2	6	8		1,215	0.2
Stafford	2	6	8		720	0.3
Doncaster	1	7	8		1,091	0.1
Grendon/Spring Hill	1	7	8		556	0.2
New Hall	0	8	8		347	0.0
Lewes	5	2	7		602	0.8

Prisons	Upheld	Not upheld	Total	Uphold rate (only given when 20 or more completed)	Population (Ministry of Justice stats, Q4 2012/13)	Upheld complaints per 100 prisoners
Birmingham	4	3	7		1,391	0.3
Bristol	4	3	7		608	0.7
Forest Bank	4	3	7		1,323	0.3
Leicester	4	3	7		355	1.1
Winchester	4	3	7		671	0.6
Moorland/Hatfield	3	4	7		1,255	0.2
Eastwood Park	2	5	7		284	0.7
Kirkham	1	6	7		614	0.2
Hollesley Bay	0	7	7		418	0.0
Durham	2	4	6		860	0.2
Swinfen Hall	1	5	6		629	0.2
Ford	0	6	6		513	0.0
Kingston*	1	4	5		198	0.5
Canterbury*	0	4	4		302	0.0
Thorn Cross	3	1	4		296	1.0
Bedford	2	2	4		475	0.4
Isis	2	2	4		520	0.4
Everthorpe	1	3	4		679	0.1
Oakwood	1	3	4		1,543	0.1
Shrewsbury*	0	3	3		332	0.0
Portland	2	1	3		519	0.4
Warren Hill	2	1	3		111	1.8
Chelmsford	1	2	3		552	0.2
Foston Hall	1	2	3		282	0.4
Preston	1	2	3		665	0.2
Rochester	1	2	3		650	0.2
Drake Hall	0	3	3		282	0.0
Exeter	0	3	3		497	0.0
Haverigg	0	3	3		617	0.0
Low Newton	0	3	3		249	0.0
Stoke Heath	0	3	3		722	0.0
Aylesbury	2	0	2		409	0.5
Hindley	2	0	2		179	1.1
East Sutton Park	1	1	2		91	1.1
Glen Parva	1	1	2		683	0.1
Standford Hill	1	1	2		456	0.2
Kennet	0	2	2		253	0.0

Prisons	Upheld	Not upheld	Total	Uphold rate (only given when 20 or more completed)	Population (Ministry of Justice stats, Q4 2012/13)	Upheld complaints per 100 prisoners
Lancaster Farms	0	2	2		524	0.0
Usk and Prescoed	0	2	2		492	0.0
No longer in prison	2	0	2		-	-
Gloucester*	1	0	1		308	0.3
Bullwood Hall*	0	1	1		233	0.0
Cardiff	1	0	1		761	0.1
Send	1	0	1		266	0.4
Wetherby	1	0	1		227	0.4
Ashfield	0	1	1		65	0.0
Askham Grange	0	1	1		107	0.0
Deerbolt	0	1	1		430	0.0
Styal	0	1	1		428	0.0
Werrington	0	1	1		129	0.0

* March 2012 population data – prison now closed.

** Peterborough total for male and female prisoners.

Immigration Removal Centre (IRC) complaints completed from 1 April 2012 to 31 March 2013

IRCs	Upheld	Not upheld	Total	Population (Home Office Immigration Detention Stats Q4 2012)	Upheld complaints per 100 detainees
Colnbrook IRC	2	9	11	364	0.5
Harmondsworth IRC	2	7	9	561	0.4
Brook House IRC	2	7	9	353	0.6
Yarl's Wood IRC	2	3	5	363	0.6
Tinsley House RC	1	1	2	192	0.5
Morton Hall IRC	1	0	1	283	0.4
Dover IRC	0	1	1	72	0.0

Probation complaints completed from 1 April 2012 to 31 March 2013

Probation Trusts	Upheld	Not upheld	Total
Thames Valley	3	1	4
London probation area	1	3	4
Bedfordshire	1	2	3
Devon and Cornwall	1	2	3
Greater Manchester	1	2	3
Staffordshire and West Midlands	0	3	3
Hampshire	1	1	2
Kent	1	1	2
Nottinghamshire	0	2	2
Cambridgeshire	1	0	1
Humberside	1	0	1
South Yorkshire	1	0	1
Avon and Somerset	0	1	1
Derbyshire	0	1	1
Hertfordshire	0	1	1
Lincolnshire	0	1	1
North Wales	0	1	1
West Mercia	0	1	1

Prisons and Probation Ombudsman financial data

Finance	2011/12	% of total (11/12)	2012/13	% of total (12/13)	Change 11/12–12/13	% change year on year
Budget allocation	£5,496,000		£5,230,000		-£266,000	-5%
Staffing costs	£4,703,240	89%	£4,517,206	91%	-£186,034	-4%
Non-pay costs	£603,394	11%	£437,525	9%	-£165,869	-27%
Total spend	**£5,306,634**	100%	**£4,954,731**	100%	**-£351,903**	**-7%**

Finance	2011/12	% of total (11/12)	2012/13	% of total (12/13)	Change 11/12–12/13	% change year on year
Staff costs	£4,703,240	89%	£4,517,206	91%	-£186,034	-4%
IT and telecoms	£156,704	3%	£117,190	2%	-£39,514	-25%
Staff travel	£148,528	3%	£92,342	2%	-£56,186	-38%
External support	£109,018	2%	£94,741	2%	-£14,277	-13%
Learning and development	£77,631	1%	£45,860	1%	-£31,771	-41%
Legal advice and Translations	£42,513	1%	£50,593	1%	£8,080	19%
Stationery and office supplies	£42,710	1%	£28,242	1%	-£14,468	-34%
Publications and research	£24,033	0%	£8,185	0%	-£15,848	-66%
Other	£2,257	0%	£372	0%	-£1,885	-84%
	£5,306,634		**£4,954,731**		**-£351,903**	**-7%**

Stakeholder feedback

Feedback from stakeholders is essential to understanding levels of satisfaction with the work of the PPO, and identifying areas for improvement. A new stakeholders' strategy has been implemented and data from general stakeholders, bereaved families and complainants are now routinely collated.

General stakeholders

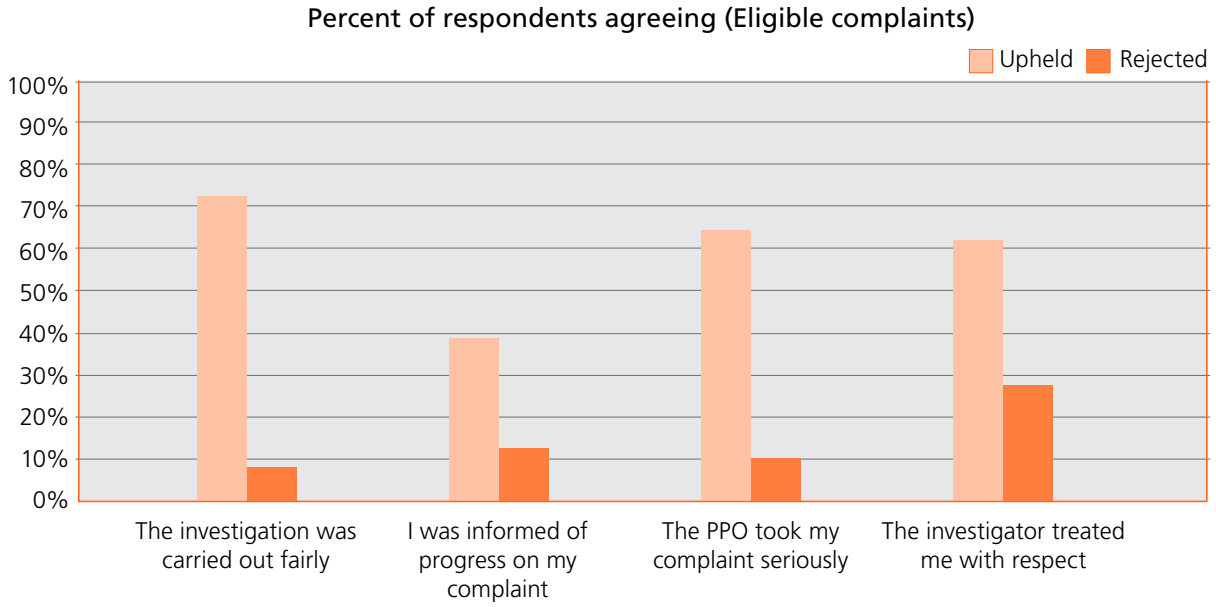
- An online survey of stakeholders was carried out in November 2012. In total, 219 responses were received from a range of people who had experience of the PPO during the preceding year. These included frontline staff across prisons and probation, and others such as HM Coroners and IMB Chairs.
- Although over half of those involved with fatal incident investigations and two-thirds involved with complaints investigations felt that investigations had been completed quickly enough or better, timeliness remained a concern for many.
- For both complaints and fatal incident investigations, six out of 10 respondents felt they were kept informed of progress. This was similar to previous years.
- Perceptions of quality remained high, with six out of 10 people rating the PPO overall as 'good' or 'very good'.
- General impression scores also remained high, with 88% rating PPO as 'very' or 'quite' influential, independent, professional and accessible. There was a drop, however, in all areas for the 'very' rating. The 'professional' rating remained the highest and 'influential' the lowest, as in previous years.

Bereaved families

- A questionnaire is sent to bereaved families at the same time as the final fatal incident report investigation. Between March 2011 and April 2013, replies were received from 59 families and these were compared to responses from the 56 families surveyed in 2009.
- Ratings of quality and levels of satisfaction increased in the four key areas: meeting expectations, treatment by the family liaison officer, how the investigation was conducted, and the overall experience of families.
- Family expectations of the investigation process remained consistent. The majority hoped to get an explanation of the events of the death from the investigation and over half of families felt that their expectations had been met between 2011 and 2013, an increase from just over a third in 2009.
- Positive perceptions of treatment by family liaison officers increased from 85% to 91% as did ratings of how the investigation was conducted. Families rated their overall experience more highly, with 85% rating it as above average (compared to 77%).

Complainants

- From November 2012, a short questionnaire has been sent to a sample of complainants. The sample is split between those whose complaint was found to be ineligible for investigation, those whose complaint was upheld after investigation and those whose complaint was rejected after investigation. Given the smaller number of complaints received from women, young people and immigration detainees all such complainants are sent a survey.
- So far, 399 surveys have been sent out relating to complaint assessments and investigations completed between October 2012 and February 2013. By the end of April 2013, 146 replies had been received, a response rate of 37%. Initial results are presented here and a full report is planned for December 2013.
- Most (55%) reported that they had received an initial reply about their complaint within four weeks and around half (49%) felt this was a reasonable time to wait. Of those whose complaint was ineligible 39%, said they understood clearly or very clearly why it was ineligible and 65% said they would use the PPO again.
- Satisfaction with the investigation into the complaint differed sharply depending on whether the complaint had been upheld or not. Overall, 38% felt the investigation had been fair but, where the complaint had been upheld, this rose to nearly three-quarters (73%).



Learning lessons publications 2012–13

Thematic reports

Learning from PPO investigations: Adjudications complaints examines one of our most common types of complaints and identifies lessons which reinforce guidance laid out in Prison Service instructions, which could improve adjudications and reduce recourse to the Ombudsman.

Learning from PPO investigations: End of life care looks at the care of prisoners who died of terminal illnesses between 2007 and 2012. The report finds some evidence that prisons are getting better at providing end of life care but identifies a number of areas for improvement.

Learning Lessons bulletins

Fatal incidents investigations issue 1 – Learning from deaths in approved premises
In the first ever analysis of this setting, specific attention is paid to the small but growing number of deaths in probation approved premises and the need for better awareness of methadone and mixed drug toxicity and improved management of prescribed medication.

Fatal incidents investigations issue 2 – Learning from the use of restraints examines the pressing need to learn lessons about properly balancing security and humanity in the use of restraints on seriously ill and dying prisoners.

Fatal incidents investigations issue 3 – Child deaths
At the request of Ministers, this bulletin looks at lessons emerging from three recent deaths of children in custody and identifies a number of learning points to safeguard vulnerable children, including the need for more child-centred processes.

Fatal incidents investigations issue 4 – Basic regime
At the request of Ministers, we looked at self-inflicted deaths where the deceased had been on basic regime before death and the bulletin emphasises the need for the management of vulnerabilities on a case by case basis.

Complaints investigations issue 1 – An overview of probation complaints identifies lessons about the handling of complaints about probation, particularly when they come from serving prisoners and may relate to assessments made in the community.

Complaints investigations issue 2 – Religion examines the lessons to be learned from complaints relating to the challenges that custodial settings place on an individual's ability to practise their religion.

PPO investigations issue 1 – Sexual abuse in prisons is the first bulletin to identify lessons from both complaints and fatal incidents that involve a sexual element. It looks at a range of issues including homophobia, transgender issues, relationships in prison and allegations of sexual assault during searches.

Performance against business plan

Objective 1: To maintain and reinforce our current reputation for absolute independence

	Key deliverable	End of year assessment
1	Work with Ministers and Parliament to pursue the possibility of placing the PPO on a statutory footing at the next legislative opportunity	Ongoing. Ministers have confirmed their support for placing the Ombudsman on a statutory basis but no legislative slot has yet been found.
2	Work with Ministers to achieve a review of the PPO's Terms of Reference by end March 2013 that ensures they are up-to-date, enshrine our independence and help the PPO operate within budget	Ongoing. The scope of the PPO's Terms of Reference review has been agreed with both the Ministry of Justice and NOMS. The review is now underway.
3	Work with MoJ officials to ensure an appropriate office location that maintains our actual and perceived independence by March 2013	Achieved. It has been agreed that the Prisons and Probation Ombudsman's office will be relocated to Rose Court, SE1. The alternative options of 102 Petty France and Clive House were rejected on the basis they did not protect the visible independence of the office. The move is scheduled to take place in November 2013.
4	Ensure stakeholders are assured of the office's independence	Achieved. As in previous years, the perceived independence of the office as measured by the annual stakeholders survey remains high at 87%.

Performance against business plan

Objective 2: To be more accessible to all who have contact with our services

	Key deliverable	End of year assessment
1	Work towards the extension of the PPO's remit to include the investigation of complaints in Secure Training Centres (STCs) and fatal incidents in Local Authority Secure Children's Homes (LASCHs)	Ongoing. The extension of the PPO's remit has been agreed. Memoranda of Understanding are being drafted with the Youth Justice Board and the Department for Education respectively. The change in remit will be reflected in the Terms of Reference review.
2	Increase accessibility of the PPO to hard-to-reach groups such as young people, women, those whose first language is not English and those with learning difficulties/ disabilities by March 2013	Ongoing. The complainants' feedback survey was launched in November 2012 with specific targeting of hard to reach groups. Initial analysis of the early findings has been conducted and a full report will be published. Feedback will be monitored and action taken where necessary to increase accessibility.
3	Improve effectiveness and timeliness of feedback through the introduction of post-investigation feedback (from complainants as well as investigated bodies and coroners) by July 2012	Ongoing. Post-investigation feedback surveys for fatal incidents investigations have been designed and the methodology for collecting feedback identified. This will be launched in 2013–14.The method of collecting post-investigation feedback for complaints investigations is yet to be designed and will be carried forward as a deliverable for 2013–14.
4	Seek feedback on the PPO's performance through the annual stakeholder survey. Seek feedback in November 2012, analyse responses and produce an action plan by January 2013	Achieved. The stakeholder survey took place in November 2012 and the findings were published on the PPO website with actions included in the business plan 2013–14.
5	Produce an annual report for April 2011 to March 2012 for publication September 2012	Achieved. This was published 14 September 2012.

	Key deliverable	End of year assessment
6	Assess and improve the role of all methods of external communication for sharing different types of information as well as promoting the work of the office to varying audiences as set out in our communications plan	Achieved. Learning lessons bulletins were launched in September 2012; the PPO website has been maintained and is currently being redesigned; the Ombudsman submits regular articles to *Inside Time*; the DVDs have been updated; PPO representatives have attended external conferences; investigators continue to promote the role of the PPO during prison visits.
7	Engage with stakeholders according to the PPO's stakeholder engagement strategy with quarterly review of progress	Achieved. Overall strategy and action plan for 2012–13 launched in September 2012.
8	Implement the PPO's media strategy in order to reassure the public that deaths in custody and detainee complaints are thoroughly investigated by an independent and impartial body by the end of March 2013	Achieved. Implemented by the PPO's press officer.
9	Review and develop Memoranda of Understanding (MoU) with all key stakeholders to clarify roles and, where appropriate, improve joint working by the end of March 2013	Achieved. MoUs agreed with: Coroners Society UK Border Agency Legal Ombudsman Ongoing. MoUs planned with: IPCC Youth Justice Board/Department for Education

Performance against business plan

Objective 3: To improve both the quality and timeliness of our investigations and resulting reports, ensuring excellence, robustness and a proportionate approach

	Key deliverable	End of year assessment
1	Design a proportionate and efficient investigation process which enables the PPO to meet both stretching timelines and a high quality standard by the end of March 2013	Ongoing. Further procedural work is needed in preparation for the PPO's organisational restructure in 2013–14. This objective will extend into next year's business plan.
2	Improve the quality of investigation reports through the development and application of better quality assurance procedures by the end of March 2013	Ongoing. While the feedback from stakeholders on the quality of investigation reports remains positive, it will take more time for all stakeholders to recognise the changes introduced in 2012–13. We expect to see an increase in positive responses to this question in future years.
3	Develop an accessible and effective internal investigation knowledge base that ensures consistency and the sharing of best practice across the office by the end of March 2013	Partially achieved. A contacts database has been developed and is in use. Standard templates for investigations are in development.
4	Reduce delays to the production of investigation reports through the provision of improved management information by the end of March 2013	Achieved. Monthly and quarterly performance scorecards have been reviewed and redesigned. Simple statistics and tables that are accessible to all staff have been developed and updates are displayed on posters every month. Delays to the production of draft fatal incident reports have been substantially reduced, as have delays in the assessment of complaints received by the office.
5	Improve the delivery targets for both complaints and fatal incident investigations which transparently reflect a proportionate and timely approach by the end of March 2013	Ongoing. New complaint investigation targets were introduced in 2012–13 and have been reviewed and revised for 2013–14. The closer monitoring of fatal incident investigation targets has driven up performance.
6	Determine eligibility of complaint within 10 working days of receipt by the office	Not achieved. The target of 80% in time was not achieved, but 64% were delivered in time compared to 40% in 2011–12.

	Key deliverable	End of year assessment
7	Provide substantive reply to complaints within 12 weeks of accepting complaint as eligible	Not achieved. The target of 70% in time was not achieved. 33% were delivered in time.
8	Visit site of death within five days of notification	This deliverable was reviewed in year as part of the organisation restructure and is no longer considered a priority.
9	Complete investigation into self-inflicted deaths and distribute draft report for consultation within 26 weeks of initial notification	Not achieved. The target of 70% in time was not achieved but a considerable improvement was achieved with 47% of drafts delivered in time compared to 19% in 2011–12.
10	Complete investigation into deaths due to natural causes and distribute draft report for consultation within 20 weeks of initial notification	Not achieved. The target of 70% in time was not achieved but a considerable improvement was achieved with 60% of drafts delivered in time, compared to 22% in 2011–12.
11	Publish anonymised fatal incident investigation reports on the PPO website within eight weeks of conclusion of HM Coroner's inquest	Not achieved. 132 anonymised reports were published on the website in 2012–13.
12	Review arrangements for the provision of clinical reviews with relevant officials in order to increase timeliness of PPO reports by the end of March 2013	Achieved. Pilot arrangements tested in year and assessed as successful. The new arrangements now agreed with the NHS Commissioning Board.

Performance against business plan

Objective 4: To be more influential so that others can learn lessons from the findings of our investigations

	Key deliverable	End of year assessment
1	Develop a cross-office recommendations database by June 2012	Achieved. The database is fully functional and accessible to all staff.
2	Support improvements in the performance of investigated bodies as a result of investigations	Achieved. A short summary of the contents of the recommendations database has been compiled with a fuller thematic analysis of recommendations planned for 2013–14.
3	Share learning across the different contexts investigated through the publication of: • regular themed bulletins based on the qualitative findings of multiple investigations • learning lessons reports based on longitudinal statistical analysis	Achieved. Learning lessons bulletins (LLB) launched in September 2012. Full list of publications described below. • LLB Complaints investigations, issue 1: Probation complaints (September 2012) • LLB Fatal incident investigations, issue 1: Deaths in approved premises (September 2012) • LLB Fatal incident investigations, issue 2: Restraints (February 2013) • LLB Complaints investigations, issue 2: Religion (February 2013) • LLB Cross-office investigations, issue: Sexual abuse (March 2013) • Thematic report: Adjudications (February 2013) • LLB Fatal incident investigations, issue 3: Child deaths (March 2013) • LLB Fatal incident investigations, issue 4: Basic regime (March 2013) • Thematic report: End of life care (March 2013)
4	Identify topics for investigation through internal and external consultation on lessons learnt themes by January 2013	Achieved. Consultation completed and priority topics identified for analysis and publication 2013–14.

Performance against business plan

Objective 5: To use our resources as efficiently and effectively as possible

	Key deliverable	End of year assessment
1	Conduct an organisational redesign that results in an efficient and effective approach to investigation without compromise to quality and timeliness and that operates within a restricted budget	On-going. Objective to continue into 2013–14 with a deadline of March 2014.
2	Hold quarterly full staff meetings in order to support strategic and organisational change and share learning across the office	Achieved. Full staff meetings were held in May, September and February. Timings were based on the need to impart important information and learning to the full staff group.
3	Implement the PPO's equality and diversity action plan	Achieved. The equality and diversity action plan has been implemented and progress is routinely monitored by the Equality and Diversity group, chaired by the Ombudsman.
4	Implement the PPO's learning and development action plan	Achieved. Priority training delivered and development needs assessed for 2013–14 plan.
5	Review and update all internal policies to ensure cross-office coverage. Conduct equality impact assessments for all PPO policies	Ongoing. The updating of internal policies will continue in 2013–14. A range of policies has been impact assessed by the Equality and Diversity Group.
6	Transfer to the MoJ IT operating system by mid-year	Ongoing. Deadlines have slipped. Current project plan suggests delivery in summer 2013.
7	Investigate and design a new case management system by the end of March 2013	Ongoing. Discussions are on-going but delays have been caused by a lack of funds.
8	Produce a business plan for the PPO 2013–14 by March 2013 and a new strategic plan 2013–16	Partially achieved. A business plan was produced for 2013–14. The strategic plan was deferred due to budget uncertainty for the review period.

Prisons and Probation Ombudsman Terms of Reference

1. The Prisons and Probation Ombudsman is wholly independent of the National Offender Management Service (including HM Prison Service and Probation Services in England and Wales), the UK Border Agency and the Youth Justice Board.[9] The Ombudsman is appointed following an open competition by the Secretary of State for Justice.

2. The Ombudsman's office is operationally independent of, though it is sponsored by, the Ministry of Justice. The Ombudsman reports to the Secretary of State. A framework document sets out the respective roles and responsibilities of the Ombudsman, the Secretary of State and the Ministry of Justice and how the relationship between them will be conducted.

Reporting arrangements

3. The Ombudsman will publish an annual report, which the Secretary of State will lay before Parliament. The report will include:

- anonymised examples of complaints investigated;
- recommendations made and responses received;
- selected anonymised summaries of fatal incidents investigations;
- a summary of the number and type of investigations mounted and the office's success in meeting its performance targets;
- a summary of the costs of the office.

4. The Ombudsman may publish additional reports on issues relating to his investigations, which the Secretary of State will lay before Parliament upon request. The Ombudsman may also publish other information as considered appropriate.

Disclosure

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

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

7. The Ombudsman and HM Inspectorates of Prisons, Probation and Court Administration, and the Chief Inspector of the UK Border Agency, will work together to ensure that relevant information, knowledge and expertise is shared, especially in relation to conditions for prisoners, residents and detainees generally. The Ombudsman may also share information with other relevant specialist advisers, the Independent Police Complaints Commission, and investigating bodies, to the extent necessary to fulfil the aims of an investigation.

8. The Head of the relevant authority (or the Secretary of State for Justice, Home Secretary or the Secretary of State for Children, Schools and Families where appropriate) will ensure that the Ombudsman has unfettered access to the relevant documents. This includes classified material and information entrusted to that authority by other organisations, provided this is solely for the purpose of investigations within the Ombudsman's Terms of Reference.

[9] NOMS (including HM Prison Service and Probation Services in England and Wales) and UKBA are referred to throughout the Terms of Reference as 'the authorities'.

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

Complaints

Persons able to complain

10. The Ombudsman will investigate complaints submitted by the following categories of person:

    i) prisoners who have failed to obtain satisfaction from the prison complaints system and whose complaints are eligible in other respects;

    ii) offenders who are, or have been, under probation supervision, or accommodated in Approved Premises, or who have had reports prepared on them by NOMS and who have failed to obtain satisfaction from the probation complaints system and whose complaints are eligible in other respects;

    iii) immigration detainees who have failed to obtain satisfaction from the UKBA complaints system and whose complaints are eligible in other respects.

11. The Ombudsman will normally act on the basis only of eligible complaints from those individuals described in paragraph 10 and not on those from other individuals or organisations. However, the Ombudsman has discretion to accept complaints from third parties on behalf of individuals described in paragraph 10, where the individual concerned is either dead or unable to act on their own behalf.

Matters subject to investigation

12. The Ombudsman will be able to investigate:

    i) decisions and actions (including failures or refusals to act) relating to the management, supervision, care, and treatment of prisoners in custody, by prison staff, people acting as agents or contractors of NOMS and members of the Independent Monitoring Boards, with the exception of those excluded by paragraph 14. The Ombudsman's Terms of Reference thus include contracted out prisons, contracted out services including escorts, and the actions of people working in prisons but not employed by NOMS;

    ii) decisions and actions (including failures or refusals to act) relating to the management, supervision, care and treatment of offenders under probation supervision by NOMS or by people acting as agents or contractors of NOMS in the performance of their statutory functions including contractors and those not excluded by paragraph 14;

    iii) decisions and actions (including failures or refusals to act) in relation to the management, supervision, care and treatment of immigration detainees and those held in short term holding facilities by UKBA staff, people acting as agents or contractors of UKBA, other people working in immigration removal centres and members of the Independent Monitoring Boards,

with the exception of those excluded by paragraph 14. The Ombudsman's Terms of Reference thus include contracted out establishments, contracted out services including escorts, and the actions of contractors working in immigration detention accommodation but not employed by UKBA.

Further provisions on matters subject to investigation

13. The Ombudsman will be able to consider the merits of matters complained of as well as the procedures involved.

14. The Ombudsman may not investigate complaints about:

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

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

    iii) actions and decisions (including failures or refusals to act) in relation to matters which do not relate to the management, supervision, care and treatment of the individuals described in paragraph 10 and outside the responsibility of NOMS, UKBA and the Youth Justice Board. This exclusion includes complaints about conviction, sentence, immigration status, reasons for immigration detention or the length of such detention, and the decisions and recommendations of the judiciary, the police, the Crown Prosecution Service, and the Parole Board and its Secretariat;

    iv) cases currently the subject of civil litigation or criminal proceedings; and

    v) the clinical judgement of medical professionals.

Eligibility of complaints

15. The Ombudsman may decide not to accept a complaint otherwise eligible for investigation, or not to continue any investigation, where it is considered that no worthwhile outcome can be achieved or the complaint raises no substantial issue.

16. Where there is some doubt or dispute as to the eligibility of a complaint, the Ombudsman will inform NOMS, UKBA, or the Youth Justice Board of the nature of the complaint and, where necessary, NOMS, UKBA or the Youth Justice Board will then provide the Ombudsman with such documents or other information as the Ombudsman considers are relevant to considering eligibility.

17. Before putting a grievance to the Ombudsman, a complainant must first seek redress through appropriate use of the prison, probation or UKBA complaints procedures.

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

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

Time limits

20. The Ombudsman will consider complaints for possible investigation if the complainant is dissatisfied with the reply from NOMS or UKBA or receives no final reply within six weeks (or 45 working days in the case of complaints relating to probation matters).

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

22. The Ombudsman will not normally accept complaints where there has been a delay of more than 12 months between the complainant becoming aware of the relevant facts and submitting their case to the Ombudsman, unless the delay has been the fault of the relevant authority and the Ombudsman considers that it is appropriate to do so.

23. Complaints submitted after these deadlines will not normally be considered. However, the Ombudsman has discretion to investigate those where there is good reason for the delay, or where the issues raised are so serious as to override the time factor.

Outcome of the Ombudsman's investigation

24. It will be open to the Ombudsman in the course of a complaint to seek to resolve the matter in whatever way the Ombudsman sees most fit, including by mediation.

25. The Ombudsman will reply in writing to all those whose complaints have been investigated and advise them of any recommendations made. A copy will be sent to the relevant authority.

26. Where a formal report is to be issued on a complaint investigation, the Ombudsman will send a draft to the Head of the relevant authority in remit to allow that authority to draw attention to points of factual inaccuracy, and to confidential or sensitive material which it considers ought not to be disclosed, and to allow any identifiable staff subject to criticism an opportunity to make representations. The relevant authority may also use this opportunity to say whether the recommendations are accepted.

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

28. The authorities within remit, the Secretary of State for Justice, the Home Secretary or the Secretary of State for Children, Schools and Families will normally reply within four weeks to recommendations from the Ombudsman. The Ombudsman should be informed of the reasons for any delay. The Ombudsman will advise the complainant of the response to the recommendations.

Fatal incidents

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

    i. prisoners and trainees (including those in Young Offender Institutions and Secure Training Centres). This includes people temporarily absent from the establishment but still in custody (for example, under escort, at court or in hospital). It generally excludes people who have been permanently released from custody;

ii. residents of Approved Premises (including voluntary residents);

iii. residents of immigration reception and removal centres, short term holding centres and persons under managed escort;

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

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

30. The Ombudsman will act on notification of a death from the relevant authority and will decide on the extent of the investigation, depending on the circumstances of the death. The Ombudsman's remit will include all relevant matters for which NOMS, UKBA and the Youth Justice Board are responsible (except for Secure Children's Homes in the case of the YJB), or would be responsible if not contracted elsewhere. It therefore includes services commissioned from outside the public sector.

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

- establish the circumstances and events surrounding the death, especially regarding the management of the individual by the relevant authority or authorities within remit, but including relevant outside factors;
- examine whether any change in operational methods, policy, practice or management arrangements would help prevent a recurrence;
- in conjunction with the NHS where appropriate, examine relevant health issues and assess clinical care;
- provide explanations and insight for the bereaved relatives;
- assist the Coroner's inquest fulfil the investigative obligation arising under Article 2 of the European Convention on Human Rights ('the right to life'), by ensuring as far as possible that the full facts are brought to light and any relevant failing is exposed, any commendable action or practice is identified, and any lessons from the death are learned.

32. These general terms of reference apply to each investigation, but may vary according to the circumstances of the case. The investigation may consider the care offered throughout the deceased's time in custody or detention or subject to probation supervision. The investigation may consider other deaths of the categories of person specified in paragraph 29 if a common factor is suggested.

Clinical issues

33. The Ombudsman's investigation includes examining the clinical issues relevant to each death in custody – such deaths are regarded by the National Patient Safety Agency (NPSA) as a serious untoward incident (SUI). In the case of deaths in public prisons and immigration facilities, the Ombudsman will ask the local Primary Care Trust or, in Wales, the Healthcare Inspectorate Wales (HIW) to review the clinical care provided, including whether referrals to secondary healthcare were made appropriately. Prior to the clinical review, the PCT will inform the NPSA of the SUI. In all other cases (including when healthcare services are commissioned from a private contractor) the Ombudsman will

obtain clinical advice as necessary, and may seek to involve the relevant PCT in any investigation. The clinical reviewer will be independent of the prison's healthcare. Where appropriate, the reviewer will conduct joint interviews with the Ombudsman's investigator.

Other investigations

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

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

Investigation reports

36. The Ombudsman will produce a written report of each investigation. A draft report will be sent, together with relevant documents, to the bereaved family, the relevant authority, the Coroner and the Primary Care Trust or HIW. The report may include recommendations to the relevant authority. Each recipient will have an agreed period to respond to recommendations and draw attention to any factual inaccuracies.

37. If the draft report criticises an identified member of staff, the Ombudsman will normally disclose an advance draft of the report, in whole or part, to the relevant authority in order that they have the opportunity to make representations (unless that requirement has been discharged by other means during the course of the investigation).

38. The Ombudsman will take the feedback to the draft report into account and issue a final report for the bereaved family, the relevant authority, the Coroner and the Primary Care Trust or HIW and the NPSA. The final report will include the responses to the recommendations if available.

39. From time to time, after the investigation is complete and the final report is issued, further relevant information may come to light. The Ombudsman will consider whether further investigation is necessary and, if so, whether the report should be re-issued.

40. Following the inquest and taking into account any views of the recipients of the report, and the legal position on data protection and privacy laws, the Ombudsman will publish an anonymised report on the Ombudsman's website.

Follow-up of recommendations

41. The relevant authority will provide the Ombudsman with a response indicating the steps to be taken by that authority within set timeframes to deal with the Ombudsman's recommendations. Where that response has not been included in the Ombudsman's report, the Ombudsman may, after consulting the authority as to its suitability, append it to the report at any stage.

Staff list

Ombudsman

Nigel Newcomen CBE

Senior Personal Secretary

Jennifer Buck

Deputy Ombudsmen

Louise Falshaw

Michael Loughlin

Elizabeth Moody

Penny Snow *(career break since June 2010)*

Personal Secretary

Janet Jenkins

Assistant Ombudsmen

Karen Cracknell

John Cullinane

Michael Dunkley

Kate Eves

Karen Johnson

Wendy Martin

Olivia Morrison-Lyons

Colleen Munro

Dionne Spence

Thea Walton *(left 31 January 2013)*

Nick Woodhead

Strategic Support Team

Mark Chawner

Dan Crockford (Team leader) *(started 6 November 2012)*

Henry Lee (Finance Manager)

Learning Lessons Team

Sarah Colover *(started 10 September 2012)*

Sue Gauge (Team leader)

John Maggi

Samantha Rodney

Helen Stacey *(started 10 September 2012)*

Craig Weeks *(started 10 September 2012)*

Family Liaison Officers

Narinder Dale

Abbe Dixon

Laura Spargo

Laura Stevenson

Complaints Assessors

Veronica Beccles

Sarah Buttery

Antony Davies

Agatha Eze

Matthew Fisher *(started 25 June 2012)*

Emma Marshall

Chris Nkwo

Tayo Olaitan *(started 1 October 2012)*

Alison Stone

Ibrahim Suma

Melissa Thomas

Zainab Zorokong-Bah *(started 11 June 2012, left 31 August 2012)*

Fatal Incidents Support Team

Durdana Ahmed

Katherine Costello

Rowena Evans

David Gire-Mooring

Lydia Gyekye *(started 16 April 2012)*

Esther Magaron

Susan Mehmet (Manager) *(started 15 October 2012)*

Marta Rodrigues (Manager) *(left 20 July 2012)*

Tony Soroye

Senior Investigators and Investigators

Sharon Adonri

Terry Ashley

Tamara Bild

Claire Bond *(started 28 January 2013)*

Tracey Booker

David Cameron

Karen Chin

Althea Clarke-Ramsey

Debbie Clarkson

Vicki Cole

Paul Cotton

James Crean

Anthony J Davies *(left 24 August 2012)*

Lorenzo Delgaudio

Rob Del-Greco

Nick Doodney

Angie Dunn

Susannah Eagle

Andrew Fraser *(left 3 January 2013)*

Kevin Gilzean

Alan Green

Christina Greer

Rachel Gyford

Helena Hanson

Diane Henderson

Siobhan Hillman

Joanne Howells *(previously Senior Family Liaison Officer)*

Ruth Houston

Joanne Hurst

Katherine Hutton

Mark Judd

Razna Khatun

Madeleine Kuevi
Lisa Lambert
Anne Lund
Steve Lusted
Steve McKenzie
Beverly McKenzie-Gayle
Mark McPaul *(left 20 July 2012)*
Kirsty Masterton
Tracey Mulholland
Anita Mulinder
Amanda O'Dwyer
Claire Parkin *(started 10 April 2012)*
Jade Philippou
Ben Rigby
Rebecca Sanders
Andrea Selch
Anna Siraut
Sarah Stolworthy
Rick Sturgeon
Tina Sullivan
Jonathan Tickner
John Unwin
Louisa Watkins
Marc Williams *(left 7 December 2012)*
Karl Williamson
Jane Willmott


GYM II
A & B WINGS
C WING
CHAPEL
CSU
KITCHEN