PRISONS AND PROBATION OMBUDSMAN
for England and Wales

Independent Investigations

PRISONS AND PROBATION OMBUDSMAN ANNUAL REPORT 2013 – 2014

Prisons and Probation Ombudsman

Annual Report
2013–2014

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

September 2014

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Role

The Prisons and Probation Ombudsman's (PPO) office exists to carry out **independent** investigations into deaths and complaints in custody. The detailed role and responsibilities of the PPO are set out in the Terms of Reference (http://www.ppo.gov.uk/terms-of-reference.html). The PPO has two main duties:

- to investigate complaints made by prisoners, young people in detention (prisons and secure training centres), offenders under probation supervision and immigration detainees
- to investigate deaths of prisoners, young people in detention, residents of approved premises and immigration detainees due to any cause, including any apparent suicides and death by natural causes.

The purpose of these investigations is to understand what happened, to correct injustices and to identify learning for the organisations whose actions we oversee, so that the PPO makes a significant contribution to safer, fairer custody and offender supervision.

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.

A RISING TOLL OF DESPAIR

Self-inflicted deaths among prisoners are tragic indicators of the level of personal distress and mental ill health in prisons. Some may even evidence broader institutional stresses and failures. It is, therefore, a troubling reflection of the state of our prisons that we recorded a 64% increase in self-inflicted deaths in 2013–14. This reverses the fall in the number of such deaths over the previous year and reflects a rising toll of despair among some prisoners.

We cannot yet offer a definitive explanation for this increase, but the case studies and learning lessons material provided in this annual report illustrate that some sadly familiar issues continue to recur. For example, there have been too many instances of prisons failing to adequately identify the risk of suicide posed by prisoners, despite clear warning signs being present. Even where risk of suicide was identified, monitoring arrangements and case reviews were too often inadequate. These are not new issues and, with self-inflicted deaths in custody increasing so worryingly, it is essential that lessons are learned from my office's investigations.

It has been suggested that prison staff are now so stretched, and the degree of need among some prisoners so high, that they may no longer be able to provide adequate care and support for some vulnerable prisoners. The evidence for this remains anecdotal and every day prison staff do save many prisoners from themselves – an achievement which goes largely unreported and without which the tragic number of suicides would be even higher. Nevertheless, the prison system is undeniably facing enormous challenges.

Suicide is not only a problem in prison, of course, and its incidence is rising in the community. We must also be honest about the limitations of what staff can do in the face of a really determined suicide bid. In one of the most extreme and tragic recent cases, a prisoner on constant supervision in a healthcare unit, killed himself by deliberately jumping headfirst from his bed onto the cell floor before supervising staff could stop him. The level of mental ill health and despair evidenced by such cases is truly shocking.

"It is, therefore, a troubling reflection of the state of our prisons that we recorded a 64% increase in self-inflicted deaths in 2013–14."

However, complacency is not an option. A rising suicide rate in prison reflects the state's difficulty in discharging its duty of care to some of the most vulnerable in its charge. My office will play its part in the urgent search for lessons that must be learned to reverse this growth, but it is now nearly a decade since the Prison Service introduced the current Assessment, Care in Custody and Teamwork (ACCT) suicide and self-harm prevention procedures. ACCT is in many ways estimable, but given the concern reflected in this annual report about the continued failures of implementation and rising toll of despair, I believe that it is time to review and refresh the current suicide prevention arrangements in prison.

Challenging times

In last year's annual report, I outlined some of the many challenges facing our prisons and these have not abated. We still have the highest prison population per head of population in Western Europe, the prisoner profile continues to age rapidly, there have been year on year reductions in resources and staffing levels, regimes have shrunk, some smaller prisons have closed and many of those remaining are much larger than those in the past. Last year, HM Inspectorate of Prisons reported a decline in 'healthy prison' outcomes in almost every area. Meanwhile, Ministers, evidently frustrated by poor reconviction rates, have introduced a demanding set of organisational changes and new policies to ensure prisoners are 'properly punished and incentivised to turn away from crime'.

The impact of such challenges is manifold, but, in terms of my responsibilities, two issues stand out. First, the ageing prison population is leading sadly, but inexorably, to an increasing number of deaths in custody from natural causes. Those over 60 are the fastest growing segment of the prison population and there was a further 7% rise in deaths from natural causes last year. Prisons designed for young men are having to adjust to the largely unexpected and unplanned new roles of secure care home and even hospice.

Commendably, our investigations suggest that some prisons and their healthcare partners are making progress towards better end of life care, but this remains variable. It is also unacceptable that prisons still struggle to achieve an appropriate balance between security and humanity when restraining terminally ill prisoners visiting hospitals and hospices. First and foremost the public must be protected, but this is not achieved by unnecessarily shackling the infirm and dying. In my view, this issue is a test of the humanity of a contemporary prison system – and one which is too often being failed.

> "I believe that it is time to review and refresh the current suicide prevention arrangements in prison."

A second area of impact is more generic. The squeeze on resources and regimes, together with a raft of tough new Government policies are likely to increase complaints from prisoners about an actual or perceived deterioration in their treatment and conditions. This will not engender much public sympathy, but ensuring appropriate avenues for legitimate complaint and effective mechanisms for independent dispute resolution are unquestionably cornerstones of a fair prison system.

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One such mechanism is the law, but less money is now available for prisoners' legal aid. This is likely to increase demand on alternative dispute resolution mechanisms such as my office. However, it must be recognised that we cannot replace lawyers: we do not provide legal advice, our timeframes are those of reactive investigators and we cannot offer the finality of the judicial process. Nevertheless, we must and will manage to the best of our ability whatever work comes to us.

Rising to the challenges

Meeting growth in demand is but one challenge for my office. Another has been to deliver, simultaneously, more for less by implementing significant budget reductions (we were asked to make efficiencies equivalent to 15% between 2011 and 2014). To do so we have completed a major change programme to reorganise and restructure, reengineer our casework processes, change IT platforms and move to smaller offices. This has enabled both efficiency gains and some marked improvement in performance. For example, when I arrived in 2011–12, only 21% of draft investigation reports regarding deaths in custody were on time. Given my staff's sheer hard work this year, the proportion has risen to an impressive 92%. Reassuringly, our stakeholder surveys, including those of bereaved families, indicate increased approval rates, not just of our timeliness, but also of the quality of our death in custody investigations.

Complaint timeliness has proved more challenging. We are working hard to reduce a large backlog and, with new ways of working, it is coming down. Importantly, more recent complainants received a better service with most new cases dealt with on time. However, the demands upon us are likely to increase significantly as a result of various Government policy changes, so we will continue to have to operate in a challenging environment. I am therefore pleased that, after three years of significant cuts, I have been assured by Ministers of some additional resources in 2014–15.

We have also had to introduce much greater proportionality, so that resources are targeted on the most serious complaints where there is most to learn and most to put right – and less on cases where there can be little by way of worthwhile outcome. While I am very conscious that small things can mean a lot to prisoners with very little, this has been a necessary, but not always popular process of rationalisation.

> “Resources are targeted on the most serious complaints where there is most to learn and most to put right – and less on cases where there can be little by way of worthwhile outcome.”

There is a long way to go, but it is noteworthy that we continue to take a robustly independent approach to well founded complaints. Thus, our uphold rate (where we found against the authorities) increased again this year, from 31% to 34%, perhaps reflecting the pressures on the services we investigate. Similarly, we continue to make large numbers of recommendations to ensure a remedy for complainants or accountability for poor prison performance, including a number of cases in which we have had to recommend disciplinary action against staff.

Again, our stakeholder surveys indicate that approval rates for our complaints work have been sustained or improved, although – perhaps unsurprisingly – levels of complainant satisfaction are closely tied to whether a complaint is upheld.

One indication of growing confidence in the work of my office has been the expansion of my remit this year to take on the investigation of complaints in secure training centres and the proposed extension of my remit to the investigation of deaths in secure children’s homes. I have also been asked to explore the possibility of undertaking a role in investigating the deaths of prisoners detained under the Mental Health Act. I welcome these extensions of independent investigation into places of custody for the most vulnerable.

Learning lessons

Another pleasing development has been the establishment of a well-received agenda of learning lessons publications designed to encourage improvement more broadly than is possible with individual investigations.

One recent publication looked at lessons to be drawn from the small number of homicides in prison. In particular, we identified the need for a strategy to manage vulnerable prisoners at risk from other vulnerable prisoners. Appropriately, action to address this concern has now been taken by senior prison managers. Similarly, I am confident that our recent reviews of the identification of risk factors in self-inflicted deaths and suicide prevention procedures will help the National Offender Management Service (NOMS) review and refresh its current safer custody procedures.

Significant lessons also emerged from our thematic reviews of complaint investigations. At the most serious end of the spectrum are allegations of physical abuse of prisoners by staff and a recent bulletin explored how to minimise the use of force and thus better protect both prisoners and staff.

At the other end of the spectrum, a review of the many property complaints we receive offered a number of lessons in avoiding the wasteful and unnecessary cost of investigating and compensating prisoners for lost or damaged property. I welcome the commitment within NOMS to require improvements based on our findings. This should not only benefit prisoners, but also save staff time and reduce cost to the public purse.

Enhancing independence

There should be no doubt about the independence of mind of my staff and I, but independence must be protected and, wherever possible, enhanced. For example, this year I declined to be rehoused in Ministry of Justice headquarters, which would have meant being inappropriately co-located with those I investigate. I am also seeking to reinforce my independence through revised terms of reference. However, placing the Ombudsman on a statutory footing would be a more substantive and visible enhancement of my independence and one called for by informed commentators for many years.

> "Another pleasing development has been the establishment of a well-received agenda of learning lessons publications designed to encourage improvement more broadly than is possible with individual investigations."

In each of my two previous annual reports I have welcomed the Government's commitment in principle to putting my office on a statutory footing. I am pleased that the Justice Secretary repeated the commitment publicly to the Joint Human Rights Select Committee in December 2013. However, no specific bill has been identified and, in a crowded pre-election legislative calendar and with little political cache attached to the issue, opportunities are limited.

I will continue to pursue every opportunity to reinforce the actual and perceived independence of my office, which reaches its twentieth anniversary in 2014. A statutory footing would buttress the commitment of my office to contribute robustly and impartially to safer and fairer custody and probation supervision – a commitment once again reflected throughout this report.

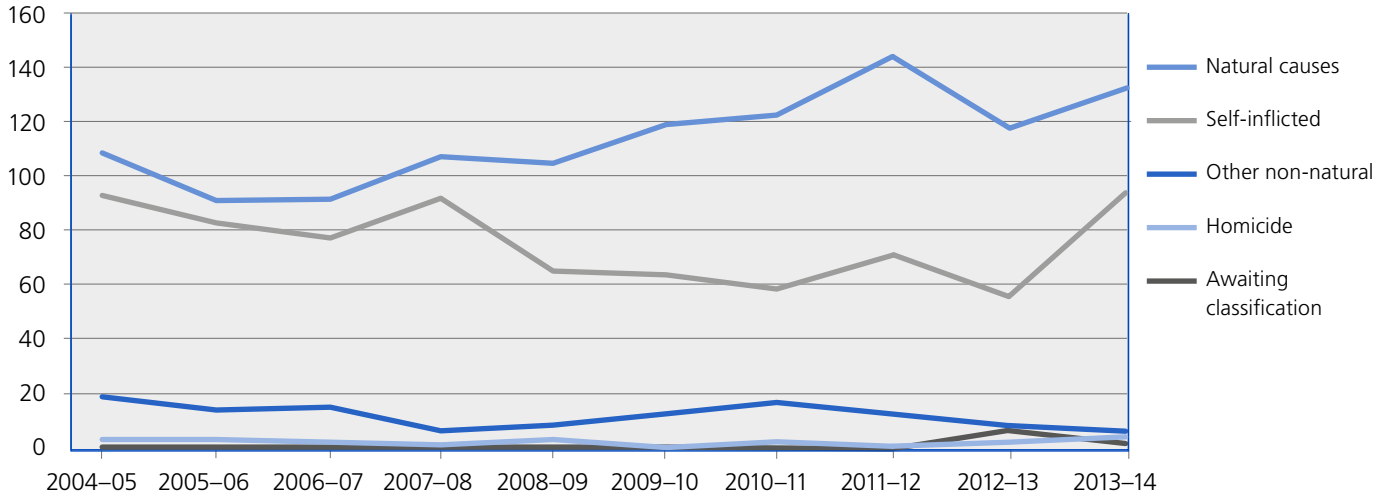
Nigel Newcomen

THE YEAR IN FIGURES

Fatal incidents

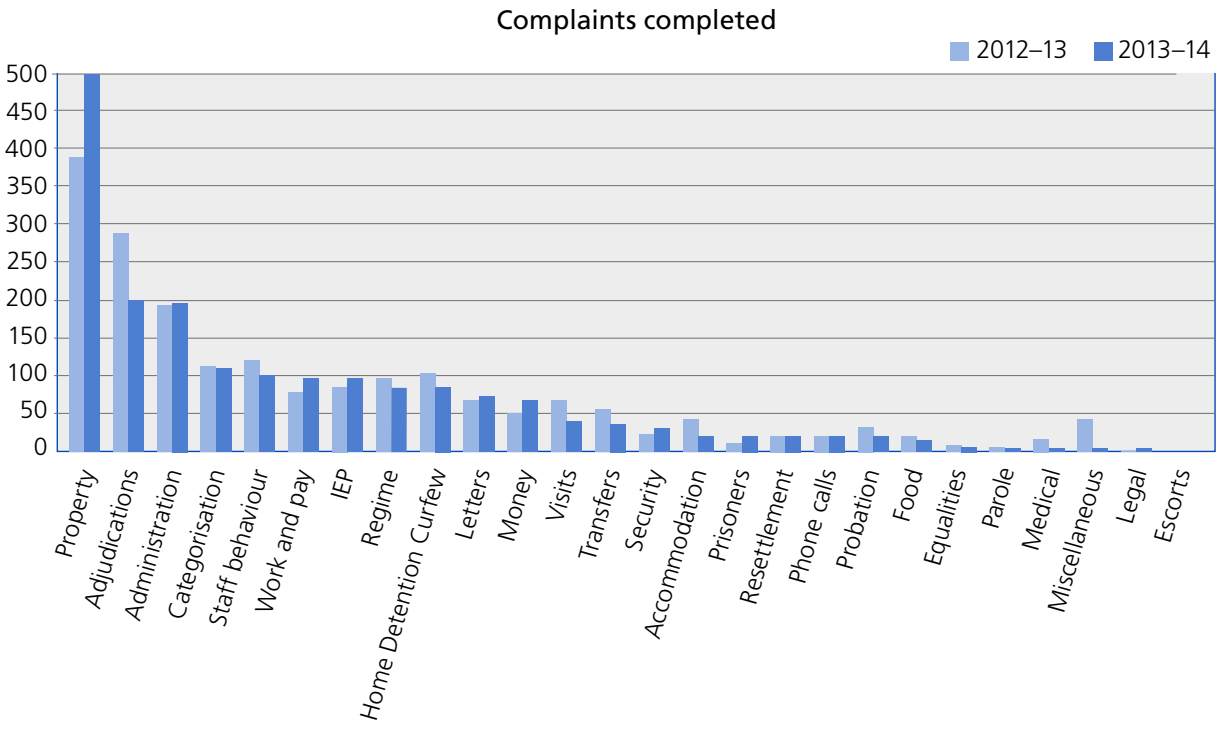
- We were notified of **256** deaths in 2013–14 (17 of which were not investigated as they were outside our remit). We started **239** investigations, **48** (25%) more than last year.
- There were **90** apparently self-inflicted deaths, **64%** more than the previous year.
- The major increase in self-inflicted deaths was among adult male prisoners. There were **6** self-inflicted deaths of those aged 18–21 years, an increase from **2** deaths last year, but the biggest rise was among 25- to 30-year-olds who accounted for **22** (**24%**) self-inflicted deaths (an increase from **8** last year).
- **130** deaths were from natural causes (**7%** more than last year) and **9** were classified as 'other non-natural'.
- We were notified of **4** apparent homicides, **twice as many** as last year.
- At the time of writing, **6** of the investigations started this year await classification. In 2012–13, there were **8** cases awaiting classification when the annual report was prepared; **7** of these were classified as either natural causes or 'other non-natural'.
- There were **224** draft reports and **258** final reports issued in 2013–14, compared to **247** and **242** last year.
- Timeliness improved substantially, with **92%** of draft reports issued on time, compared to **56%** last year.
- The average time taken to produce a draft report into a natural cause death was **20 weeks**, **8 weeks shorter** than last year. The average time taken for self-inflicted and other cases also reduced significantly to **27 weeks** from **40 weeks** last year.
- Issued reports concerned some extremely serious and complex cases, including **4** draft reports into prisoner deaths by homicide.

Fatal incident investigations



Complaints

- **4,879** complaints were received this year, **495** fewer than last year. Of these **4,435** (**91%**) were about the Prison Service, **375** (**8%**) were about the Probation Service, **66** (**1%**) were about immigration detention and **3 were about secure training centres**.
- The eligibility rate for complaints was **53%** this year, compared to **59%** in 2012–13.
- Overall, **2,111** new investigations were started, **25%** fewer than in 2012–13. However, **74** more eligible cases (a total of **448**) were not investigated because we judged there was no substantial issue or worthwhile outcome. In addition, **307** eligible complaints were withdrawn, for example, because the complainant had been released and did not wish to pursue the complaint.
- **1,941** complaints investigations were completed, **121** fewer than last year. A total of **1,881** (**97%**) were about prisons, **22** (**1%**) about probation and **38** (**2%**) about immigration detention.
- Overall, **63%** of complaints were assessed for eligibility within the target of **10** working days. This is similar to last year when **64%** were completed in time. On average, it took **12** working days to complete an assessment.
- Timeliness of investigations reduced slightly, with **29%** of investigations completed within **12 weeks** (compared to **33%** last year). The average time taken to investigate a complaint rose from 1**9 weeks** to **26 weeks**.



- **34%** of complaints investigated were upheld in favour of the complainant, a **3%** increase on last year.
- The largest category of complaints was about property, accounting for **26%** of the investigations completed, up from **18%** in 2012–13. Over half (**56%**) of the complaints about property were upheld.
- **11%** of prison investigations concerned just **2%** of complainants, who each accounted for more than five of the completed investigations in 2013–14.
- There were **480** complaints investigations completed about high security prisons. This was **26%** of all investigations into prisoner complaints, yet just **7%** of the prison population are in high security prisons. Of these complaints, **30%** were upheld in favour of the complainant, lower than for other prisons (**34%**).
- In our annual stakeholder survey, **two-thirds** of respondents with experience of complaints investigations felt the investigations had been quick enough or better. In our new complainants' survey, **seven out of 10** complainants whose complaint had been upheld felt their complaint was taken seriously by the PPO. A similar proportion said the PPO had met their expectations.

INVESTIGATING FATAL INCIDENTS

Learning lessons about fatal incidents

During 2013–14, we published three learning lessons publications, drawing on evidence from our fatal incident investigations and completed work on two others.[1] In December 2013, we published a bulletin about homicides in prison, focusing on three investigations which concluded in 2013. This was in the disturbing context of the number of apparent homicides notified to us, doubling from two to four; three prisoners and one resident of a probation approved premises. Learning focused on the need for prison staff to have access to – and make use of – all available information when assessing the risk involved in a prisoner sharing a cell, the need to manage carefully the risks that vulnerable prisoners pose to one another and the need for safe and consistent cell locking procedures.

Another bulletin concentrated on immigration removal centre investigations and examined some recurring themes arising from fatal incidents and complaints from detainees. Thankfully there have been relatively few deaths among immigration detainees, but the inadequacy of the response to medical emergencies has been a common theme in our investigations. Indeed, it is unacceptable that such a fundamental safety issue recurs and that Home Office Immigration Enforcement has failed to ensure its contractors consistently address the issue. The bulletin identified the need for the nature of the emergency to be correctly communicated, for healthcare and detention staff to be sufficiently trained and equipped to handle emergencies when they occur and for NHS ambulance guidelines to be followed by all staff when a detainee is taken ill.

A thematic review of all recommendations made in 2012–13 was also published and this highlighted some familiar issues surrounding fatal incidents, including weaknesses in sharing and accessing information, inconsistent care for prisoners with chronic diseases, inappropriate use of restraints on frail or seriously ill prisoners in hospitals and hospices, failures to identify risk of suicide and self-harm, frailties in supporting prisoners identified as at risk, and the need for improved communication with families.

> “We completed two thematic reviews which exposed a range of frailties and are particularly topical given the troubling rise of self-inflicted deaths of prisoners seen during 2013–14.”

Work was also completed during the year on two thematic reviews, one examining learning around the assessment of risk of self-harm and suicide in prisons and the other on the quality of suicide and self-harm prevention procedures where risk was identified. These reports, published in April 2014, exposed a range of frailties and are particularly topical given the troubling rise of self-inflicted deaths of prisoners seen during 2013–14.

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

Individual investigations: self-inflicted deaths

Early days in custody

The Prison Service recognises the need to give special support to prisoners during their first days in custody, a particularly vulnerable time when the risk of suicide or self-harm is increased. Despite this, we have seen a sharp increase during the year, in the number of prisoners who have killed themselves, including a number in their first days and weeks in custody. We cannot yet explain this increase, but it reinforces the need for prisons to focus their efforts on supporting prisoners during their early days, to make sure that they do everything they can to keep prisoners safe. The case of Mr A illustrates how this does not always happen.

Mr A was convicted of sexual offences against a family member and sentenced to 14 years. He was elderly (73) and this was his first time in prison. On the morning he had gone to court, he had considered suicide, but when he arrived at the prison, he told staff that he no longer had suicidal thoughts and suicide and self-harm prevention procedures were not begun. Mr A was classed as a vulnerable prisoner because of the nature of his offence. However, there was no space in the vulnerable prisoners' unit, so Mr A was given a cell in the main induction unit where he was unable to mix with other prisoners. He was given an individual induction in his cell, where he remained for most of the next two days to keep him apart from the general prison population. There was no evidence that he was offered any time outside or the opportunity to mix with other vulnerable prisoners. He was found hanged in his cell three days after he had arrived at the prison.

We were concerned that an elderly man serving his first custodial sentence was left isolated and without any support after his initial induction. The problem of newly arrived vulnerable prisoners 'lodging' on other wings because dedicated units are full, is one we have identified in a number of investigations. Such prisoners can be threatened and intimidated by other prisoners passing their cell door and often have little staff support. We recommended that vulnerable prisoners who cannot be housed in the appropriate unit should have an equivalent regime to other prisoners and a nominated officer should check their wellbeing regularly.

> "We have seen a sharp increase during the year, in the number of prisoners who have killed themselves, including a number in their first days and weeks in custody."

Assessing risk

In a number of our investigations concerning prisoners who had killed themselves, we were concerned that they should have been managed under ACCT (Assessment, Care in Custody and Teamwork) suicide and self-harm procedures, but prison staff had failed to recognise or take into account known risk factors. In most of these cases, there was a clear risk of suicide or self-harm, but officers relied too much on the prisoners' assurances that they would not harm themselves, rather than their known history and evident risk.

Mr B was remanded into custody charged with a violent offence against family members. This was his first time in prison and he was withdrawing from alcohol, but these factors were not appropriately considered. Mr B was not identified as being at risk of suicide or self-harm and was not monitored. He hanged himself on his first night at the prison.

Mr C was remanded to prison charged with harassing his wife. He had taken an overdose a few days earlier and had voiced suicidal thoughts at court. A mental health worker at the court had contacted the prison with concerns that Mr C was suicidal. However, when he arrived, he told a nurse and officer that he did not have any suicidal thoughts and they did not monitor him. Despite several other occasions when he clearly expressed thoughts about dying and his acknowledged mental health problems, ACCT procedures were not started at any time and he was found hanging in his cell just three weeks after he arrived at the prison. He left a note in which he made it clear that staff had not supported him.

The investigation identified at least eight separate occasions during Mr C's time at the prison which we considered should have led to an ACCT plan being opened to support him.

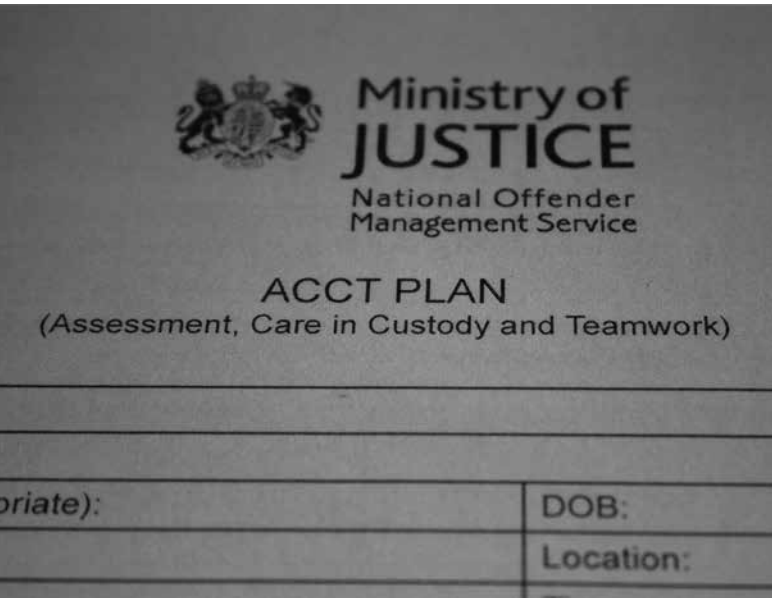
> "We recommended that staff should be given clear guidance about procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them"

In both these cases, we were very critical that officers and healthcare staff had not recognised the risk of suicide and self-harm. Static risk factors such as offence, first time in custody, alcohol withdrawal and recent suicide attempts were ignored in favour of a reliance on the prisoner's presentation. We were not satisfied that these risk factors had been given sufficient weight and we recommended that staff should be given clear guidance about procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them.

Assessment, Care in Custody and Teamwork (ACCT)

In cases where prisoners had been managed under ACCT procedures, too frequently we found that staff did not follow guidance, the ACCT documents were of poor quality and prisoners were not offered sufficient support. Frequent issues arising included: the poor quality of care maps (which should set out how the support and care of the prisoner are to be delivered); a lack of consistency in case management; weak assessment of ongoing risk of suicide and self-harm; and the setting of inappropriate levels of observations.

While we believe that the ACCT process can be an excellent tool to help keep prisoners safe, if it is not implemented correctly, it can provide false assurance for both staff and prisoners. Our thematic review of ACCT procedures shows that there is a need for prisons to re-focus their efforts to ensure that the ACCT process is operated effectively by all members of staff involved in it and that everyone is aware of their responsibility to keep prisoners as safe as possible. This is particularly important with the number of self-inflicted deaths in prisons rising so sharply.



> "There is a need for prisons to re-focus their efforts to ensure that the ACCT process is operated effectively by all members of staff involved in it and that everyone is aware of their responsibility to keep prisoners as safe as possible"

Mr D had an extensive history of self-harm in prison and was frequently monitored under ACCT procedures. Within a week of his arrival at a new prison, he harmed himself again and an ACCT was opened. However, Mr D's self-harming continued and he was found hanged in his cell less than two months later.

Our investigation found, that although Mr D had been identified as at risk of suicide, and an ACCT had been opened, it appeared that staff were not confident that the process was achieving anything. Mr D harmed himself repeatedly, which was difficult for prison staff to manage, but rather than seeking to address the root cause of Mr D's distress, it appeared that they were just going through the motions of the procedures. We found that the level of Mr D's risk was not assessed properly and a case review regarded him as low risk the day after he had cut himself. Care map actions did not provide him with sufficient support or address identified concerns. Significant

events reflecting his risk were not recorded in the ACCT document and the ACCT was closed before the care map actions had been completed. We found there was a general need at the prison to ensure that identified prisoners at risk of suicide and self-harm are being managed in line with national guidelines.

Mr E was remanded to prison charged with violent offences against his estranged wife. He was appropriately identified as at risk of suicide and self-harm when he arrived at the prison and staff opened an ACCT. The ACCT was closed after eight days when all the care map actions had been completed. Ten days later, he was found hanged in his cell.

The investigation found that Mr E had been properly assessed as being at risk of self-harm or suicide and that prison staff had correctly identified his risk factors. However, the care map designed to ensure he had the correct support to meet his identified needs was inadequate, as it merely required referrals to services rather than ensuring that Mr E received the support he needed to reduce his level of risk before the monitoring ended. We recommended that care maps should contain specific and meaningful actions aimed at reducing risk, and that they should be reviewed and updated at each ACCT review, as is expected to happen.

Deaths in segregation units

During the year there were a number of deaths in segregation units, including some prisoners who were being supported through ACCT procedures. Prison Service instructions recognise that there are a disproportionately high number of self-inflicted deaths in segregation units and require that prisoners on an open ACCT should only be segregated

“We recommended that care maps should contain specific and meaningful actions aimed at reducing risk, and that they should be reviewed and updated at each ACCT review, as is expected to happen.”

when they are such a risk to others that no other suitable location is appropriate and then only in exceptional circumstances. We did not find evidence in any of the cases we investigated that the circumstances were exceptional enough to justify the prisoner being segregated when they were vulnerable and at risk of harming themselves. Of more concern, is that there was little evidence that this had been considered by managers authorising or reviewing segregation, although this is a mandatory requirement.

Mr F was a foreign national prisoner who had been diagnosed with paranoid schizophrenia and had recently transferred to the prison. Mr F had refused to have a depot injection by which his antipsychotic medication was administered, and there was no mental health assessment at the new prison. He received no outside support and had no prison job, so did not have money to buy tobacco from the prison shop. He was desperate for tobacco and threatened to self-harm if he could not get any, so ACCT procedures were begun. A senior manager decided to move Mr F to the segregation unit for his own protection as he was pestering other prisoners for tobacco. Although he had been assessed as at risk of suicide and self-harm there was no consideration that the segregation unit was not an appropriate place for a man with his mental health problems and no exceptional reasons were given to justify holding him there.

Mr F remained in the segregation unit and the reasons for his segregation seemed to have been forgotten. The segregation unit procedures were poor and Mr F had a very restricted regime without even a radio in his cell to distract him, although his mental healthcare plan had noted he needed to be kept occupied. His needs were consistently overlooked by staff involved with his ongoing segregation, his ACCT reviews and his day-to-day care. Despite daily visits from a number of managers, chaplains and healthcare staff, no one questioned why Mr F was held there when he was on an open ACCT and neither did representatives of the Independent Monitoring Board. Mr F's mental health deteriorated and, after two weeks in the segregation unit, he was found hanged in his cell.

> "We did not find evidence in any of the cases we investigated that the circumstances were exceptional enough to justify the prisoner being segregated when they were vulnerable and at risk of harming themselves."

HM Inspectorate of Prisons has also been critical of the number of prisoners on open ACCTs held in the segregation unit at the prison without proper justification. We noted that at the time of his death, Mr F was one of five prisoners on ACCT plans in the segregation unit.

Inappropriate use of segregation also arose in the case of Mr G, who had a history of self-harm and had attempted suicide several times. He also had mental health problems and had been prescribed medication for attention deficit hyperactivity disorder (ADHD). He was recalled to prison after being released on licence and when he arrived back at the prison he had not taken his prescribed medication for two months. Referrals were made for him to see the prison's mental health team and the consultant who had been treating him in the community, who also ran a clinic at the prison. In the meantime, a GP prescribed a low dose of medication.

Mr G was transferred to a different prison a week after he first arrived in custody. On arrival there, he refused to leave the escort vehicle and was taken to the segregation unit by force. A review of Mr G's medical records showed that he had been transferred before he had attended either of his medical appointments and arrangements were made to transfer him back the next day.

Mr G was taken straight to the segregation unit when he returned to the original prison. His behaviour was erratic and he told staff that he needed an increased dose of his medication, but his referral to the mental health team was not expedited. The day after he was segregated, Mr G self-harmed and ACCT procedures were begun. No one reviewed the appropriateness of him being held in the segregation unit and the Duty Governor authorised his continuing segregation without giving exceptional reasons. He was not monitored in line with the prison's policy and received only the same standard hourly checks as any other segregated prisoner. His requests to see someone from the mental health team were not actioned and he was found hanging in his cell after two days in the segregation unit.

Deaths of 18–24-year-olds

Sadly, during the year, we have investigated 13 self-inflicted deaths of young adults aged between 18 and 24, compared to nine the year before. While such deaths in this age group are not disproportionate in relation to their representation in the prison population, it is alarming that so many young people take their own lives. It is therefore welcome that Ministers have asked the Independent Advisory Panel on Deaths in Custody to review self-inflicted deaths among 18–24-year-olds. We will submit a learning lessons bulletin on this subject to the panel, which will explore any particular vulnerabilities and issues that we can identify, for example the risks associated with the transfer of young people to the adult prison estate at the age of 18. However, as can be seen from the following case studies, many of the same issues that occur among older prisoners are repeated in this age group, but it is all the more concerning that risk factors for young adults are not always recognised and addressed with appropriate support.

"Sadly, during the year, we have investigated 13 self-inflicted deaths of young adults aged between 18 and 24, compared to nine the year before."

Mr H was 20 at the time of his arrest for possession of an offensive weapon. He had threatened to cut his own throat with the weapon and had mental health problems. He said that he had previously attempted suicide over 30 times. He arrived at a young offender institution with a suicide and self-harm warning form from the courts identifying his risk. The initial health screen recorded his history of self-harm and mental health problems and that he had recently spent time in a psychiatric hospital.

The nurse recording this had received no training in suicide and self-harm procedures and did not assess him as at risk of suicide and self-harm. We were also very concerned that none of the other staff in reception recognised his obvious risks.

At a secondary health screen the next day, Mr H's risks were identified and staff began to monitor him under ACCT procedures. Mr H was open about his continued suicidal thoughts. However, despite an act of self-harm, the breakdown of his relationship with his girlfriend and a family bereavement, staff did not appropriately review his risk levels or consider further ways that Mr H could be supported. His ACCT was poorly managed and we were concerned that such an evidently troubled young man did not have consistent care. During the three months Mr H was managed under ACCT procedures, six different case managers chaired 11 separate ACCT reviews. This did not provide the continuity of care he needed. On the day of his death, Mr H was not checked as frequently as he should have been. An officer found him hanging in his cell and he was taken to hospital where he died later that day.

Mr I was just 18 when he was released on licence from a custodial sentence for assaulting a family member. The next month he was charged with an assault on another family member and remanded back to prison. He arrived with a suicide and self-harm warning form on his escort record. He had scars on his arms and other risk factors should have been evident. The reception officer did not complete the local self-harm screening form as he was supposed to and staff in reception, including a nurse, did not consider that he was at risk of suicide or self-harm. Mr I spoke to a Listener (a prisoner trained by the Samaritans to offer confidential support to other prisoners in distress) twice that evening and told the Listener that he was feeling suicidal but did not want this information passed to staff. The next morning, the wing manager became aware that there was a warning about previous self-harm on Mr I's Police National Computer record, but did not consider that Mr I needed to be monitored. Later that morning, healthcare staff discussed Mr I because a nurse at court had contacted them with concerns about him. Staff at the meeting made a number of appropriate referrals for Mr I, but no one considered whether he needed to be monitored as at risk of suicide and self-harm and healthcare staff did not share the court nurse's concerns with wing staff.

Mr I asked an officer if he could speak to a Listener before he was locked in his cell over lunchtime and was asked to wait until after lunch. At the end of the lunchtime period another prisoner looked through the observation hatch in Mr I's cell door and saw him hanging. Mr I was taken to hospital but did not recover and died the following day.

> "During the three months Mr H was managed under ACCT procedures, six different case managers chaired 11 separate ACCT reviews. This did not provide the continuity of care he needed."

Individual investigations: natural causes

Restraints

In the 2012–13 annual report, we highlighted the high number of investigations where there was an inappropriate use of restraints. We also published a *learning lessons bulletin*[2] on the subject to emphasise the need for prisons to make appropriately informed and justified decisions. It is therefore concerning that, once again, we found many failures by prisons to ensure an appropriate balance between security and humanity in the use of physical restraints on elderly, infirm and dying prisoners. On too many occasions we have repeated recommendations to the same prisons with seemingly little improvement.

A judgement in the High Court in 2007 made it clear that a distinction needs to be made between the risk of escape (and the risk to the public in the event of an escape) posed by a prisoner when fit and those risks posed by the same prisoner when suffering from a serious medical condition. The judgement found that handcuffing a prisoner receiving chemotherapy (and, by implication, other life saving treatment) was degrading and that such restraint is likely to be regarded as inhumane unless justified by other relevant considerations. Despite this, and reminders by senior Prison Service managers, we still frequently find that there is no satisfactory healthcare input into risk assessment for seriously ill prisoners being taken to hospital. Prison managers need to do more to ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and ensure that dying and infirm prisoners are treated with dignity.

> "Once again, we found many failures by prisons to ensure an appropriate balance between security and humanity in the use of physical restraints on elderly, infirm and dying prisoners."

2 Learning lessons bulletin – Fatal incidents investigations issue 2: Restraints, February 2013

Mr J was 58 years old, a category C prisoner serving a sentence for a violent offence. Tests revealed that he had cancer and required radiotherapy at hospital. Escort risk assessments for Mr J were inconsistent, often incomplete and assessments of risk changed with no recorded justification. There was insufficient medical input into the assessment, with no information on how his health impacted on his risk of escape. The level of restraint used included double handcuffs (when the prisoner's hands are cuffed in front of him and one wrist is attached to a prison officer by an additional set of handcuffs) despite Mr J being assessed as a low risk of escape and a low risk to staff.

Double cuffing is usually required for moving category A or category B prisoners in good health. When, exceptionally, double cuffs are used for a category C prisoner like Mr J, the Prison Service requires that reasons should be recorded in writing. This was not done and we could find no justifiable reason for the level of restraints used. Prison managers accepted that the risk assessments were inadequate, but we had raised similar concerns previously with the prison.

Mr K was 66 years old. He had a number of chronic conditions, including rheumatoid arthritis that severely restricted his mobility. He was diagnosed with lung cancer and had undergone a course of radiotherapy treatment. As a result of his cancer, he developed pneumonia and died in hospital.

When Mr K started his radiotherapy treatment, the escort risk assessment indicated he was to be escorted by two prison officers and restrained using a single cuff (when the prisoner is handcuffed to one of the escorting officers). Mr K was assessed at this time as a low risk of escape and low risk to hospital staff. There had been no previous concerns about his behaviour in prison, previous escorts or previous time spent in hospital. Healthcare staff simply recorded no objections to the use of restraints rather than reporting on how his state of health impacted on his risk.

On one occasion, the escort risk assessment indicated an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer) was to be used during radiotherapy. The risk assessments for the remaining radiotherapy sessions were not fully completed by medical staff and there was no mention of Mr K's arthritis or his reduced mobility when assessing his risk of escape. Mr K was admitted to hospital as an emergency the day before he died. He was restrained by an escort chain, despite his increased frailty and breathlessness as a result of pneumonia. Restraints were not removed until just a few hours before he died.

Mr L was 65 years old. He had a number of chronic medical conditions including asthma, diabetes and chronic obstructive pulmonary disease (COPD encompasses a number of lung diseases including chronic bronchitis and emphysema). Mr L was admitted to hospital when he developed a cough which did not respond to treatment. He died three weeks later and a post-mortem examination revealed he had lung cancer.

Mr L was double cuffed and escorted by three officers when he was taken to hospital. The original escort risk assessment did not include any medical opinion about whether Mr L's poor health would affect his risk of escape, as the court judgement requires. Mr L required assistance to use the bathroom, was receiving oxygen therapy and his condition had deteriorated significantly during his time in prison and later in hospital. The use of double cuffs, while escorted by three officers, could not be justified. Although the risk assessments were reviewed during his time in hospital, there is no evidence that his health was considered and no record of any consultation with medical staff about how his condition affected his mobility and risk of escape. Mr L remained restrained until he was given just 24 hours to live.

Restraints on immigration detainees

It was not only in prisons that we were concerned about the use of restraints on the terminally ill. During the year, we also investigated the case of an elderly man in immigration detention who had never been any risk to the public, yet restraints were used when he was taken to hospital and he continued to be restrained until he died.

Mr M was 84 years old when he arrived at Gatwick on an overseas flight and immigration officers initially detained him at the airport because he seemed confused and could not give a clear account of his travel plans. The next morning, a doctor assessed him and was concerned about his health and sent him to hospital. At hospital, he suffered a heart attack, but refused all medication and treatment and was discharged four days later. Mr M was then detained in an immigration removal centre (IRC) while arrangements were made to take him back to his home country. He continued to refuse to take any medication or have any medical treatment. Immigration staff attempted to find more suitable accommodation, but no one else was willing to take responsibility for Mr M.

Ten days later, Mr M's health deteriorated and he was taken to hospital handcuffed to an escort officer. He refused any treatment and so was returned to the IRC. Two days later, he was taken to hospital again suffering from chest pain. Mr M was handcuffed on the journey and then restrained by an escort chain in hospital. Some hours later, a nurse could not find a pulse and hospital staff began to attempt resuscitation, at which point the restraints were removed, but Mr M had already died chained to the officer.

We were seriously concerned that Mr M, an elderly, infirm and vulnerable man, who was no risk to the public, was restrained by handcuffs and an escort chain when he was taken to hospital. We found that immigration detainees were routinely restrained during escort and this appeared to be a default position. We consider that restraints should only be used on immigration detainees where there is a properly assessed and specific risk of escape or to the safety of the public or staff. This was not the case with Mr M. We recommended that the Home Office issue appropriate and up-to-date guidance about the use of restraints in IRCs.

“We were seriously concerned that Mr M, an elderly, infirm and vulnerable man, who was no risk to the public, was restrained by handcuffs and an escort chain when he was taken to hospital.”

Palliative care

In March 2013, we issued a thematic report about end of life care,[3] focusing on what we have learned from our investigations into deaths of prisoners from terminal or incurable diseases. Although prisoners of all ages can suffer serious health problems and be diagnosed with terminal illnesses, with an increasingly ageing prison population, the care of those at the end of their life is a growing responsibility for the Prison Service.

3 Learning from PPO investigations – End of life care, March 2013

“Although prisoners of all ages can suffer serious health problems and be diagnosed with terminal illnesses, with an increasingly ageing prison population, the care of those at the end of their life is a growing responsibility for the Prison Service.”

Palliative care is longer-term care that is not curative, but may extend life. It includes chemotherapy, symptomatic and pain relief and planning for all care needs, including pastoral and spiritual. We expect to see regular care planning meetings that include the patient and, where possible, family members. Patients should be offered the opportunity to discuss advance care planning and their wishes about resuscitation should be included.

End of life care is more specific, usually to the last weeks of life, when the emphasis is on minimising symptoms and pain, and where the pastoral and spiritual needs of the patient are considered. Regular care planning meetings should continue and should include the patient (while still possible) and any family.

During the year, we have seen some excellent examples of palliative and end of life care, which our clinical reviewers considered at least equivalent to the care that would have been available in the community.

> “During the year, we have seen some excellent examples of palliative and end of life care, which our clinical reviewers considered at least equivalent to the care that would have been available in the community”

Mr N was diagnosed with malignant melanoma (skin cancer) which progressed rapidly. After his diagnosis, there was excellent liaison between the prison and the hospital about palliative care, including input from a skin cancer nurse. Mr N regularly attended a nurse-led cancer support group at the prison where he received support, advice and guidance, an initiative which we commended. There were good, clear care plans for Mr N and these were well communicated to healthcare staff and discussed with him and his wife. As Mr N became increasingly ill, his end of life care was very good. He received pain relief and other symptomatic relief. He was nursed well, with frequent repositioning and appropriate skin and mouth care. He received fluids and some soft foods such as jelly and yoghurt when he could no longer take medicines by mouth. A syringe driver was set up to administer pain relief and palliative medication. Nurses remained with Mr N and supported him until he died. We considered that much of his treatment represented best practice.

However, not all care was of this standard.

Mr O had a number of conditions including chronic obstructive pulmonary disease (COPD). His health deteriorated significantly and he was considered at the end stage of his life. He received all necessary care, but there was no palliative or end of life plan in place. Care was therefore not delivered in a planned way and there was no input from palliative care specialists. Although this did not significantly affect his medical care, the lack of a formal palliative care plan meant that the wider aspects of Mr O’s care, such as his pastoral and spiritual needs, were not fully taken into account.
Mr P suffered from many chronic health conditions, was weak and had limited mobility. His health steadily deteriorated and he was diagnosed with bronchopneumonia for which he declined any active treatment. His condition was considered terminal. Secondary services advised that it would be appropriate to implement an end of life pathway, but this did not happen. Nurses caring for Mr P considered he needed additional pain relief, but were unable to give this without a doctor’s authorisation. The doctor on site was not contactable and no additional pain relief was prescribed. Nurses found the situation stressful and not all healthcare staff fully understood the end of life pathways.

The investigation identified a need for staff to receive palliative care training.

Emergency response: use of appropriate codes

As a result of learning from previous Ombudsman investigations, the Prison Service agreed that a standard approach was needed in medical emergencies in prisons to ensure a timely, appropriate and effective response to maximise the likelihood of a positive outcome and save lives. Prison Service Instruction (PSI) 03/2013 requires Governors to have a medical emergency response code protocol in place. This should instruct staff how to communicate the nature of a medical emergency using agreed emergency codes and ensure that the prison control room calls an ambulance automatically as soon as an emergency code is used. The instruction requires a two-code system that differentiates between a blood injury and all other injuries (usually code red for blood/burns and code blue for breathing/ collapses).

Local protocols should provide guidance to staff on efficiently communicating the nature of a medical emergency, ensure that staff called to the scene bring relevant equipment and ensure that there are no delays in calling, directing or discharging ambulances.

We very much welcome the new instruction, but investigations over the last year have found that some prisons either do not have a protocol based on PSI 03/2013 or, where they do, too many staff are not aware of, do not understand it, or do not use it. Where such protocols were understood and used we observed more effective and efficient emergency responses. It is important that such protocols make responsibilities during a medical emergency clear to staff and that staff act accordingly.

“The Prison Service agreed that a standard approach was needed in medical emergencies in prisons to ensure a timely, appropriate and effective response to maximise the likelihood of a positive outcome and save lives.”

Mr Q had liver cancer and was being nursed in a normal shared cell. At 3.10pm, an officer was talking to Mr Q’s cellmate in their cell, when she saw that Mr Q had stopped breathing. The officer radioed an emergency code and began to attempt resuscitation. She was joined by another officer and the emergency response nurse. An ambulance was not called until a member of healthcare staff asked for one at 3.23pm. Paramedics arrived at the cell at 3.38pm, nearly half an hour after Mr Q collapsed. We were told that control room staff would not call an ambulance automatically and would only call one when healthcare staff asked for one. Although the prison had an emergency code procedure, the codes were set out in its suicide and self-harm policy and were not readily understood by staff.

The codes did not indicate to staff the type of incident they would encounter or what equipment to bring and thus did not comply with PSI 03/2013. Staff did not understand that an ambulance should be called immediately and did not need the authority of healthcare staff.

An officer found Mr R hanging in his cell around 1.50pm. He called for assistance, but did not use an emergency code. Several other officers responded, but did not know what type of emergency they were attending. An officer unlocking cells on the landing above said he heard a shout for help. When he got to the cell he was told there was a medical emergency and to call a doctor. A minute or two later, he called the control room and said that Mr R had tried to hang himself and a defibrillator was needed. None of the officers administered emergency first aid. An officer went to the medication hatch to get help from healthcare staff. At around 2.00pm, nurses got to the cell and asked for an ambulance to be called, but this was not done until 2.05pm. Another officer went to the unit office to call a doctor, who arrived at 2.10pm, followed by paramedics at 2.15pm. Mr R could not be resuscitated and was pronounced dead at 2.26pm.

Had an appropriate emergency code been called, staff would have known the nature of the emergency, relevant staff would have attended with the appropriate equipment and an ambulance would have been called immediately.

Late diagnosis and missed hospital appointments

We have investigated a number of cases in the last year where the diagnosis of a life limiting disease has been delayed and has resulted in late treatment to ease symptoms or in some cases extend life.

There are two clear reasons emerging for late diagnosis. Sometimes prison and healthcare staff are distrustful of prisoners and put too much emphasis on the risk of them trying to manipulate the system for access to drugs or to be excused from work, even when the prisoner involved has presented with the same symptoms on a number of occasions. There is also a problem with prisons cancelling hospital appointments, sometimes repeatedly for the same prisoner, thus delaying important investigative procedures. Often this is due to a lack of available staff for escorts, but sometimes it is because the prisoner has become aware of the time and date of the appointment and this is automatically considered an escape risk. The Prison Service's National Security Framework does not require hospital appointments to be cancelled automatically in these circumstances – it expects that an appropriate risk assessment should be completed and the prisoner's condition and the urgency of the treatment required should be taken into account. Alternative security arrangements should be made if necessary. We see too little evidence that this happens.

"We have investigated a number of cases in the last year where the diagnosis of a life limiting disease has been delayed and has resulted in late treatment to ease symptoms or in some cases extend life."

Mr S was 60 and died in hospital of bowel cancer. Although he had been in prison for several years he had had little interaction with healthcare staff until early 2013, when he complained of abdominal pain. He was seen by healthcare staff a further 13 times with abdominal pain, but was not referred to hospital or examined appropriately. In August, a nurse was very concerned about him and arranged for him to be taken to hospital. Tests revealed he had widespread cancer and he died just a month later.

We were concerned that so many health professionals saw Mr S without identifying the need for further urgent investigation and his care did not appear to have been coordinated well. While earlier diagnosis might not have changed the outcome for Mr S, it would have allowed appropriate pain relief and care in the weeks leading up to the end of his life. Our clinical reviewer considered that healthcare staff at the prison had failed to ensure there was an appropriate and timely diagnosis of Mr S's condition, and concluded that his care fell below that he could have expected to receive in the community.

Mr T was 58 and died in hospital of cancer of the oesophagus. Mr T had a number of health problems when he arrived in prison in 2012 and, in October, complained of pain when swallowing. In November 2012, a doctor referred him for a diagnostic scan, but did not make an urgent referral under the NHS cancer pathway (where someone should see a specialist within two weeks if cancer is suspected). It was therefore a number of weeks before the hospital arranged the scan. The scan was inconclusive and the radiographer requested that it was repeated in one week as a matter of urgency. Despite this, the hospital did not prioritise the scan and healthcare staff at the prison did not pursue it, although they had been informed it was urgent. A further six rescheduled appointments were cancelled by the prison, due to the lack of available escort staff and because Mr T became aware of the time and date. He eventually had the scan five months later when he was diagnosed with cancer which was too advanced to treat. Mr T was cared for at the prison, but developed a gastric bleed and was admitted to hospital in September. He died a few days later.

INVESTIGATING COMPLAINTS

Learning lessons about complaints

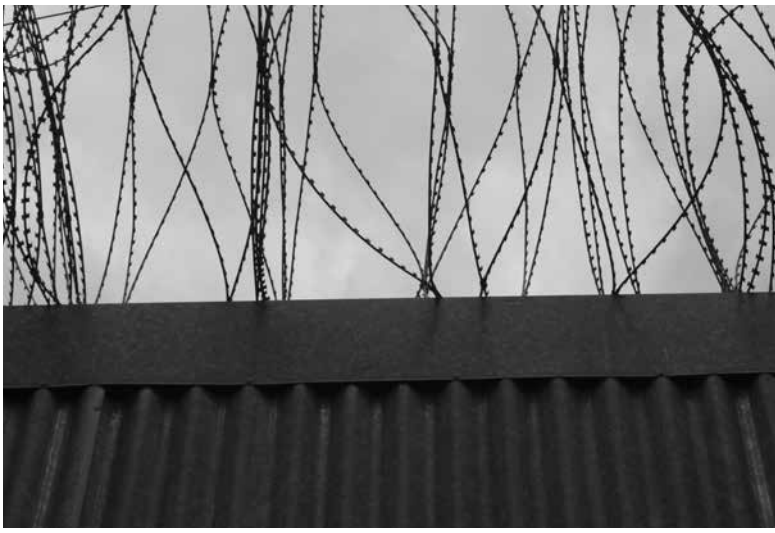
We published four learning lessons publications in 2013–14, drawing on evidence from across our complaints investigations.[4] The first sought to identify lessons from complaints about dismissal of prisoners from employment, including the need for prisons to have a clear employment policy and a compact explaining to prisoners what is expected of them. Modelling good employment practices in the community in this way could also encourage a positive work ethos and contribute to rehabilitation.

Two publications looked at how better to manage property, one in prisons and the other in immigration removal centres. In both of these custodial contexts, lost or damaged property is our most common source of complaint and the one with the highest uphold rate against the authorities. This reflects poor recording and management of property and leads not merely to frustration among prisoners and immigration detainees, but also to an unacceptable cost to the public purse in compensation and wasted staff time.

At the other end of the spectrum of seriousness, a learning lessons bulletin looked at complaints about the use of force and drew a number of lessons that could minimise its use, thus protecting both staff and prisoners.

Finally, a thematic review analysed recommendations made in complaint cases in 2012–13. Around a third of upheld complaints led to formal recommendations, which are invariably accepted by the authorities. Recommendations were most common when complaints about equality issues, adjudications and staff behaviour were upheld. Recommendations were less common in the frequently upheld complaints about property, as we were often able to resolve these amicably and efficiently by way of mediation between the parties.

4 See appendices for the full list of publications.



Individual complaint investigations

As in previous years, the majority of the complaints received (91%) came from prisoners, particularly adult male prisoners.

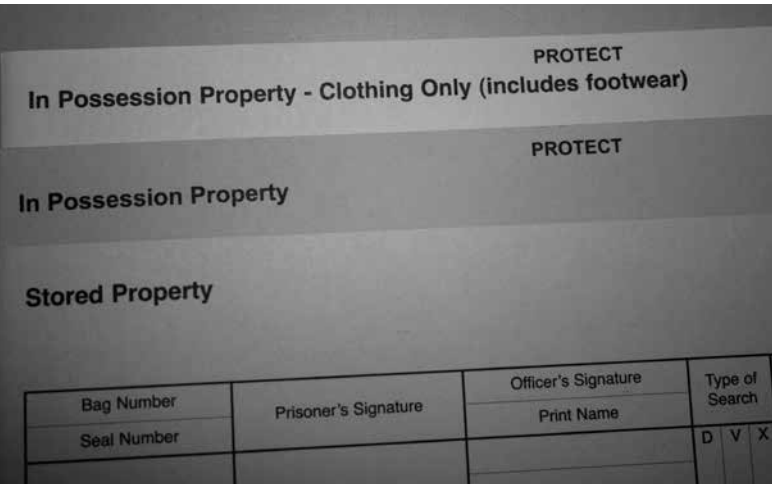
To make the best use of our limited resources, we continued to decline to investigate complaints that did not raise a substantial issue or where we considered that there was no worthwhile outcome that an investigation could achieve. However, it is important to stress that, in pursuing this necessary proportionate approach, we ensure that our assessors do not lose sight of the fact that some apparently trivial problems may be important to complainants.

A good example of this was the case of Mr A who complained that his name had been misspelt on the certificates he had earned in prison. He attached considerable value to these certificates because they were the first educational qualifications he had ever obtained. He was also worried that a future employer might not accept them as genuine if his name was incorrect. He had complained and been told that the mistake would be corrected but, when this had still not happened after some months, he approached us and we were able to get new certificates issued for him.

Property

Those in detention often have very little and they can therefore attach a great deal of importance to their personal belongings. It is perhaps not surprising, therefore, that this was, once again, the most frequent subject for complaint (26% of completed investigations). As in previous years, we were struck by the cavalier way prisoners' property is often treated by establishments and by the poor quality of the responses prisoners and immigration detainees often receive when they complain about lost or damaged items. This is reflected in the fact that while our average uphold rate across all complaints is 34%, our uphold rate for complaints about property is significantly higher (56%).

As illustrated in our thematic study of property complaints,[5] many of the complaints could and should have been dealt with effectively by the prisons to which the complaints were first made. National policies and instructions set out clear procedures and responsibilities, but too often, following the loss or damage of items, prisons or immigration removal centres did not accept their responsibility. This creates unnecessary frustrations and wastes public funds on compensation and investigative work by staff – including the Ombudsman's staff.



5 Learning from PPO investigations – Prisoners' property complaints, February 2014

> "As in previous years, we were struck by the cavalier way prisoners' property is often treated by establishments and by the poor quality of the responses prisoners and immigration detainees often receive when they complain about lost or damaged items."

A very typical example was the case of Mr B who complained that his stored property did not travel with him when he was transferred from one prison to another, leaving him with just the clothes he was wearing. The previous prison initially told him that his property had been located and would be sent on to him. When it had not arrived two months later, he complained again and was told that it had been sent to him that day. When the property still did not arrive, he complained again and the previous prison said that they had posted his property to him but, because the sender's details had not been included on the parcel, his new prison had refused to accept it and the parcel had been returned to Royal Mail. He was given a Royal Mail tracking number and was told to make a claim to Royal

Mail. He could not do so, however, because he was not the sender. No claim was made by the prison. By the time we became involved, the parcel had been sent to Royal Mail's lost property centre in Belfast and could no longer be located. We concluded that the sending prison had been at fault and recommended that they pay Mr B compensation for his losses.

In general, prisoners are responsible for any property they hold in their possession. However, when prisoners are unable to safeguard their own property – for example, when they are transferred to another cell or prison – their property becomes the responsibility of the prison and it is, therefore, important that staff follow the procedures for securing cells and checking property cards. It is disappointing that we regularly encounter staff – at all grades – who believe that prisons have no responsibility to safeguard prisoners' in-possession property in any circumstances.

An example was the case of Mr C, whose property, including spectacles and legal paperwork, went missing when he went to court. When he complained, prison staff said that he should have taken his property with him and that the prison had no responsibility for in-possession property. Our investigation found that Mr C was new to prison and that, when he had been to court on previous occasions, he had left his property behind and always returned to the same cell. We were satisfied that no one had told him that he would be transferring to a different prison this time, or that he needed to take his property with him. In addition, staff had not followed the mandatory procedures – Mr C had not been asked to check and sign his property card when he left the prison, and his cell had not been secured or cleared, as it should have been. The prison had effectively left Mr C's property available for other prisoners to steal. Therefore, we upheld Mr C's complaint and recommended that the prison offer him compensation for the missing items.

Mr D complained that some of his clothes were damaged when staff accidently spilt diluted bleach on them during a routine cell search. The prison accepted that staff had caused the damage, but told Mr D that he would not receive an apology because it was a disciplinary offence for him to have had the bleach in his cell (and that this had been noted on his records). They said that he should submit an application to have the damaged items destroyed. Our investigation found that possession of the bleach had not been a disciplinary offence, indeed the prison had issued prisoners with bleach tablets on request to sterilise razors, together with a leaflet explaining how to use them. We were also able to confirm that, although the clothes were still technically wearable, they were badly marked. As they had been damaged through no fault of Mr D's, we recommended that he receive compensation.

Most property complaints are about missing or damaged clothes or electrical items. To determine a suitable sum of compensation we research how much similar items would cost new and, in most cases, make a deduction for wear and tear. In the case of allegedly high

value 'designer' items, we ask to see receipts. As a result, most of the compensation we recommended was for small sums. We did, however, see a number of worrying cases where valuable property went missing while in the care of a prison.

Mr E, for example, complained that his wedding ring had gone missing while he was in prison. We established that Mr E had entered the prison via police custody and court and that the ring had been recorded in a sealed bag with his other property in both locations. There was, however, no record of it arriving at the prison, although the other property in the bag was recorded as having arrived. We also noted a number of other complaints received about the loss of valuable property at the same prison at about the same time. We visited the prison to discuss the matter with the Governor. We were assured that the procedures for transferring valuable property from reception to the cashier's office had been tightened up and investigations into staff behaviour had begun.

We recommended that Mr E should be compensated for the loss of his wedding ring and that the Governor should send us the outcome of the prison's internal investigation into the losses.

Staff behaviour

Compared with complaints about property, serious complaints about staff behaviour made up only a small part of our caseload, but were, nevertheless, some of the most important complaints we dealt with. This year, a l*earning lessons bulletin*[6] reviewed complaints about the use of force by staff against prisoners. In most of these cases there was agreement that force was used and our role was to consider whether this was reasonable, necessary and proportionate. Use of force is not justified merely because a prisoner refuses to obey a 'lawful order'. If there is an equally effective and less injurious alternative, it should be used. Similarly, no more force than necessary should be used, the decision-making process should be made clear and the justification for each action taken, made explicit. Use of force forms must be completed in sufficient detail to include this and should also detail which actions were considered and taken to de-escalate the situation.

Mr F complained that unnecessary force had been used to move him. Staff went to Mr F's cell during the lunch hour, while prisoners were locked in their cells, and told him that he was required to move to another wing. He said he was willing to move, but asked to be allowed to pack his own possessions because some of his property had gone missing the last time he had been moved. He was told that this was not possible and was given a direct order to move. When he refused, he was restrained and moved forcibly. Our investigation established that, prior to the use of force, Mr F was sitting on his bed talking to staff and, although he had been refusing to move, he had not been aggressive or threatening. Force was used solely to enforce compliance with the order.

6 Learning lessons bulletin – Complaints investigations, issue 4: Use of force, January 2014

> “Use of force is not justified merely because a prisoner refuses to obey a ‘lawful order’. If there is an equally effective and less injurious alternative, it should be used.”

We considered that there was no reason why Mr F should not have been allowed to pack his property and we were satisfied that, if he had been able to do so, he would probably have moved voluntarily. He posed no risk to staff or property and, as other prisoners were locked in their cells at the time, he posed no risk to the good order of the wing. We concluded that the use of force had not been justified as there had been a ‘less injurious, but equally effective’ alternative. We recommended that disciplinary action be initiated against the member of staff who ordered the use of force.

Another example was that of Mr G who complained that, during a restraint, he had been punched and kicked in the face by staff and that an officer had tried to break his arm. Our investigation found that force had been used on Mr G after he repeatedly refused to move cells in the segregation unit.

After reviewing the CCTV of the incident, the use of force paperwork and Mr G’s medical records, we concluded that it had been reasonable and appropriate to use force to move him against his will. We also concluded that there was no evidence that Mr G had been punched or kicked by staff. However, we were not satisfied that the force used, particularly on Mr G’s arm, was proportionate and we recommended a disciplinary investigation be initiated against the staff involved in the use of force.

Our investigation of Mr G’s complaint was greatly aided by the fact that the CCTV of the incident had been retained. In many cases, however, the use of force either took place outside of CCTV coverage, or the CCTV was destroyed before we became involved. At the request of the Ombudsman, NOMS recently instructed all Governors and Directors to retain CCTV for 12 months where a serious complaint has been made.

Sometimes our investigations raised concerns about the follow-up to a use of force, where internal investigations were insufficiently thorough, or did not address whether force was justified. In some cases, there had been a good quality internal investigation but the complainant was given too little detail and, as a result, complained to this office that no action had been taken.

Mr H complained that an officer had punched him in the face during a restraint and that the prison did not investigate his complaint. Mr H and staff gave very different accounts of what had happened. There was no CCTV coverage on the wing where the incident occurred and the use of force statements completed by staff lacked detail, as did the medical report.

Although we interviewed Mr H and the staff, we had to conclude that there was insufficient evidence to allow us to determine what had happened. We did not, therefore, uphold Mr H's complaint that he had been assaulted. We did conclude, however, that the prison had failed to investigate his complaint adequately. The Governor who conducted the internal investigation did not keep a record of who he interviewed, what they said, or why he reached the conclusion that the use of force had been reasonable, necessary and proportionate. We also concluded that Mr H's written request for police involvement had not been actioned, as it should have been. We recommended that Mr H should receive an apology for these failings and that the Governor should improve the arrangements at the prison for recording and investigating serious complaints about staff.

Adjudications

We continued to receive a significant number of complaints about adjudications. Our role here is not to rehear the evidence, but to satisfy ourselves that the adjudicator followed procedures, inquired sufficiently into the prisoner's defence to ensure a fair hearing and imposed a proportionate punishment. Some of the procedural failings we identified were relatively minor, but others amounted to fatal flaws that compromised the fairness of the adjudication and, in these cases, we recommended that the findings be quashed.

Mr I complained about an adjudication at which he was found guilty of committing an assault on another young offender. Mr I accepted that he had hit the other young offender, but said that he did so because he had been hit first. In other words, he was claiming that he acted in self-defence, which is a potential defence to a charge of assault. Mr I did not ask for legal advice or representation. He was 18 at the time, and the day after the hearing he was assessed as having significant learning disabilities and was subsequently admitted to a secure mental hospital. Although the adjudicator could not know about the mental health assessment and was not, therefore, aware of the full extent of Mr I's vulnerability, it was apparent from the record of hearing that Mr I was not able to articulate his defence effectively.

Given the serious nature of the charge, together with Mr I's age, inexperience and vulnerability, and the fact that he had received no legal assistance, the adjudicator had a particular responsibility to inquire into Mr I's defence. He did not do so – or, if he did, he did not record it in the extremely brief record of hearing, which gave no clue as to why he did not accept Mr I's defence or why he found him guilty. He did not, for example, make any reference to the medical evidence which tended to support Mr I's account that the other young offender had hit him. We, therefore, concluded that the adjudication finding was unsafe and recommended that the finding be quashed. We also made a general recommendation about the conduct of adjudications at the establishment.

A different issue arose in the case of Mr J who complained that he was not provided with copies of the adjudication papers in time for him to appeal against a finding of guilt. Mr J's solicitors wrote to the prison after the hearing, asking for the paperwork and enclosing a form of authority to act on Mr J's behalf. They said that Mr J had asked for the papers himself, but had not received a reply. They were told, correctly, that under PSI 47/2011 papers are not supplied directly to legal advisers, but that the prisoner can ask

for them and send them on to their solicitors at their own expense. What was less reasonable was that the prison then required Mr J to ask for the papers separately, when they knew this was what he wanted. As a result, his appeal was out of time.

We took the view that this was unnecessarily bureaucratic and obstructive. Prisoners only have six weeks in which to lodge an appeal and time is, therefore, of the essence. The fact that Mr J was not provided with the papers until eight weeks after the adjudication meant that he was denied the opportunity to appeal. We recommended that, in the circumstances, Mr J's appeal should be heard out of time.

Contact with family and friends

Maintaining prisoners' contact with family and friends is another very important issue for all concerned – and often key to future rehabilitation.

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Mr K, for example, complained that his wife and son had waited three hours to be admitted for a booked visit and were then turned away without seeing him.

We concluded that there had been a very unfortunate administrative muddle and we upheld Mr K's complaint. We recommended that he receive an apology and that he be offered another visit.

The complaints we receive on this subject are not always so straightforward, however, as they can involve a difficult balance between the rights of prisoners and the rights of others. This is particularly the case where contact with children is concerned.

Mr L complained about being made subject to child protection measures, although he had never been convicted of any charges involving children. He said he was a burglar, not a child abuser, and that being subject to child protection measures was putting him in danger from other prisoners and preventing him having any contact in person, by letter or by phone with his young children.

> “The safety and wellbeing of children must always be paramount. Nevertheless, stopping contact between a parent and a child can have significant consequences for both parties and is not a decision that should be taken lightly. ”

Our investigation found that the measures had been put in place because Mr L's former partner had previously made allegations about domestic violence. Mr L denied these allegations and his former partner had raised no objections to him having visits from the children. The safety and wellbeing of children must always be paramount. Nevertheless, stopping contact between a parent and a child can have significant consequences for both parties and is not a decision that should be taken lightly. In this case, we concluded that it had been reasonable for the prison to identify Mr L as a potential risk to children on the basis of the information available to them, but that he should not have been maintained on full no contact restrictions without an up-to-date risk assessment, including input from external agencies.

We also saw a disturbing number of cases where prisoners' applications to attend the funeral of a close relative were not processed quickly enough. Funerals are an important part of the grieving process and, although security concerns will legitimately prevent some prisoners attending, applications need to be treated with respect, processed as a matter of urgency and lead to a response before the day of the funeral. This does not always happen.

Mr M complained that he had not been allowed to attend his mother's funeral. Our investigation established that Mr M had completed an application to attend, but that it had been misplaced by staff and was not, therefore, forwarded for a risk assessment. As he had heard nothing to the contrary, Mr M and his family assumed he would be attending and only learned the day before the funeral that his application had not been processed.

We upheld Mr M's complaint and recommended an apology and improvements to the prison's processes for funeral applications.

Legally privileged mail

We continued to receive a steady stream of complaints about another issue concerning contact with the outside world – the opening of legally privileged mail (generally known as Rule 39 mail). PSI 49/2011 (which covers prisoners' correspondence) provides that letters from solicitors and other privileged sources should not be opened and read by staff. If there is any doubt that the letter is from a privileged source, it must only be opened in the presence of the prisoner. If prison staff accidentally open a Rule 39 letter (for example, because the source of the letter is unclear), this must be recorded in the prisoner's correspondence log. As in previous years, we saw a great many cases where these provisions had not been followed. Sometimes,

even mail clearly marked with Rule 39, had been opened by staff and this had not been recorded. We have not seen anything to suggest that this is being done deliberately – although we obviously remain alive to this possibility. It appears, rather, to be down to poor staff training and poor management.

A typical case is that of Mr N. He made a series of complaints to us about his Rule 39 mail being opened. We upheld them all and recommended each time that he receive an apology. Mr N believed that his mail was being intentionally targeted, but we could find no evidence of this. The prison told us that they had put measures in place to stop letters being opened in error in future. When we received another complaint from Mr N showing that mistakes were still being made, we recommended that the Governor undertake a thorough review of mail processing and arrange for all the staff involved to be retrained within two months.

Equality and diversity

Equality and diversity issues are a priority for the Ombudsman. However, while complaints about alleged discrimination are potentially serious, they are not always recognised as such, or investigated as they should be.

Mr O complained that he had not been considered for an orderly role. He said that this was the result of discrimination against black prisoners and that there had never been any black orderlies at the prison and never would be.

Our investigation established that Mr O had not been considered for an orderly role because his index offence involved drugs and the prison's policy at that time, debarred him from consideration. We were satisfied that this decision was not unreasonable and we did not uphold this part of his complaint. However, there was no evidence that this reason had ever been communicated to Mr O. We established that there were currently no black orderlies, but the number of orderlies was so small that we did not feel we could draw any conclusions from this. We were, however, concerned that equality of access to activities and roles was not being monitored at the prison.

We were also concerned about the way Mr O's complaints about racial discrimination had been handled. The complaints had not been logged on a discrimination incident reporting form as they should have been and, although Mr O had made a number of detailed and specific complaints about racial discrimination, the prison had not addressed any of the points he made, beyond a bald statement that there was 'no way' race or religion had played any part in their decisions. We recommended that the prison should undertake an equality

impact assessment and that the handling of complaints about discrimination be improved.

In another case, Mr P complained that he was restricted to making two 10-minute foreign language phone calls a week. He said that this was not enough to maintain contact with his family and that he wanted to be allowed to make a foreign language call every day. Mr P is a high risk Category A prisoner serving a life sentence in a high security prison. His phone calls are monitored for security reasons and phone calls in a foreign language have to be translated into English with a short turn around time to enable them to be monitored.

Our investigation established that Mr P mainly made foreign language calls to his mother, who did not speak English and that he was allowed to make foreign language calls totalling 20 minutes on two specified, successive days a week. It is important that prisoners should be able to maintain ties with their families and, where families live too far away to visit regularly – as in Mr P's case – phone calls provide a vital means of contact.

However, the Prison Service's primary responsibility is to protect the public by keeping securely, those committed to custody. There is, therefore, a fine balance to be struck between facilitating contact with the outside world for high-risk prisoners and maintaining safety and security. The restrictions placed on Mr P were less permissive than at some high security prisons, but in line with others. Given the logistical and financial implications of translating his calls, we concluded that we could not say that limiting Mr P to 20 minutes a week was so restrictive as to be unreasonable. We did, however, recommend that he should be able to make calls at the beginning and middle of the week, as we considered that this would enable more 'normal' contact than calls on successive days.

"There is, therefore, a fine balance to be struck between facilitating contact with the outside world for high-risk prisoners and maintaining safety and security."

We also investigated some complaints this year from transsexual prisoners about their access to female clothes and make up.

Ms Q complained that she was not allowed to wear female clothes on the wing, in education or during visits. PSI 07/2011 covering the care and management of transsexual prisoners, provides that male to female transsexual prisoners should be allowed to wear female clothes, regardless of any restrictions imposed through the incentives and earned privileges scheme. It says that this 'is not a privilege' but is 'necessary to ensure that such prisoners can live in the gender role that they identify with'. The prison told us that they had imposed restrictions because it would not be possible to distinguish Ms Q from visitors during visits if she was wearing women's clothes and also because Ms Q's behaviour and

dress 'provoked' other prisoners and could lead to disorder. However, the PSI is quite clear that Ms Q should be allowed to wear female clothes and we, therefore, upheld her complaint.

We recognise that male to female transsexual prisoners may be at risk of physical and sexual violence from other prisoners in male prisons and that, in imposing restrictions on the wearing of female clothes and make up, prisons may be trying to act in what they perceive to be the prisoner's best interests. However, there are many other prisoners who are equally vulnerable because of their offence, their sexual orientation or their behaviour and prisons must manage the risks to transsexual prisoners in the same way as they manage the risks to other vulnerable prisoners and in line with existing instructions.

Re-categorisation, release on temporary licence (ROTL) and home detention curfew (HDC)

When considering complaints about these issues our role is generally to consider whether procedures have been followed and whether the prison's decision is reasonable in the light of the evidence. We cannot simply substitute our judgement for that of prison staff who see the complainant on a daily basis and know him or her much better than we do. Generally, we have found that procedures have been followed and that decisions taken have not been unreasonable, hence we upheld relatively few of these complaints. However, there are always some exceptions.

Mr R complained that he was unable to progress to category C because he did not have the opportunity to reduce his risk. Our investigation found that Mr R's sentence plan included a requirement that he undertake the rolling sex offender treatment programme (SOTP). However, he was unable to do so because the prison had suspended the programme. The core SOTP was still available, but Mr R had been assessed as unsuitable for it because he did not pose a sufficiently high risk.

We concluded that Mr R's sentence plan was no longer realistic and we recommended that his plan – and those of other prisoners in the same position – should be reviewed.

Mr S complained about being returned from an open prison to closed conditions. Mr S was told that the decision had been taken because there was reason to believe that he was involved in drugs and bullying. Our investigation found that there was some security intelligence connecting Mr S with illicit activities, but that its reliability was questionable. The Security Governor of Mr S's new prison told us that, in her opinion, there was insufficient intelligence to have warranted Mr S's removal from the open prison. We also noted a striking inconsistency between the security intelligence and the extremely positive reports Mr S had received at the open prison for his behaviour and willingness to cooperate with staff. We noted in particular that it was widely known that, a few years previously, he had come to the aid of a member of staff who was being assaulted by another prisoner. We thought it was possible

that this had made Mr S vulnerable to false allegations from other prisoners and, given the doubtful nature of the intelligence, we upheld Mr S's complaint. As he was about to be released on parole, he was content to remain in the closed prison.

We recommended that Mr S receive an apology for the way his case had been handled and that the Governor of the open prison review the arrangements for evaluating intelligence.

Drug testing

Illicit drugs are a serious issue in prison, but their nature and use vary over time, requiring prisons to adjust their response. This can raise new issues, for example we have started to receive complaints about testing for the presence of steroids.

Mr T complained that the chain of custody for the test sample had been broken. He also complained that he should not have been punished following the positive test result, as he had not been found guilty at an adjudication.

Drug testing for steroids raises a number of complex and technical issues. After a detailed investigation we concluded that the testing procedure had not been fatally flawed in Mr T's case and we did not uphold this aspect of his complaint. However, our investigation also established that Mr T had not been charged under the Prison Rules, but had instead been made subject to 'administrative measures' with the kind of punishments that can follow a guilty finding at an adjudication, but without the procedural safeguards. We were concerned that, because he had not been charged and adjudicated on, he had not been able to challenge the positive test result or to put forward a defence. We also expressed concern that, although testing for steroids appears to be of increasing importance in prisons, there was a lack of clear national guidance about testing and adjudication procedures, despite previous recommendations from this office. We therefore recommended, that NOMS should issue an amendment to PSO 3601 on drug testing.

Incentives and earned privileges (IEP)

Towards the end of the year we also started to receive the first complaints about implementation of the changes to the incentives and earned privileges (IEP) policy (PSI 30/2013, introduced in November 2013).

Ms U, for example, complained about being downgraded from Enhanced to Standard status following an IEP review. Ms U had been an Enhanced prisoner for six weeks before her review. She was told she no longer met the new criteria for Enhanced as there was no evidence of her helping other prisoners or prison staff.

We concluded that this decision was in line with the PSI and was not, therefore, unreasonable. We were, however, concerned that the prison had failed to document the review and the reasons for the downgrading as they should have done. We were also concerned that, although the PSI says that existing prisoners will not be affected by the new IEP policy until their next routine annual review or as a consequence of good

or bad behaviour or performance, the prison had conducted an automatic review of all prisoners following the introduction of the new policy which had disadvantaged Ms U, who might otherwise have expected to remain on Enhanced for another 11 months if her behaviour merited it.

Impact of budget reductions on prisons' regimes

We have also received increasing numbers of complaints about the impact of budget reductions on prison regimes.

Mr V complained that he was no longer getting a weekly visit to the prison library and had been able to attend the library only once in six weeks. He said he needed regular access to consult legal reference books and obtain photocopying for his ongoing litigation. The manager of the vulnerable prisoner wing where Mr V was located was sympathetic, but said that priority had to be given to the prison's other commitments and that library visits had to be dropped if an officer could not be made available to escort prisoners.

Our investigation established that PSI 45/2011 provides that all prisoners must be allowed access to library books for a minimum of 30 minutes a week or 'at least once every two weeks as an absolute minimum'. As it was clear that Mr V had not been receiving this basic entitlement, we upheld his complaint and recommended that the Governor write to Mr V to apologise. We were told that the prison was going through the 'benchmarking' efficiency process and that, once this had been completed, all prisoners should be able to access the library at least once a fortnight. We recommended that the Governor should confirm to us in writing when this had been achieved.

Young people

Young people made relatively few complaints to us. When they did, property and adjudications were the most frequent topics, but there were also a small number of complaints about the use of force.

"We have also received increasing numbers of complaints about the impact of budget reductions on prison regimes."

Mr W, a 17-year-old young offender, complained that his hand was broken by staff when he was restrained. After investigating, we concluded that the use of force had been justified and that there was no evidence that Mr W's hand was injured during the restraint. However, we were not satisfied that the use of a pain compliance technique was either necessary or proportionate or that it was reasonable, necessary or proportionate to have subsequently removed Mr W's clothes by force.

We made national recommendations that a pain inducing technique should never be used on a young person where a non-painful alternative can achieve the same objective and that force should only be used to remove a young person's clothes where there is no alternative means of protecting a young person from harm.

Women

We also received very few complaints from women prisoners. Adjudications and administrative issues were the most frequent topics. However, there were some serious cases.

Ms X complained that she had been restrained unnecessarily. After investigating, we were satisfied that it had been appropriate for a male officer to use force spontaneously to protect both Ms X and himself from harm. The officer acknowledged that he had pulled Ms X's top down during the restraint to preserve her dignity.

We were satisfied that, although this was unorthodox, it was not inappropriate in the circumstances. However, we were not satisfied that there was sufficient justification for Ms X to have been strip searched by female staff after the restraint. We recommended that Ms X receive an apology.

Immigration detainees

The number of complaints from immigration detainees fell significantly this year and we are taking steps to examine the reasons for this. The most frequent subject of complaint, as with prisoners, was missing property and a learning lessons bulletin highlighted the considerable scope that exists for improving the care and recording of detainees' property. However, detainees also made a number of serious complaints about staff behaviour.

One such case was that of Mr Y, who complained that, during an attempted removal from the UK, the escort staff had beaten and punched him, covered his mouth, restrained him in a position that restricted his breathing, and handcuffed him too tightly. After a wide-ranging and thorough investigation we found no evidence to support any of these very serious allegations, although we did find that one of the escort staff required medical treatment after being badly bitten by Mr Y. However, we were not satisfied that it had been necessary to keep Mr Y handcuffed for a significant period after the failed removal. We made recommendations about this and other matters related to his health.

The subject of restraints also arose in the case of Mr Z who complained about being handcuffed during a hospital appointment.

Our investigation established that the escort staff had refused to remove Mr Z's handcuffs and leave him alone with a doctor during a medical appointment at an outside hospital and that, as a result, the consultation did not go ahead – although whether this was the doctor's decision or Mr Z's decision was not clear. We found that there was no evidence that a risk assessment had been conducted before the appointment, setting out the circumstances in which Mr Z's handcuffs could be removed, and that escort staff appeared to be completely unaware of policy on the use of restraints on detainees. In the absence of a risk assessment, we could not say whether the handcuffs should have been removed or not, but we upheld Mr Z's complaint on the grounds that procedures had clearly not been followed.

Probation

As in previous years, we received only a small number of complaints from probation supervisees. Those we did receive were usually either complaints about the behaviour of the offender manager or about the content of reports written on the supervisee, or both, and typically included a number of very detailed grievances. The cases of Mr AA and Mr BB provide examples.

Mr AA complained that his offender manager had not had any contact with him and that the Probation Trust had failed to investigate his complaint adequately. He also complained that his offender manager had inappropriately reported him to the Multi-Agency Public Protection Panel and shared information about him with Social Services in relation to child contact decisions.

We found that, following its internal investigation, the Trust had provided Mr AA with a well-deserved apology for the fact that his offender manager had not replied to any of his letters over a 12-month period. We considered, however, that the Trust had been wrong to conclude that there was evidence that the offender manager had, nevertheless, taken the content of Mr AA's letters into consideration. We could not, for example, see any evidence that the offender manager had given any consideration to a request by Mr AA to travel abroad for a family wedding. We found that, although it was very unlikely that this would have been agreed, the offender manager had been at fault for not replying to

Mr AA's request, and we upheld this aspect of his complaint. We were satisfied that the offender manager had behaved appropriately in other respects and did not uphold the other aspects of Mr AA's complaints.

Mr BB made a number of very detailed complaints about the OASys (risk assessment) report compiled by his offender manager which resulted in him being assessed as a high risk of harm to children. In particular, he complained that the report wrongly interpreted some entirely innocent actions as evidence of grooming activities, including involvement with the Scouts, giving children lifts, providing employment for young people, installing a trampoline and allowing boys to use his shower.

Our investigation established that Mr BB was serving a lengthy prison sentence for serious sexual offences against a child over a period of years. We reviewed the Crown Prosecution Service paperwork, including witness statements and transcripts of the trial and appeal. We were satisfied that, although the activities described were not a cause for concern in themselves, in the light of Mr BB's conviction and the extensive evidence given by witnesses, it was not unreasonable for the offender manager to have described them as evidence of grooming. We also concluded that, given the evidence of grooming over a protracted period, the long-standing and serious nature of the abuse against the victim and the fact that Mr BB did not accept responsibility for his behaviour, it was not unreasonable for him to have been assessed as a high risk to children. We did not, therefore, uphold the complaint.

APPENDICES

Statistical tables

Fatal incident investigations started	Total 2012/13	% of total (12/13)	Total 2013/14	% of total (13/14)	Change 12/13–13/14	% change year on year
Natural**	121	63%	130	54%	9	7%
Self-inflicted	55	29%	90	38%	35	64%
Other non-natural***	12	6%	9	4%	-3	-25%
Homicide	2	1%	4	2%	2	*
Awaiting classification	1	1%	6	3%	5	*
Total	**191**	**100%**	**239**	**100%**	**48**	**25%**

* The % changes in small numbers are not meaningful.
** Five of the natural cause deaths in 2012/13 and 12 in 2013/14 were originally unclassified.
***'Other non-natural' includes investigations where post-mortem and toxicology reports have been unable to establish cause of death.

Fatal incident investigations started	Total 2012/13	% of total (12/13)	Total 2013/14	% of total (13/14)	Change 12/13– 13/14	% change year on year
Male prisoners	172	90%	214	90%	42	24%
Female prisoners	6	3%	6	3%	0	*
Young offenders (under 21)	2	1%	6	3%	4	*
Approved premises residents**	9	5%	11	5%	2	22%
IRC residents**	2	1%	2	1%	0	*
Total	**191**	**100%**	**239**	**100%**	**48**	**25%**

* The % changes in small numbers are not meaningful.
** In 2012/13 one approved premises resident was female. In 2013/14 one IRC resident was female.

Fatal incident investigations started 2013/14	Male prisoners	Female prisoners	Young offenders (under 21)	Approved premises residents	IRC residents**	Total
Natural	122	3	0	3	2	130
Self-inflicted	80	3	6	1	0	90
Other non-natural*	3	0	0	6	0	9
Homicide	3	0	0	1	0	4
Awaiting classification	6	0	0	0	0	6
Total	**214**	**6**	**6**	**11**	**2**	**239**

* 'Other non-natural' includes investigations where post-mortem and toxicology reports have been unable to establish cause of death.
** In 2013/14 one IRC resident was female.

Fatal incident reports issued	Total 2012/13	% in time*	Total 2013/14	% in time*	Change 12/13–13/14	% change year on year
Draft reports	247	56%	224	92%	-23	-9%
Final reports	242	33%	258	43%	16	7%
Anonymised reports	131	–	348	–	217	166%

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

Complaints received	Total 2012/13	% of total (12/13)	Total 2013/14	% of total (13/14)	Change 12/13–13/14	% change year on year
Prison	4,894	91%	4,435	91%	-456	-9%
Secure training centres	-	-	3	0%	-	-
Probation	369	7%	375	8%	6	2%
Immigration detention	111	2%	66	1%	-45	-41%
Total	**5,374**	**100%**	**4,879**	**100%**	**-495**	**-9%**

Complaints investigations started	Total 2012/13	% of total (12/13)	Total 2013/14	% of total (13/14)	Change 12/13–13/14	% change year on year
Prison	2,704	96%	2,030	96%	-671	-25%
Secure training centres	-	-	3	0%	-	-
Probation	47	2%	46	2%	-1	-2%
Immigration detention	64	2%	32	2%	-32	-50%
Total	**2,815**	**100%**	**2,111**	**100%**	**-704**	**-25%**

Complaints investigations completed	Total 2012/13	% of total (12/13)	Total 2013/14	% of total (13/14)	Change 12/13–13/14	% change year on year
Prison	1,986	96%	1,881	97%	-105	-5%
Probation	38	2%	22	1%	-16	-42%
Immigration detention	38	2%	38	2%	0	0%
Total	**2,062**	**100%**	**1,941**	**100%**	**-121**	**-6%**

Prison complainants 2013/14 (completed complaints)	Number of complainants	% of complainants	Number of complaints	% of complaints
Male prisoners	1,335	97%	1,827	97%
Female prisoners	17	1%	28	1%
Young offenders (under 21)	26	2%	26	1%
Total	**1,378**	**100%**	**1,881**	**100%**

Complaints completed per prison complainant (2013/14)	Number of complainants	% of complainants	Number of complaints	% of complaints
11 and above	10	1%	123	7%
6 to 10	13	1%	92	5%
2 to 5	210	15%	521	28%
1	1,145	83%	1,145	61%
Total	**1,378**	**100%**	**1,881**	**100%**

Prisons fatal incident investigations started in 2013–14

Prisons	Natural	Self-inflicted	Other non-natural*	Homicide	Awaiting classification	Total
Isle of Wight	12	1	0	0	0	13
Preston	8	1	0	0	0	9
Holme House	6	2	0	0	0	8
Sheppey cluster	5	2	0	0	0	7
Hewell	1	4	0	0	1	6
Leeds	3	3	0	0	0	6
Norwich	4	2	0	0	0	6
Wakefield	6	0	0	0	0	6
Cardiff	2	2	0	1	0	5
High Down	4	0	1	0	0	5
Liverpool	3	1	0	0	1	5
Parc	4	0	0	0	1	5
Woodhill	1	4	0	0	0	5
Wormwood Scrubs	1	4	0	0	0	5
Belmarsh	1	2	0	0	1	4
Birmingham	1	3	0	0	0	4
Channings Wood	3	0	1	0	0	4
Chelmsford	0	4	0	0	0	4
Exeter	2	2	0	0	0	4
Full Sutton	3	1	0	0	0	4
Leyhill	4	0	0	0	0	4
Maidstone	2	1	1	0	0	4
Northumberland	3	1	0	0	0	4
Nottingham	3	1	0	0	0	4
Ranby	2	2	0	0	0	4
Winchester	3	1	0	0	0	4
Altcourse	1	2	0	0	0	3
Brixton	2	1	0	0	0	3
Bullingdon	0	3	0	0	0	3
Dovegate	0	3	0	0	0	3
Forest Bank	1	2	0	0	0	3
Highpoint	1	2	0	0	0	3
Long Lartin	2	1	0	0	0	3
Moorland	2	1	0	0	0	3
Whatton	3	0	0	0	0	3
Wymott	0	3	0	0	0	3
Dorchester	1	1	0	0	0	2
Durham	1	1	0	0	0	2
Ford	1	1	0	0	0	2
Frankland	2	0	0	0	0	2
Glen Parva	0	2	0	0	0	2
Kirkham	2	0	0	0	0	2
Low Newton	1	1	0	0	0	2
Manchester	0	2	0	0	0	2

Prisons	Natural	Self-inflicted	Other non-natural*	Homicide	Awaiting classification	Total
Stafford	2	0	0	0	0	2
Usk and Prescoed	2	0	0	0	0	2
Wandsworth	1	1	0	0	0	2
Wealstun	1	1	0	0	0	2
Whitemoor	0	1	0	0	1	2
Bedford	0	1	0	0	0	1
Blantyre House	0	1	0	0	0	1
Blundeston	0	1	0	0	0	1
Bure	1	0	0	0	0	1
Coldingley	1	0	0	0	0	1
Dartmoor	1	0	0	0	0	1
Doncaster	1	0	0	0	0	1
Downview	0	1	0	0	0	1
Eastwood Park	1	0	0	0	0	1
Everthorpe	0	1	0	0	0	1
Featherstone	1	0	0	0	0	1
Gartree	1	0	0	0	0	1
Lancaster Farms	0	1	0	0	0	1
Lincoln	0	0	0	1	0	1
Lindholme	0	0	0	1	0	1
Littlehey	0	0	0	0	1	1
Lowdham Grange	1	0	0	0	0	1
New Hall	0	1	0	0	0	1
North Sea Camp	1	0	0	0	0	1
Pentonville	0	1	0	0	0	1
Peterborough	0	1	0	0	0	1
Portland	0	1	0	0	0	1
Risley	1	0	0	0	0	1
Spring Hill	0	1	0	0	0	1
Styal	1	0	0	0	0	1
Sudbury	1	0	0	0	0	1
Swansea	0	1	0	0	0	1
Swinfen Hall	0	1	0	0	0	1
Thameside	0	1	0	0	0	1
The Mount	0	1	0	0	0	1
Wayland	0	1	0	0	0	1

* 'Other non-natural' includes investigations where post-mortem and toxicology reports have been unable to establish cause of death.

IRC fatal incident investigations started in 2013–14

IRCs	Natural	Self-inflicted	Other non-natural*	Homicide	Awaiting classification	Total
Pennine House	1	0	0	0	0	1
Yarl's Wood	1	0	0	0	0	1

*'Other non-natural' includes investigations where post-mortem and toxicology reports have been unable to establish cause of death.

Approved premises fatal incident investigations started in 2013–14

Approved premises	Natural	Self-inflicted	Other non-natural*	Homicide	Awaiting classification	Total
Norfolk Park	0	0	2	0	0	2
Albion Street	0	0	0	1	0	1
Brighton	0	1	0	0	0	1
Cardigan House	1	0	0	0	0	1
Dickson House	1	0	0	0	0	1
Elliott House	0	0	1	0	0	1
Manor Lodge	1	0	0	0	0	1
Ozanam House	0	0	1	0	0	1
Plas-Y-Wern	0	0	1	0	0	1
Stafford House	0	0	1	0	0	1
Total	**3**	**1**	**6**	**1**	**0**	**11**

*'Other non-natural' includes investigations where post-mortem and toxicology reports have been unable to establish cause of death.

Prisons complaints completed from 1 April 2013 to 31 March 2014

Prisons	Upheld	Not upheld	Total	Uphold rate*	Population **	Upheld complaints per 100 prisoners
Frankland	33	72	105	**31%**	778	4.2
Wakefield	21	80	101	**21%**	740	2.8
Long Lartin	21	56	77	**27%**	617	3.4
Lowdham Grange	19	55	74	**26%**	916	2.1
Isle of Wight	22	38	60	**37%**	1133	1.9
Whitemoor	20	38	58	**34%**	456	4.4
Full Sutton	11	45	56	**20%**	600	1.8
Gartree	15	38	53	**28%**	706	2.1
Oakwood	16	29	45	**36%**	1597	1.0
Manchester	14	24	38	**37%**	1151	1.2
Stocken	12	26	38	**32%**	841	1.4
Ranby	9	29	38	**24%**	1091	0.8
Woodhill	16	19	35	**46%**	793	2.0
Highpoint North and South	8	26	34	**24%**	1321	0.6
Swaleside	10	22	32	**31%**	1110	0.9
Garth	12	19	31	**39%**	666	1.8
Lindholme	7	24	31	**23%**	1002	0.7
Dovegate	17	11	28	**61%**	1108	1.5
Whatton	9	17	26	**35%**	837	1.1
Lincoln	11	14	25	**44%**	699	1.6
Northumberland	9	16	25	**36%**	1345	0.7
The Mount	7	18	25	**28%**	768	0.9
Bullingdon	13	11	24	**54%**	1095	1.2
Wayland	4	20	24	**17%**	986	0.4
Hewell	13	10	23	**57%**	1274	1.0
Onley	7	13	20	**35%**	676	1.0
Parc	6	14	20	**30%**	1348	0.4
Featherstone	4	16	20	**20%**	674	0.6
Sudbury	12	7	19		588	2.0
Rye Hill	9	10	19		626	1.4
High Down	2	16	18		1124	0.2
Wandsworth	13	4	17		1574	0.8
Moorland Hatfield	8	9	17		1259	0.6
Nottingham	7	10	17		1093	0.6

Prisons	Upheld	Not upheld	Total	Uphold rate*	Population **	Upheld complaints per 100 prisoners
Ford	6	11	17		516	1.2
North Sea Camp	5	12	17		395	1.3
Guys Marsh	3	14	17		564	0.5
Huntercombe	3	14	17		408	0.7
Wolds	3	14	17		367	0.8
Risley	7	9	16		1094	0.6
Altcourse	6	10	16		1122	0.5
Brixton	2	14	16		772	0.3
The Verne****	2	13	15			
Littlehey	5	9	14		1110	0.5
Bure	2	12	14		618	0.3
Pentonville	6	7	13		1311	0.5
Elmley	4	9	13		1243	0.3
Erlestoke House	3	10	13		487	0.6
Haverigg	3	10	13		626	0.5
Dartmoor	8	4	12		648	1.2
Blundeston***	7	5	12			
Leyhill	2	10	12		506	0.4
Leeds	9	2	11		1214	0.7
Winchester	6	5	11		657	0.9
Coldingley	5	6	11		510	1.0
Buckley Hall	4	7	11		445	0.9
Belmarsh	7	3	10		875	0.8
Rochester	5	5	10		732	0.7
Hull	4	6	10		758	0.5
Stoke Heath	4	6	10		632	0.6
Holme House	3	7	10		1209	0.2
Peterborough	3	7	10		947	0.3
Wymott	7	2	9		1097	0.6
Norwich	4	5	9		764	0.5
Isis	3	6	9		616	0.5
Channings Wood	4	4	8		720	0.6
Durham	4	4	8		925	0.4
Forest Bank	4	4	8		1449	0.3
Leicester	4	4	8		372	1.1
Thameside	4	4	8		886	0.5
Everthorpe	3	5	8		684	0.4

Prisons	Upheld	Not upheld	Total	Uphold rate*	Population **	Upheld complaints per 100 prisoners
Grendon / Springhill	3	5	8		537	0.6
Liverpool	3	5	8		1266	0.2
Wealstun	3	5	8		811	0.4
Wormwood Scrubs	3	5	8		1247	0.2
Holloway	7	0	7		513	1.4
Doncaster	3	4	7		1143	0.3
Usk and Prescoed	3	4	7		503	0.6
Ashfield	0	7	7		387	0.0
Foston Hall	1	5	6		290	0.3
Maidstone	1	5	6		587	0.2
Bedford	2	3	5		480	0.4
Bronzefield	1	4	5		486	0.2
Swinfen Hall	3	1	4		585	0.5
Bristol	2	2	4		593	0.3
Chelmsford	2	2	4		580	0.3
Stafford	2	2	4		731	0.3
Wellingborough***	2	2	4			
Thorn Cross	0	4	4		310	0.0
Portland	3	0	3		572	0.5
Lewes	1	2	3		673	0.1
Kingston***	0	3	3			
Kirklevington	0	3	3		292	0.0
Birmingham	1	1	2		1434	0.1
Dorchester***	1	1	2			
Exeter	1	1	2		547	0.2
Feltham	1	1	2		616	0.2
Hollesley Bay	1	1	2		430	0.2
Lancaster Farms	1	1	2		400	0.3
Low Newton	1	1	2		312	0.3
Shepton Mallet***	1	1	2			
Standford Hill	1	1	2		459	0.2
Warren Hill	1	1	2		46	2.2
Aylesbury	0	2	2		404	0.0
Canterbury***	0	2	2			
Cardiff	0	2	2		801	0.0
Drake Hall	0	2	2		313	0.0
Kirkham	0	2	2		626	0.0

Prisons	Upheld	Not upheld	Total	Uphold rate*	Population **	Upheld complaints per 100 prisoners
New Hall	0	2	2		409	0.0
Northallerton***	0	2	2			
Preston	0	2	2		699	0.0
Swansea	0	2	2		442	0.0
Bullwood Hall***	1	0	1			
Eastwood Park	1	0	1		339	0.3
Blantyre House	0	1	1		121	0.0
Downview	0	1	1		0	
Glen Parva	0	1	1		657	0.0
Reading***	0	1	1			
Send	0	1	1		270	0.0
Shrewsbury***	0	1	1			
Styal	0	1	1		428	0.0

* Only given when 20 or more complaints have been completed.
** *Prison Population Bulletin – Monthly, March 2014,* Ministry of Justice.
https://www.gov.uk/government/publications/prison-population-figures-2014
*** No population data is given as these prisons are now closed.
****Since March 2014, The Verne has only held immigration detainees.

IRC complaints completed from 1 April 2013 to 31 March 2014

IRCs	Upheld	Not upheld	Total	Population*	Upheld complaints per 100 detainees
Colnbrook	3	7	10	353	0.8
Morton Hall	5	4	9	351	1.4
Dover	5	1	6	256	2.0
Harmondsworth	2	4	6	629	0.3
Brook House	2	3	5	357	0.6
Campsfield House	0	1	1	92	0.0
Yarl's Wood	0	1	1	303	0.0

**Detention data tables – immigration statistics, October to December 2013,* Home Office.
https://www.gov.uk/government/collections/immigration-statistics-quarterly-release

Probation complaints completed from 1 April 2013 to 31 March 2014

Probation Trusts	Upheld	Not upheld	Total
Merseyside	0	3	3
Staffordshire and West Midlands	0	3	3
Greater Manchester	1	1	2
London Probation Area	2	0	2
Wales	1	1	2
Avon & Somerset	0	1	1
Derbyshire	1	0	1
Devon & Cornwall	0	1	1
Gloucestershire	0	1	1
Hampshire	1	0	1
Humberside	0	1	1
Norfolk & Suffolk	0	1	1
North Yorkshire	0	1	1
Northamptonshire	1	0	1
South Yorkshire	1	0	1

Category of complaints completed from 1 April 2013 to 31 March 2014

Complaint category	Upheld	Not upheld	Total	Uphold rate*
Property	281	222	503	56%
Adjudications	59	149	208	28%
Administration	62	136	198	31%
Categorisation	22	101	123	18%
Staff behaviour	31	78	109	28%
Work and pay	24	74	98	24%
Incentives and earned privileges	17	75	92	18%
Regime	20	59	79	25%
Home detention curfew	8	69	77	10%
Letters	27	50	77	35%
Money	32	40	72	44%
Visits	11	31	42	26%
Transfers	4	36	40	10%
Security	8	28	36	22%
Accommodation	10	16	26	38%
Prisoners	6	19	25	24%
Resettlement	9	16	25	36%
Phone calls	6	18	24	25%
Probation	9	15	24	38%
Food	6	15	21	29%
Equalities	2	12	14	
Parole	1	8	9	
Medical	3	3	6	
Miscellaneous	3	3	6	
Legal	1	4	5	
Escorts	1	1	2	

*Only given when 20 or more complaints have been completed.

Financial data

Finance	2012/13	% of total (12/13)	2013/14	% of total (13/14)	Change 12/13–13/14	% change year on year
Budget allocation	£5,180,000		£5,144,000		-£36,000	-1%
Staffing costs	£4,611,947	94%	£4,695,365	92%	£83,418	2%
Non-staff costs	£298,635	6%	£388,433	8%	£89,798	30%
Total spend	**£4,910,582**	**100%**	**£5,083,798**	100%	**£173,216**	**4%**

All figures exclude depreciation and therefore differ from those presented in the PPO annual report 2012–13.

Finance	2012/13	% of total (12/13)	2013/14	% of total (13/14)	Change 12/13-13/14	% change year on year
Staff costs	£4,611,947	94%	£4,695,365	92%	£83,418	2%
IT and telecoms	£73,041	1%	£98,394	2%	£25,353	35%
Staff travel	£92,342	2%	£102,993	2%	£10,651	12%
Learning and development	£45,860	1%	£122,145	2%	£76,285	166%
Legal advice and translations	£50,593	1%	£29,265	1%	-£21,328	-42%
Stationery and office supplies	£28,242	1%	£21,111	<1%	-£7,131	-25%
Publications and research	£8,185	<1%	£14,525	<1%	£6,340	77%
Other	£372	<1%	£0	0%	-£372	-100%
TOTAL	**£4,910,582**	**100%**	**£5,083,798**	**100%**	**£173,216**	**4%**

All figures exclude depreciation and therefore differ from those presented in the PPO annual report 2012–13.

The staff costs figure now represents the costs of all permanent, fixed-term and fee-paid staff and so a separate 'external support' line is no longer needed.

Stakeholder feedback

Feedback from stakeholders is essential to understanding levels of satisfaction with the work of the Ombudsman and to support the delivery of a high quality service. In line with our stakeholder strategy, feedback from general stakeholders, bereaved families and complainants is now routinely collected. Reports of the findings of these surveys can be found on our website.

General stakeholders

- In November 2013, 179 respondents to our annual general stakeholder survey gave insight into their impressions of us and their experience of our investigations and publications in the last 12 months. Responses were received from across prison, probation and immigration services, Independent Monitoring Boards, HM Coroners, NHS England, and others.
- Two-thirds of respondents involved in fatal incident investigations and two-thirds of respondents with experience of complaints investigations felt the investigations had been quick enough or better.
- Three-quarters of respondents felt they were kept sufficiently informed during fatal incident investigations. Of those who had experience of fatal incident investigations in both 2012 and 2013, nearly 40% recognised that investigations were quicker in 2013, affirming our efforts to reduce the time taken to draft investigation reports.
- The general impressions of stakeholders remain positive: over 90% rated us as 'very' or 'quite' professional, influential, accessible, and independent. Seven out of 10 respondents rated the quality of complaints and fatal incident investigations as 'very good' or 'good'.
- Of the learning lessons publications, the End of life care thematic was most widely read by stakeholders, with nearly 90% finding the publication 'quite' or 'very' useful. The Use of restraints bulletin was also widely read and nearly three-quarters of those who read it, found it useful.

Bereaved families

- A questionnaire is sent to bereaved families at the same time as the final fatal incident investigation report. This data is analysed on a bi-annual basis and the current survey period will end in March 2015.
- Responses in 2011–13 highlighted positive perceptions of our family liaison officers and that the majority of families believed that our investigation helped them understand the events surrounding the death. The majority of families reported high levels of satisfaction with the investigation and subsequent reports.

Complainants

- Nearly a thousand paper questionnaires have been sent out to complainants. Each month a sample of complainants whose cases have been closed in the previous month are selected. The sample is split between cases which were upheld, those which were not upheld and those which were not eligible for investigation.
- The first year's data covers complaints completed between October 2012 and September 2013. We received 344 responses and a full report into the results was published on our website in April 2014.
- Word of mouth was the main way complainants learned about us.
- Levels of satisfaction with us were closely related to the outcome of the complaint. Seven out of 10 complainants whose complaint had been upheld felt we had

taken their complaint seriously and a similar proportion felt the investigation was fair. By comparison, when the complaint was not upheld, just two out of 10 complainants felt their complaint was taken seriously.

- Seven out of 10 of those whose complaint was upheld said their expectations were met in full or in part.
- Looking beyond the outcome of the complaint, communication was key. Satisfaction and confidence in the investigation appeared to be closely related to the communication between us and the complainant.

Post investigation

- In early 2014, we began a new way of collecting feedback from stakeholders involved in our fatal incident investigations.
- The post investigation survey collects feedback from the prison liaison officer, Governor, head of healthcare and coroner at the end of each investigation. Rather than the overview provided by the general stakeholder survey, this online questionnaire asks for experience of a single case and is specific to that investigation. The survey is sent out by email at both draft and final report stage.
- Although the survey does not require the inquest to have taken place, some coroners may choose to wait until this stage to reply.
- We hope to publish findings from this feedback towards the end of 2014–15.

Learning lessons publications 2013–14

Learning lessons publications	Title	Publication date
Learning from PPO investigations thematic report	Making recommendations	July 2013
Learning lessons bulletin – Complaints investigations, issue 3:	Prisoner dismissal from employment	November 2013
Learning lessons bulletin – Fatal incident investigations, issue 5:	Prison homicides	December 2013
Learning lessons bulletin – Complaints investigations, issue 4:	Use of force	January 2014
Learning from PPO investigations thematic report	Prisoners' property complaints	February 2014
Learning lessons bulletin – PPO investigations, issue 2:	Immigration removal centres	March 2014

Performance against business plan 2013–14

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

	Key deliverable	Measure of success	Progress
1	Support the Parliamentary process to secure a statutory footing for the PPO at the next legislative opportunity	Consideration in the next relevant Bill with resultant change in law	Not achieved No legislative opportunity has been identified despite support in principle from the Justice Secretary.
2	Agree a review of the PPO's ToR that enhances our independence and clarifies our remit and operational scope by end March 2014	Agreed ToR [as endorsed by Ministers and the PPO]	Ongoing A suggested redraft has been submitted to MoJ officials and work will continue to deliver a final draft for consultation and then sign-off by Ministers in 2014–15.
3	Work with MoJ officials to ensure the move of the PPO's office to a location that maintains our actual and perceived independence by December 2013	Delivered to the satisfaction of the PPO	Achieved We successfully secured an office location that cemented our independence by housing us separately from those we investigate and relocated in November 2013.
4	Increase stakeholders' assurance in the office's independence	Improved response to independence question in annual stakeholder survey to be conducted November 2013.	Achieved Over 90% of respondents considered us an unbiased, fair and impartial organisation.

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

	Key deliverable	Measure of success	Progress
1	Ensure appropriately funded extension of the PPO's remit to include the investigation of: • complaints in secure training centres (STCs) • fatal incidents in secure children's homes (SCHs) • serious self-harm incidents in prison custody	Agreed additions to ToR [as endorsed by Ministers and the PPO]	Partly achieved The extension of our remit to include the investigation of complaints from STCs has been formally added to our Terms of Reference. The agreement for us to investigate deaths in SCHs is being implemented. NOMS have deferred discussions about investigating serious self-harm incidents, to 2014–15.
2	Seek feedback on the PPO's performance through post-investigation and annual surveys of complainants and other stakeholders	Delivered to time and quality [as endorsed by the PPO]	Achieved In addition to our annual stakeholder feedback exercise, regular feedback is now sought from complainants, bereaved families and coroners.
3	Develop a method of seeking feedback from stakeholders on the quality and timeliness of complaint investigations by July 2013	Delivered to time and quality [as defined by the project plan timelines and endorsed by the PPO]	Not proceeded with A separate feedback survey for complaint stakeholders proved impractical, but they can comment through the annual stakeholder and complainant surveys.

4	Publish stakeholder feedback findings and action plan on the PPO website by March 2014	Delivered to time and quality [as defined by the project plan timelines and endorsed by the PPO]	**Achieved** All feedback findings have been published on our website with actions incorporated into the business plan 2014–15.
5.	Produce an annual report for April 2012 to March 2013 for publication in September 2013	Delivered to time and quality [as defined by the publication timelines and endorsed by the PPO]	**Achieved** Published on 17 September 2013.
6.	Engage with stakeholders according to the PPO's stakeholder engagement plan, incorporating the communications plan and media strategy, with quarterly review of progress	Delivered to time and quality [as defined by the stakeholder management action plan, supported by stakeholder feedback and endorsed by the PPO]	**Achieved** Increased national and specialist media engagement, including regular learning lessons articles published in *Inside Time*. The dedicated website was maintained.
7.	Ensure up-to-date Memoranda of Understanding with all key stakeholders to encourage effective joint working by end of March 2014	Delivered to time and quality [as endorsed by the PPO]	**Achieved** MoUs agreed with: • YJB • Home Office Immigration Enforcement • HM Inspectorate of Prisons • MoJ ICT **Ongoing** MoUs in progress with: • DfE • HM Inspectorate of Probation • IPCC • CPIG/HSE

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

	Key deliverable	Measure of success	Progress
1	Apply a continuous improvement approach to PPO investigation methodology in order to produce a proportionate and efficient investigation process and to improve staff engagement, which enables the PPO to meet both stretching timelines and a high quality standard, by end March 2014	Delivered to time and quality [as measured by the project plan for the organisational redesign process and endorsed by the PPO]	Ongoing Lean methodology applied to the investigation process in November 2013 with a focus on reducing the complaints backlog. Early improvements achieved.
2	Improve the quality of investigation reports through the development and application of improved quality assurance procedures by end March 2014	Delivered to time and quality [as measured by the project plan for the organisational redesign process and improved feedback through the surveys from stakeholders]	Achieved The introduction of lean methods, a more proportionate approach to investigation and a new more specialist team structure has improved quality assurance. Positive stakeholder feedback on quality.
3	Achieve year on year improvement in casework performance and quality for both complaints and fatal incident investigations, irrespective of demand, by end March 2014	Delivered to time and quality [as endorsed by the PPO]	Ongoing See detail of progress below.

Complaints			
4	Determine the eligibility of complaints within 10 working days of receipt by the office	At least 80% delivered to time and quality [as indicated by management information and endorsed by the PPO]	**Not achieved** 63% were delivered in time in 2013–14. Our office re-location caused a delay in receipt of re-directed post, which had a detrimental impact.
5	Provide a substantive reply to complaints within 12 weeks of accepting the complaint as eligible	At least 60% delivered to time and quality [as indicated by management information and endorsed by the PPO]	**Not achieved** 29% were delivered on time in 2013–14. However, since introducing lean methods, a new backlog strategy and a dedicated backlog team in November 2013, 87% of new cases have been on time and 73% of backlog cases have been delivered within 12 weeks of allocation.
6	Design and implement time-bounded strategies to reduce the backlog of unallocated complaints cases and improve overall timeliness	Delivered to time and quality [as endorsed by the PPO]	**Achieved** Action plan agreed and followed with monthly monitoring.
Fatal incidents			
7	Complete the investigation into self-inflicted death and distribute the draft report for consultation within 26 weeks of initial notification	At least 70% delivered to time and quality [as indicated by management information and endorsed by the PPO]	**Achieved** The target was significantly exceeded with 87% delivered on time 2013–14.
8	Complete the investigations into deaths due to natural causes and distribute the draft report for consultation within 20 weeks of initial notification	At least 70% delivered to time and quality [as indicated by management information and endorsed by the PPO]	**Achieved** The target of was significantly exceeded with 95% delivered on time 2013–14.

9	Publish anonymised fatal incident investigation reports on the PPO website within eight weeks of conclusion of HM Coroner's inquest	At least 70% delivered to time and quality [as indicated by management information and endorsed by the PPO]	Not achieved 347 anonymised reports were published on the website 2013–14.
10	Work with the NHS to ensure improved quality and timeliness of clinical reviews by end March 2014	Delivered to time and quality [as endorsed by the PPO]	Achieved The agreed arrangements have delivered better quality and more timely clinical reviews.

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

	Key deliverable	Measure of success	Progress
1	Support improvements in the performance of investigated bodies as a result of investigations	High acceptance of recommendations by the investigated bodies as indicated following the production of the final reports; and high implementation of PPO recommendations as measured by HM Inspectorate of Prisons on the Ombudsman's behalf during their inspections	Achieved The Recommendations thematic published in July 2013 found that 97% of our recommendations were accepted by the investigated body (almost 100% in the case of complaint recommendations). Qualitative feedback on progress against recommendations continues to be received from HM Inspectorate of Prisons.
2	Promote timely learning from individual investigations through the publication of themed quarterly *Learning lessons bulletins* for both fatal incidents and complaints investigations	Delivered to time and quality [as measured by the agreed publication timelines and the PPO's endorsement]	Achieved 4 bulletins were published in 2013–14.

3	Share wider learning from individual investigations through the publication of Learning lessons thematics based on longitudinal statistical analysis	Delivered to time and quality [as measured by the respective project plan timelines and the PPO's endorsement]	Achieved 2 thematics were published in 2013–14.
4	Identify topics for learning lessons analysis through internal and external consultation on learning lessons themes by February 2014	Delivered to time and quality [as endorsed by the PPO]	Achieved Consultation completed.

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

	Key deliverable	Measure of success	Progress
1	Complete a redesign of the organisation ensuring it provides structural support to performance improvement and delivers the required cost reductions	Delivered to time and quality [as measured by the organisational redesign timelines and the PPO's endorsement]	Achieved Restructure completed and cost reductions delivered.
2	Hold quarterly full staff meetings in order to support strategic and organisational change and share learning across the office	Delivered to time and quality [as measured by positive feedback on staff evaluation forms]	Achieved Full staff meetings held in June and September 2013 and February 2014. The office relocation in November 2013 meant a fourth full staff meeting could not be timetabled.
3	Conduct a survey of staff views of their workplace by November 2013 and devise an action plan in response to concerns	Delivered to time and quality [as measured by the level of response to the survey]	Achieved Staff engagement survey completed and action plan put in place.

	Key deliverable	Measure of success	Progress
4	Implement the PPO's equality and diversity action plan	Delivered to time and quality [as measured through quarterly monitoring by the Equality and Diversity (E&D) Group and positive response to the staff diversity survey]	Achieved The E&D group, chaired by the Ombudsman, meets quarterly and ensures delivery against the E&D action plan. E&D issues are a standing agenda item at team, senior management and full staff meetings.
5	Implement the PPO's learning and development action plan	Delivered to time and quality [as measured through improved response to the staff survey on development opportunities]	Achieved New investigators must attend bespoke investigator training. Other cross-office training priorities have been identified and pursued. Individual learning and development needs are discussed with line managers.
6	Continue to review all internal policies/guidance to ensure cross-office coverage	Delivered to time and quality [as endorsed by the PPO and the E&D Group]	Ongoing Programme of review is continuing into 2014–15.
7	Ensure the MoJ IT operating system is fully operational post-transfer	Delivered to time and without impact on the case management function of the office [as endorsed by the PPO]	Ongoing Transfer to a new IT platform was successfully completed 29 July 2013 with few IT issues post-transition.

	Key deliverable	Measure of success	Progress
8	Investigate and design a new case management system to be in place by end March 2014	Delivered to time and quality [as endorsed by the PPO]	Ongoing A market testing process was completed by end October 2013. A bid for funds for a replacement system was unsuccessful. This remains a priority to be pursued 2014–15.
9	Produce a business plan for the PPO 2014–15 and a new strategic plan 2014–17 by March 2014	Delivered to time and quality [as endorsed by the PPO]	Achieved Plans drafted, consulted on and published.

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[7] and the Youth Justice Board.[8] 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[9]

7 Now Home Office Immigration Enforcement

8 NOMS (including HM Prison Service and Probation Services in England and Wales), Youth Justice Board and Home Office Immigration Enforcement are referred to throughout the Terms of Reference as 'the authorities'.

9 Now Department for Education

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. 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) trainees in secure training centres who have failed to obtain satisfaction from the STC 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 trainees in secure training

centres, by prison custody officers, Youth Justice Board staff or by people acting as agents or contractors of the Youth Justice Board in the performance of their statutory functions including contractors and those not excluded by paragraph 14;

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

    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 (PCT) 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 PCT 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 PCT 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 *(left 30 June 2013)*

Dionne Spence *(left 30 June 2013)*

Nick Woodhead

Strategic Support Team

Durdana Ahmed

Mark Chawner

Catherine Costello

Dan Crockford (Team Leader)

Rowena De Waas

Lydia Gyekye

Henry Lee

Esther Magaron

Susan Mehmet (Admin Staff Manager)

Tony Soroye

Alison Stone *(left 28 February 2014)*

Ibrahim Suma

Learning Lessons Team

Sarah Colover

Sue Gauge (Team Leader)

John Maggi

Samantha Rodney

Helen Stacey

Craig Weeks (left 27 February 2014)

Complaints Assessors

Veronica Beccles

Sarah Buttery

Antony Davies

Agatha Eze

Matthew Fisher *(left 28 February 2014)*

David Gire-Mooring

Emma Marshall

Chris Nkwo

Tayo Olaitan *(left 4 October 2013)*

Melissa Thomas

Family Liaison Officers

Narinder Dale

Abbe Dixon

Laura Spargo

Laura Stevenson *(left 19 October 2013)*

Seema Vishram *(started 5 March 2014)*

Senior Investigators and Investigators

Sharon Adonri
Terry Ashley
Georgina Beesley *(started 21 October 2013)*
Tamara Bild
Claire Bond *(left 22 November 2013)*
Tracey Booker
Nicole Briggs *(started 29 April 2013)*
Simon Buckley *(started 31 March 2014)*
Timothy Byrom *(started 29 May 2013)*
David Cameron
Karen Chin
Althea Clarke-Ramsey
Debbie Clarkson
Akile Clinton *(started 6 January 2014)*
Vicki Cole
Paul Cotton
Joseph Cottrell-Boyce *(started 31 March 2014)*
James Crean
Lorenzo Delgaudio
Rob Del-Greco
Peter Dixon *(started 12 August 2013)*
Nick Doodney
Angie Dunn
Susannah Eagle
Kevin Gilzean
Alan Green *(left 31 December 2013)*
Christina Greer
Rachel Gyford
Helena Hanson
Diane Henderson
Siobhan Hillman
Joanne Howells
Ruth Houston *(left 30 April 2013)*
Joanne Hurst
Katherine Hutton
Mark Judd
Razna Khatun
Madeleine Kuevi
Lisa Lambert
Karl Lane *(started 4 November 2013)*
Anne Lund
Steve Lusted
Steve McKenzie
Beverly McKenzie-Gayle
Eluned Malone *(started 6 January 2014)*
Sonja Marsh *(started 6 November 2013)*
Kirsty Masterton
Ruby Moshenska *(started 30 September 2013)*
Anita Mulinder
Amanda O'Dwyer
Caroline Parkes *(started 4 November 2013)*
Claire Parkin
Katherine Pellatt *(started 25 November 2013)*
James Peters *(started 9 December 2013)*
Jade Philippou
Amy Powell *(started 4 November 2013)*
Ben Rigby *(left 15 July 2013)*
Rachel Rodrigues *(started 23 September 2013)*
Jessica Rule *(started 6 January 2014)*
Rebecca Sanders
Andrea Selch
Anna Siraut
Sarah Stolworthy
Rick Sturgeon
Tina Sullivan
Paul Televantou *(started 22 April 2013)*
Jonathan Tickner
John Unwin
Louisa Watkins *(left 31 August 2013)*
Karl Williamson
Jane Willmott


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