

Learning from the Ombudsman's reports

Every Ombudsman office has two main aims. First, to carry out independent investigations on the part of members of the public who believe they have been treated unfairly by public authorities or powerful private interests. And second, to identify ways in which the problems that have arisen in one case can be prevented from occurring again.

This second part of the agenda sometimes goes under the name 'Learning the Lessons', and I am proud to say it is a core element of the public value delivered by the Prisons and Probation Ombudsman's office. We do so by ensuring that our formal recommendations to the three services we oversee are properly

focussed, and that their implementation is followed up. In addition, we try to use all possible vehicles to share insights from investigations: whether through publications like *On the Case*, via our website, or by contributing to conferences and training events.

Wherever possible, we like to share the lessons in a collaborative way. We have an excellent relationship with the NOMS Safer Custody and Policy Group – whose functions embrace both fatal incidents and the policy areas that arise in connection with much of our complaints work. I am also especially pleased by the partnership we have recently entered into with the NHS National Patient Safety Agency. The NPSA is now receiving all our fatal incident reports and clinical reviews and this has greatly increased the reach and influence of our investigations into deaths from natural causes. As I have pointed out on other occasions, the archive of fatal incident reports on our website is a unique resource.

Its importance will continue to grow as the number of published reports begins to approach 1,000.

The PPO's complaints work generates important learning too. However, because the volume of complaints investigations is so much higher than the number of fatal incidents, and because our default position is to try to settle the complaint informally, it is more difficult to ensure that the lessons are disseminated effectively. We are looking at how we can do this better. Establishing more of a presence in those jails that generate the most complaints is one of the ways forward.

For the last year or so, the Ministry of Justice has also been exploring how best to integrate findings from the Ombudsman's investigations into a 'regulatory framework' for the National Offender Management Service (NOMS). (It has been asking the same question of the inspection reports from HM Chief Inspectors of Prisons and Probation and the annual reports of each prison's Independent Monitoring Board.) Achieving this objective while respecting the independent status of the PPO, the Inspectorates and IMBs is not straightforward. But the objectives of informing policy decisions and enabling a more rounded judgement of NOMS' performance are ones with which we can identify.

Stephen Shaw



The Prisons and Probation Ombudsman's mission is to deliver two services contributing to a just and humane penal system. First, providing prisoners, detainees, and those under community supervision with an independent and effective means to resolve their complaints; second, conducting high quality investigations of deaths in custody and other deaths in remit.

Unproven adjudications stay off the record

Mr A complained about details of a dismissed adjudication being disclosed to the Parole Board.

The Investigator examined Chapter 5 of Prison Service Order (PSO) 6000 (Parole, Release and Recall) which specifically deals with the discretionary conditional release (DCR) scheme. Paragraph 9 of Appendix G of Chapter 5 states, "*Other than in exceptional circumstances, any unproven adjudications, or adjudications which have subsequently been quashed, must not be included in the dossier.*" In the case of PSOs, instructions given in italics are compulsory and must be followed.

The Ombudsman was satisfied that the prison had not complied with the requirements of Chapter 5, the purpose of which was to remove a possible bias against the prisoner. Indeed, the prison had already taken responsibility for this error and had agreed to send a written apology to Mr A.

Having examined the reasons given by the Parole Board for refusing parole, the Ombudsman did not consider it at all likely that the details of the dismissed adjudication affected their decision. However, this was a matter for the Parole Board to confirm, and Mr A was entitled to approach the Board to request a special

review on the grounds that details of his dismissed adjudication were disclosed to them in error.

The Ombudsman therefore upheld the complaint and recommended that the Governor of the prison should issue Mr A with a written apology; that Mr A's Personal Officer should offer him assistance in making representations to the Parole Board; and, if unhappy with their decision, he should be offered further assistance in applying to the Early Release and Recall Section who would reconsider the Board's decision.

The Ombudsman also made two further recommendations. First, that the Governor of the prison should issue a notice, reminding all staff involved in the preparation of parole dossiers of the need to follow the guidance set out at Annex G. Secondly, that NOMS should consider and clarify exactly what procedures prisons should follow in removing details of unproven adjudications from the parole dossiers of determinate sentenced prisoners. A relevant notice should then be issued to all Governors. The Ombudsman asked for both of these notices to be copied to his office.

**STOP
PRESS**

Stephen Shaw, Ombudsman since 1999, will be stepping down at the end of April following his appointment as the inaugural Chief Executive of the Office of the Health Professions Adjudicator. More news in the next issue of On The Case.

Care of elderly prisoners in question

Mr W was imprisoned for one year for sexual offences. He was elderly and frail, with complex medical problems including heart disease, type two diabetes, asthma and poor hearing. Later, he developed chronic kidney disease and confusion with some loss of memory.

Four months before his release, his offender manager referred Mr W to social services in Mr W's home town for assistance with his care upon release. They said that they were unable to help, as Mr W currently resided outside their area. The offender manager also contacted Approved Premises (probation hostels) and housing associations to try to find accommodation for Mr W. However, accommodation had still not been identified by Mr W's release date.

Mr W was released from custody and met by his sister who took him to his local probation office. Eventually, the staff arranged for Mr W to spend one night in a hostel and his sister took him there. The following day a housing association placed Mr W in a hotel. A social worker assessed his care needs there three days later.

However, Mr W was admitted to hospital after saying he wanted to take his own life. He was discharged the following day but, because of his risk of self-harm, the housing association refused him accommodation. A senior offender manager revoked his licence

and he returned to prison.

He was received into custody frail, confused and in poor health. When his health deteriorated further he was admitted to hospital. A week later, Mr W was discharged back to prison. Discipline and nursing staff supported him on the wing. He then transferred to another prison for 24 hour nursing care. The following day, he returned to hospital, where he died two weeks later from multiple-organ failure.

In the investigation report, the Ombudsman wrote, "I conclude that the agencies involved in Mr W's custodial and community care failed to offer support and assistance on his release from prison. He was an elderly, frail, confused man who was released from prison with no accommodation or continuity of care."

His recommendations focussed on the care of elderly, confused prisoners; the use of electronic records in prison and the pre-release and discharge plans of vulnerable elderly prisoners.

Complaint prompts national review of PSRs

Mr X complained about the quality and content of two pre-sentence reports (PSRs) prepared by the local Probation Area, which were in respect of two different offences.

The Ombudsman was satisfied that the factual errors identified in the two PSRs were minor and caused no real detriment to Mr X. However, he was concerned that the contradictions, poor analysis and over-reliance on Mr X's bi-polar condition in the second PSR were not identified either through the quality control process (sometimes known as 'gate-keeping') or during the Probation Area's internal investigation into Mr X's complaint.

During the investigation, the investigator questioned the gate-keeping practices. Such procedures were not mandatory but were considered best practice and, if used properly, should be adequate to identify shortcomings in a PSR. However, since the process relies on the completion of tick boxes on a form, there was a danger that it would be disregarded or viewed as a paper-filling exercise.

The Probation Area was unclear whether or not these forms had been retained in respect of Mr X's PSRs. This suggested that maybe they were not being used to best

effect as the quality control measure they were intended to be. Also, unless the forms were sampled or reviewed at a more senior level, the Ombudsman was unclear how far they could improve standards across the Probation Area. Indeed, if quality control measures did not identify best practice and drive up standards, they could be viewed as merely burdensome.

The Ombudsman therefore recommended that the Chief Officer for the Probation Area should conduct a review of quality assurance procedures for PSRs, and this was accepted. The Ombudsman was hesitant to extrapolate the findings of his investigation to the Probation Service as a whole. Nevertheless, he considered that there might well be a case for a nationally approved quality assurance/gate-keeping document. The Ombudsman therefore further recommended that a copy of his report should be shared with the relevant policy lead in the National Offender Management Service.

Fatal incidents

There were 60 self-inflicted deaths in prison during 2009 – the same number as in 2008. However, taking account of the rise in the number of prisoners, the rate of self-inflicted deaths per 100,000 of the total prison population fell slightly from 73 to 72. This compares with a rate of 128 per 100,000 in 2004, when the Ombudsman's office began its independent investigations into all deaths in prison custody – a reduction of 44 per cent.

Given that one year's figures may go up or down randomly, it is usually considered more reliable to compare the three-year 'moving' average. However, this too shows a marked reduction in the rate of self-inflicted deaths in prisons – down by 34 per cent from 130 to 86.

The Ombudsman's investigators investigate deaths from all causes. Of the 44 deaths to have occurred since the last issue of *On the Case*, 28 were the result of natural causes, 12 were apparently self-inflicted, one was the result of a drug overdose in an Approved Premises (probation hostel), and three were awaiting classification.

The location of these 44 deaths is shown in the table below:

- 24 in local prisons
- 9 in category B or C training prisons
- 4 in the high security estate
- 2 in Young Offender Institutions
- 1 in an open prison
- 1 in a female prison
- 3 deaths were of residents of Approved Premises

Despite the pressure on individual fatal incident investigators, the timeliness of the Ombudsman's reports has improved significantly over the past year. A record number of reports were issued in January 2010. Of those reports that have been most seriously delayed, the vast majority involve either continuing police investigations or delays in the delivery of clinical reviews over which the Ombudsman has no control.

A review of one year's PPO fatal incident investigation reports is being published. It is the first paper of its kind by the Ombudsman's office and is based on our newly created database of investigations. It illustrates the deaths we investigate, the issues we encounter and the recommendations we make, encouraging a collective understanding of the PPO's work.

PPO research round up

We are also publishing the results of three stakeholder surveys conducted in the autumn. Separate surveys were carried out for complainants, bereaved families and stakeholders from the services in remit and elsewhere.

We received nearly 500 responses to our survey of people who had sent us a complaint. We were not surprised that complainants gave us better ratings if we had upheld their complaint. However, it was good to see that people appreciated having their issues thoroughly investigated, even if they did not get the result they were hoping for.

All families bereaved by a death in custody are offered the services of our family liaison team, but we have not asked them for feedback until now. We are very grateful to the fifty bereaved friends and family members who took part in our survey, as we now have a better understanding from the families' point of view.

Managers are considering the results, as well as those from the second annual survey of our general stakeholders, in the continuous review of our services. The reports of all the surveys will be available on the PPO website www.ppo.gov.uk.

Out Tray

- Mr Z complained that letters to the Independent Police Complaints Commission (IPCC) and the Directorate of Professional Standards at the Metropolitan Police were not treated as confidential access correspondence.

Paragraph 5 of Prison Service Order (PSO) 4411 lists the 15 bodies to which confidential access arrangements apply. These arrangements were put in place to enable prisoners to correspond with their legal advisers about any legal matters in confidence. They also allowed prisoners to contact others - including the Ombudsman - about their treatment in prison, which they might not want prison staff to know about. In the Ombudsman's view, these criteria did not apply to either the IPCC or the DPS.

It was open to Mr Z to contact the IPCC and DPS via his legal advisers, the Criminal Cases Review Commission, or his Member of Parliament - all of which were subject to confidential access arrangements. In view of this, the Ombudsman was satisfied that there were existing avenues for Mr Z to raise matters in a confidential way and he did not therefore uphold Mr Z's complaint.

- Mr B was found hanging in his healthcare cell. Staff and paramedics attempted resuscitation, and Mr B was taken to hospital. Sadly, he did not recover but died the next day. He was 31 years old.

Mr B, a recalled licensee, had been taking methadone prior to his arrival at the prison. However, the staff there did not prescribe it to him at the time. This upset Mr B and he continually complained of feeling ill. Suicide and self-harm monitoring (ACCT) procedures were opened, but Mr B continued to harm himself. Twelve days after the suicide monitoring began, Mr B was found hanging.

The main issues in the Ombudsman's investigation concerned Mr B's drug withdrawal, and the management of ACCT procedures. The report contained six recommendations and one note of good practice. The prison accepted five recommendations and responded that the prescribing of methadone was already in place.

- Mr D collapsed in his cell and was taken by ambulance to hospital. Hospital doctors told Mr D that he was terminally ill and his life expectancy was a matter of weeks. Just over three weeks later he was released on temporary licence (ROTL) and taken by ambulance to a hospice. The following day, hospice staff requested that Mr D leave the hospice as they regarded him as terminally ill but not in need of hospice care. Mr D returned to the prison healthcare centre. He continued to deteriorate and six days later he returned to the hospice. He died three days after his second admission.

In the investigation report, the Deputy Ombudsman considered it sad that a very ill man's health seemed to improve when he left prison the first time, and that he had to return from the hospice. She was sure that his subsequent return to custody was difficult and did not help the decline in his health.

- Mr A was unhappy that he had to wear restrictive clothing during visits. This was a one piece boiler suit with a zip up front and no pockets.

Mr A had been found in possession of a mobile phone, which was a prohibited item linked to the supply of drugs in prison. Following an adjudication, Mr A was informed that he would have to wear restrictive clothing during visits for a minimum of three months. This decision

would be reviewed on a monthly basis.

In order to restrict the smuggling of drugs, the prison had followed the recommendations made in the Blakey Report and introduced the wearing of restrictive clothing for prisoners found in breach of certain prison rules. This supported the security measures already in place to prevent the smuggling of any unauthorised items into the prison during visits. A 'Notice to Prisoners' had also been issued, informing them about the introduction of overalls during visits. The Ombudsman did not uphold this complaint because he considered the prison's actions to be reasonable.

- Mr K complained about being denied access to Prison Service Order (PSO) 1600 'Use of Force'.

The Investigator discussed the complaint with the National Offender Management Service's Data Access and Compliance Unit (DACU). They confirmed that, as the PSO was only accessible through the internet, the prison should print a copy of the PSO to allow Mr K access to it. On the general point of access to restricted PSOs, they said prisoners could make Freedom of Information requests for copies. Prisons should then refer the requests to DACU who would provide an edited copy, with sections removed where appropriate. DACU had the authority to withhold information under exemptions from the Freedom of Information Act, where it related to the maintenance of security and good order in prisons (section 31(1) (f)).

The prison agreed that those pages of PSO 1600 accessible on the Prison Service website would be printed and placed in library. Mr K would then be able to ask for a copy on loan. Therefore, whilst upheld this complaint, the Ombudsman made no further recommendations.

wanted

Contributions, comments and suggestions for future issues are always welcome. If you have any that you would like us to consider before the next issue, please write by mid April 2010 – marking your envelope 'On The Case' – to Ries-William Lamont (Editor) or Ruth Houston (Editor) at:

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