Introducing the Prisons and Probation Ombudsman for England and Wales

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Alternatives to imprisonment: identification and exchange of good practice
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Agenda

• History
• Role and vision
• Independence
• Staff and resources
• Complaint investigations
• Fatal incident investigations
• The future
History of PPO

• Following prison riots in 1990, a judicial inquiry said part of cause was lack of prisoner confidence in complaint processes and lack of any independent adjudication

• To restore legitimacy, an independent prison Ombudsman was established in 1994
  – In 2006, role expanded to complaints from offenders on probation and immigration detainees

• In 2004, in response to Article 2 ECHR, responsibility for investigating all deaths in prison added
  – In 2006, deaths in immigration detention and probation hostels added
Role and vision

• Independent investigation of:
  – Complaints by prisoners, young people in detention, immigration detainees and offenders on probation
  – Deaths of prisoners, young offenders, immigration detainees and offenders living in probation hostels

• Vision:
  – To carry out independent investigations to make custody and community supervision safer and fairer
Independence

• The boundaries of independence must be patrolled
  – Ombudsman a “public appointment” approved by Parliament (staff are civil servants)
  – Published Terms of Reference (administrative)
  – Completely separate from services investigated
  – Budget “sponsored” by Ministry of Justice/Home Office
  – Unfettered access to people, places and records, and of publication (but no legal duty to cooperate)
Staff and resources

• I am the 4th Ombudsman and was appointed in 2011
• I have a budget of around £5 million (Euro 8m)
• I have over 100 staff
  – 3 Deputy Ombudsman
  – 9 Assistant Ombudsman
  – 29 Fatal Incidents Investigators
  – 3 Family Liaison Officers
  – 35 Complaint Investigators
  – 25 Assessors, support staff, including 3 researchers
Jurisdiction

- England and Wales
- 140 public and (13) private prisons
  - 85,700 prisoners
- 11 public and (8) private immigration removal centres
  - 3,500 detainees
- National Probation Service
  - 30,000 high risk offenders
- 21 Community Rehabilitation Companies (private\voluntary\social)
  - 200,000 low/medium risk offenders
- 101 Approved Premises
  - 2,000 residents
Complaints
Why is an independent element in complaints important?

- Article 3 ECHR
- Allow legitimate means to ventilate concerns
- Help prevent unfairness
- Provide redress
- BUT also assure public about staff behaviour
- Encourage learning of lessons – avoid future complaints
Numbers

• Apex of system
  – PPO deals with only about 1% of complaints in prison
• 5000 complaints received in 2014-5 (up 2%)
• About 50% eligible for investigation
  – Must exhaust internal complaint system
  – Must complain within 3 months of end of internal process
  – Must be within remit
• 2400 investigations 2014-15 (up 13%)
• Investigation targets
  – Assess complaints within 10 working days
  – Investigate within 12 weeks
  – Serious complaints 20 weeks.
Complaints: issues

- Most complaints (97%) from prisoners
  - 27% from long term and high security prisoners
  - 2% complaints from probation
  - 1% from immigration detainees
- Juveniles, women and those on short-sentences rarely complain
- Huge range of complaints from assaults by staff (0.2%), other staff behaviour (2%), administration (9%), adjudications (7%) and property (28%)
Complaints: outcomes

- 39% upheld in favour of complainant (up 4%)
  - Of which 13% mediated
- Local and national recommendations
  - Apology
  - Compensation
  - Policy change
  - Disciplinary action against staff
- 99% accepted
- Action plans for improvement
Fatal incidents
Why independent investigations of fatal incidents?

- Article 2 ECHR
- Establish circumstances and good/bad practice
- Give answers to bereaved families
- Assist coroner
- Improve safety in custody by encouraging learning of lessons
Fatal incidents: issues

• I investigated 250 deaths in 2014-15:
  – 155 (62%) natural causes
  – 76 (30%) self-inflicted
  – 4 (2%) homicide
  – 15 (6%) other (mainly drug related)

  – 241 in prison
  – 7 in probation hostels
  – 2 in immigration detention
Fatal incidents: outcomes

• Bereaved families central to investigation
  – consulted and involved
  – supported by Family Liaison Officers

• Local and national recommendations
  – 99% accepted - if rejected, Head of service writes personally to the Ombudsman
  – Action plans required
  – Recommendations followed up by inspectors
Learning Lessons

• Since appointment I have placed a new emphasis on encouraging services to learn lessons from investigations
• Aim: avoid preventable deaths and avoid the next complaint
• Thematic studies 2016 (on web-site):
  – Mental health of prisoners (January 2016)
  – Deaths in the early days in custody (February 2016)
  – Complaints of assault by prisoners (March 2016)
  – Dementia among prisoners (March 2016)
The future

More complaints

• Highest prison population per head in EU (148 per 100,000)
• More long-term prisoners
• More to complain about?
  – 28% reduction in prison staff
  – Reductions in regime
  – Radical reform of probation
• Less legal aid – more use of Ombudsman
The future

More deaths

• More deaths from natural causes
  – Prisoners ageing: 12,000 over 50; 4000 over 60
  – Fastest growing segment of prison population over 60
  – Longer sentences and late in life prosecutions for historic sex offences

• Sharp 30% increase in suicide and doubling of homicides 2015-16
  – Mental ill-health
  – New psychoactive substances (“legal highs”)
  – Stresses in system
The future

- No sign of reduction in complaints or deaths
- No sign of reduction in demand for independent investigations
- But reduction in resources
- Need for smarter investigations and more thematic learning
- And the *audacity of hope* that lessons from investigations will be learned, and complaints and preventable deaths avoided