

Prisons and Probation Ombudsman Stakeholder Feedback 2008

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Every organisation needs to know how it is seen by those with whom it conducts its business. Sue Gauge, my Senior Research Officer, has recently carried out a wide ranging survey of stakeholders to establish what they think of us and the work we do, and what we could do better. The survey looked in detail at all aspects of our work: focussing on complaints and fatal incidents investigations, but also including more general questions about the office as a whole. This report outlines the findings.

I would like personally to thank everyone who participated in the survey. The number of responses (nearly 600 in total) has really helped us to understand what we do well and where we need to improve. I am particularly grateful to those many Governors and other senior managers who found time to complete the questionnaire we had sent them.

A particularly pleasing result concerned the professionalism of PPO staff. When respondents were asked to rate PPO on a number of characteristics, we scored most highly on this dimension with 70 per cent rating us as 'very professional'. This was reflected in specific comments about staff being polite, helpful and respectful.

However, only half as many rated PPO as 'very efficient'. It is clear that delays in completing investigations and issuing reports are seen by many stakeholders as reflecting a failure of systems and personal productivity. (For what it may be worth, my own view is that there is a resource issue here as well: I believe that the PPO office has been desperately under-funded for many years given the significance and nature of our work.) Those Coroners who took part in the survey were particularly dissatisfied with the time it takes to complete a fatal incident report through all of its stages. Although Coroners differ in the use they make of PPO investigation reports, this finding confirms the priority we have attached this year to improving relationships with the Coronial Service.

I also note that many stakeholders felt that insufficient information is provided about the progress of investigations. We can certainly do more in this regard and I will be encouraging investigators to ensure that interested parties are kept properly up to date with progress.

This report provides a detailed analysis of the responses to the survey, and reproduces a great many of the actual comments received. The issues raised have been pulled together in Appendix I, and my colleagues and I are already considering them as part of the business planning process for 2009-10 and beyond.

This is the first of three strands of stakeholder feedback being undertaken by PPO. Plans are currently being developed to solicit views from the bereaved families with whom we have worked, and from those – whether in prison, immigration detention, or in the community – who have made complaints.

Stephen Shaw
Prisons and Probation Ombudsman

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PPO Stakeholder Feedback

Executive Summary

Overall, nearly 600 questionnaires were completed, over half from operational staff – including more than 90 from Governors, Directors and Centre Managers. Over 70 IMB chairs responded, as did some 35 Coroners.

PPO investigators and other staff were praised for being professional, with many comments received about their helpful and courteous manner. The investigations were rated highly for being thorough, transparent and unbiased. Less positive ratings were received on whether investigators show a good understanding of the systems in establishments.

Lack of timeliness of investigations and reports was highlighted as an issue. This was particularly marked for fatal incidents reports, where only half the respondents thought reports were always or usually produced in a reasonable time. Coroners were particularly concerned by the delays in reports. Some respondents indicated that they would like more information about the progress of investigations or earlier disclosure of the key messages.

There were mixed views on the effectiveness of PPO recommendations. Although over half felt that recommendations always or usually lead to changes in practice, some felt that lessons had already been learned by the time the reports were received.

Respondents who had seen PPO publications generally felt they were good. Although Governors and IMB chairs often saw the PPO newsletter, *On the Case*, awareness was low amongst complaints clerks, safer custody officers and family liaison officers. Few people regularly visited the website, and it was suggested that awareness could be improved by links from the prison or probation service intranets.

The survey asked those completing it to rate how influential, impartial, professional, effective and efficient they consider PPO to be. 'Professionalism' and 'impartiality' scored highest and 'efficiency' lowest, the latter reflecting the delays in investigations and reports.

Respondents were also asked to suggest ways PPO could improve its effectiveness. Increased timeliness was by far the most commonly suggested improvement. Better communication, such as providing progress reports during investigations, having more direct contact with appropriate staff such as Safer Custody Officers, and improving staff awareness of the PPO's role were also suggested.

PPO Stakeholder Feedback

1. Aim

This report summarises the results of the first strand of a project to collect feedback from stakeholders on the work of the Prisons and Probation Ombudsman (PPO). The aim was to seek views from a wide variety of interested parties, ranging from prisoners, people on probation and immigration detainees to bereaved families and more general stakeholders.

The project aimed to identify stakeholders' perceptions of the PPO and find out what they think of PPO investigations, reports and work in general. It was also designed to establish the external profile of the PPO and what improvements could be made.

The project was split into three strands, focussing separately on the PPO's three groups of stakeholders:

- i. General stakeholders*
- ii. Prisoners, people on probation and detainees*
- iii. Bereaved families.*

This paper reports the findings of the first strand of the project: feedback from general stakeholders. The other strands of the project are currently at the planning stage.

2. Methodology

An on-line survey was chosen as the most suitable method to obtain feedback from general stakeholders. Questionnaires were designed on surveymonkey.com and email invitations were sent to as many stakeholders as possible. Any who were not accessible via email or who could not access the on-line survey were sent a postal version. The survey was carried out in November 2008. Appendix I provides more practical details of the survey.

The following frontline stakeholders were identified for the first strand of the project:

- Prison Governors / Directors / Immigration Removal Centre managers (referred to collectively as Governors in the rest of this report)
- Approved Premises managers
- Coroners
- Safer Custody Officers
- Complaints Clerks
- Family Liaison Officers.

As each of these has a unique viewpoint of the work of the PPO, questionnaires were tailor-made for each group in order to collect information from different perspectives.

It was impractical to have individual questionnaires for every different type of stakeholder, so a generic version was designed for all the other stakeholders, including:

- HMPS Area Managers and other HMPS/NOMS senior managers
- Probation Service Area Chief Officers and other senior managers
- Safer Custody Group and Area Safer Custody Advisors
- UK Board Agency (UKBA) managers involved with Immigration Removal Centres
- Offender Health / Strategic Health Authorities / Primary Care Trusts (PCTs)
- Inspectorates and Independent Monitoring Board (IMB) chairs
- Ministry of Justice (MoJ) / Home Office senior managers
- Third sector / Academia / Solicitors / Media.

3. Response rate

The on-line survey produced a very fast response, with the first replies appearing only minutes after the email invitations had been sent. The first postal replies took a few days to arrive.

Overall, by the time the survey closed (a few days after the deadline), 644 responses had been received. Some of these were incomplete where people had either had technical difficulties with the website or had intended to complete it later but never did. Table 3.1 shows the numbers received from different types of stakeholders. There were 586 responses which were either complete or partially complete. Those who answered the first question only are shown in the table as 'Barely started'.

Table 3.1 Numbers of questionnaires received from each group of stakeholders

	Completed	Partly completed	Barely started	Completed & partly completed	Total received
Governors	82	9	11	91	102
Complaints Clerks	95	2	12	97	109
Safer Custody Officers	60	0	1	60	61
Family Liaison Officers	85	10	13	95	108
Coroners	31	4	1	35	36
Approved Premises managers	20	3	1	23	24
IMB chairs	71	0	0	71	71
Related central government & agencies	52	0	0	52	52
Health	23	0	2	23	25
Other / not specified	28	11	17	39	56
Total	547	39	58	586	644

The greatest number of responses came from Complaints Clerks and Family Liaison Officers, with 109 and 108 responses respectively. Looking just at completed or partly completed questionnaires, these groups still had the highest response, with 98 and 95 responses respectively. There were 91 complete or partially complete responses from Governors.

It is difficult to indicate an overall response rate as some questionnaires were sent via other bodies (for example the Governors were contacted by NOMS Communications) so exact numbers sent are not known. Of those distributed by us, Complaints Clerks showed the best response rate at 72%. It is interesting to note the marked difference in response between the different types of prison staff. Governors, Complaints Clerks and Family Liaison Officers received the on-line survey and all showed a very good response. Safer Custody Officers were sent a postal questionnaire and showed a much lower response.

4. Findings

4.1 Complaints

Complaints investigations

A total of 212 respondents said they knew about PPO complaints investigations, including 70 Governors, 7 Approved Premises Managers, 55 IMB chairs and 45 in central government.

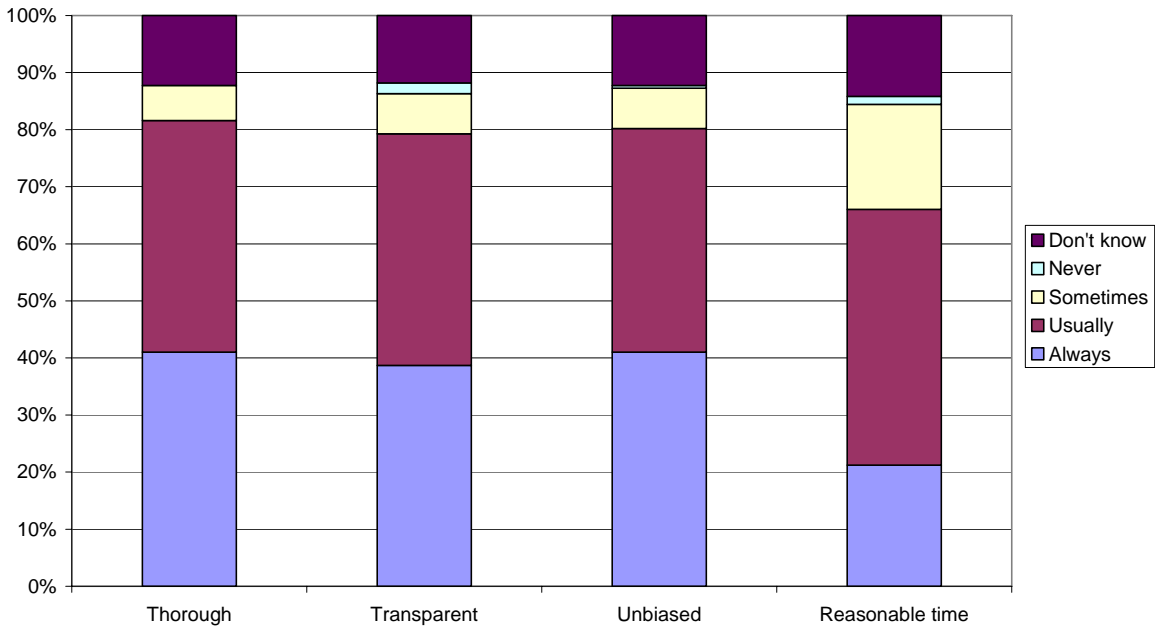
There was praise for the complaints investigations and staff, such as:

'You provide a national expertise on a miscellany of problems confronted by prisoners.'

'I always find PPO staff friendly and approachable. They invariably have a balanced view of events and are not afraid to place criticism where it is needed.'

Fig 4.1 summarises how these 212 respondents rated their experience of complaints investigations.

Fig 4.1: All respondents' views on complaints investigations (N=212)



Complaints investigations were felt *always* to be thorough, transparent and unbiased by around 40% of respondents and around 80% thought this was *always* or *usually* the case. One person thought that investigations were *never* unbiased.

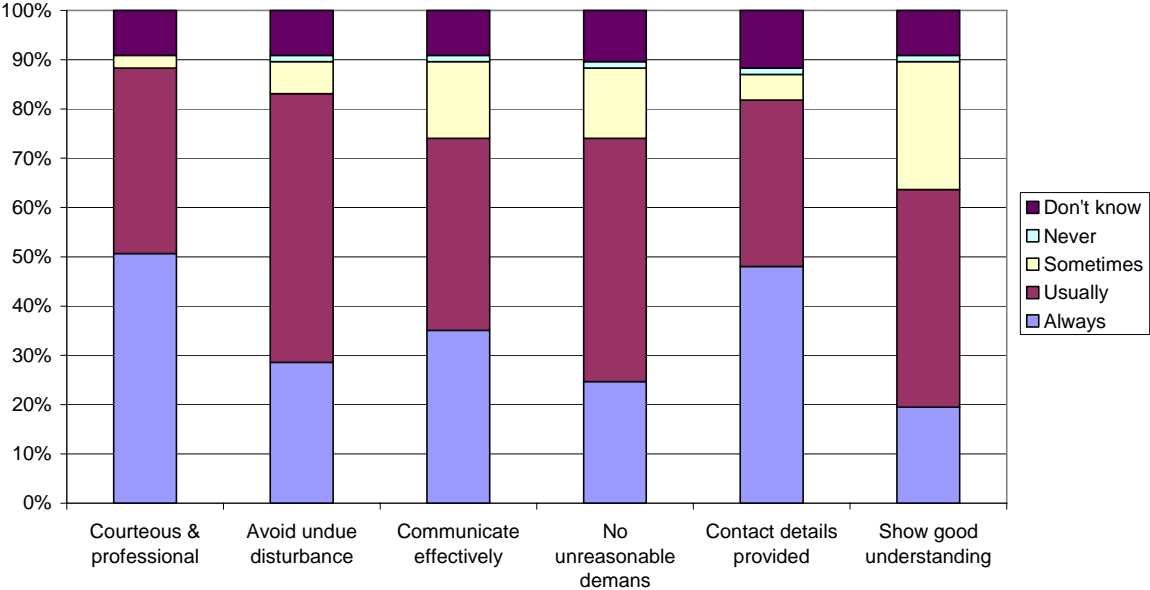
Fewer respondents felt that investigations took a reasonable length of time, with only 21% answering *always* and 66% *always* or *usually*. Three people thought they were *never* completed in a reasonable time. Many commented that investigations take too long, although as one person said: *'There is clearly a balance between the thorough nature of the reports and the time taken.'* It was felt that in cases of unavoidable delay, it would be helpful to inform interested parties of the progress of the investigation and to distribute interim reports if appropriate.

There was a feeling from a number of IMB chairs that it would help their monitoring role if they knew about the complaints that were being investigated by the Ombudsman. Some would like to be able to contribute to investigations, others would like to receive copies of reports/letters, and one thought it would be helpful to receive a list of complaints and their outcomes at the end of the year.

In addition to these general questions asked of everyone, Governors and Approved Premises Managers were asked more detailed questions about the investigations. Of the 102 Governors who responded to the survey, 21 did not recall any complaints having been sent to the PPO whilst they had been the Governor at their current establishment. This was far lower for Approved Premises Managers, with only 7 out of 24 being aware of any complaints from their establishment having been sent to the PPO.

Fig 4.2 shows the ratings of the 70 Governors and 7 managers who answered the questions relating to their experiences of PPO complaints investigations.

Fig 4.2: Governors' & Approved Premises Managers' views of complaints investigations (N=77)



Just over 50% of Governors and Approved Premises Managers felt that complaints investigations are *always* conducted in a courteous and professional manner, rising to 88% for those who felt that they are *always* or *usually* conducted in this manner. There were many positive comments about polite, helpful and professional staff.

The question which provoked the lowest rating from Governors and Approved Premises Managers related to whether complaints investigators show a good understanding of the system and issues involved. Slightly less than 20% thought PPO investigators *always* show a good understanding and less than 65% thought this was true *always* or *usually*.

One commented that, *'in some cases there is a lack of understanding of systems and prison procedures, this can only be improved by training.'* However, there were also many comments indicating that the investigators do have a good understanding of the systems. For example, one manager said that it works well when *'the investigating officer understands the complexities of Approved Premises.'*

The collection of evidence relating to a complaint was mentioned in a number of comments, which urged investigators to *'allow more time for the information gathering process which sometimes involves a number of people, making it difficult to meet short deadlines.'*

Complaints liaison with Governors

Some 91% of Governors and Approved Premises Managers who knew of complaints which had been sent to the PPO from their establishment said they were happy with the way they were informed of the outcome of the complaints. A couple were unhappy that they could not comment on the decision letters before they were sent.

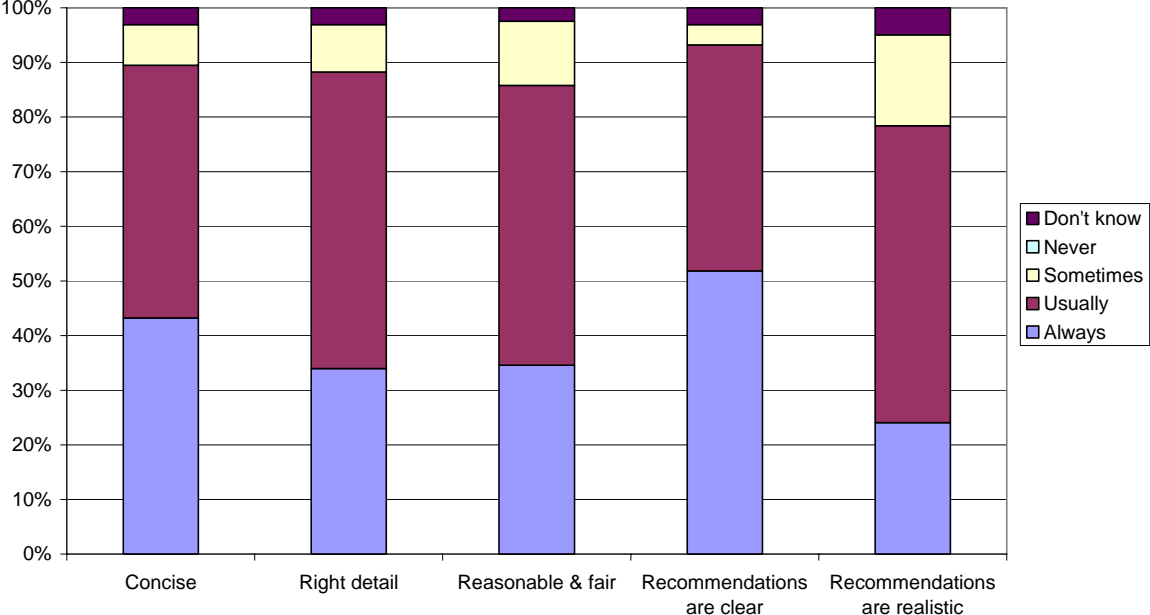
There were a couple of comments suggesting that Governors would appreciate PPO having *'improved dialogue with establishments'* during investigations, more visits and possibly alerting them out of courtesy that the investigator is visiting.

Governors were asked whether they would like more face to face contact with PPO complaints investigators. Of the 72 who answered the question, 32 (44%) would like more face to face contact during investigations. There were also 32 Governors (only 10 were the same) who would like to have an annual meeting with PPO complaints staff to discuss themes. Only 10 Governors would like to have regular meetings with complaints staff and 17 said they have enough face to face contact.

Complaints reports and letters

Governors and others who indicated they knew about complaints investigations were asked whether they had ever read a PPO complaints report or letter. The responses for the 70 Governors and 92 others who answered questions relating to PPO complaints reports are shown in Fig 4.3.

Fig 4.3 All respondents' views on complaints reports (N=162)

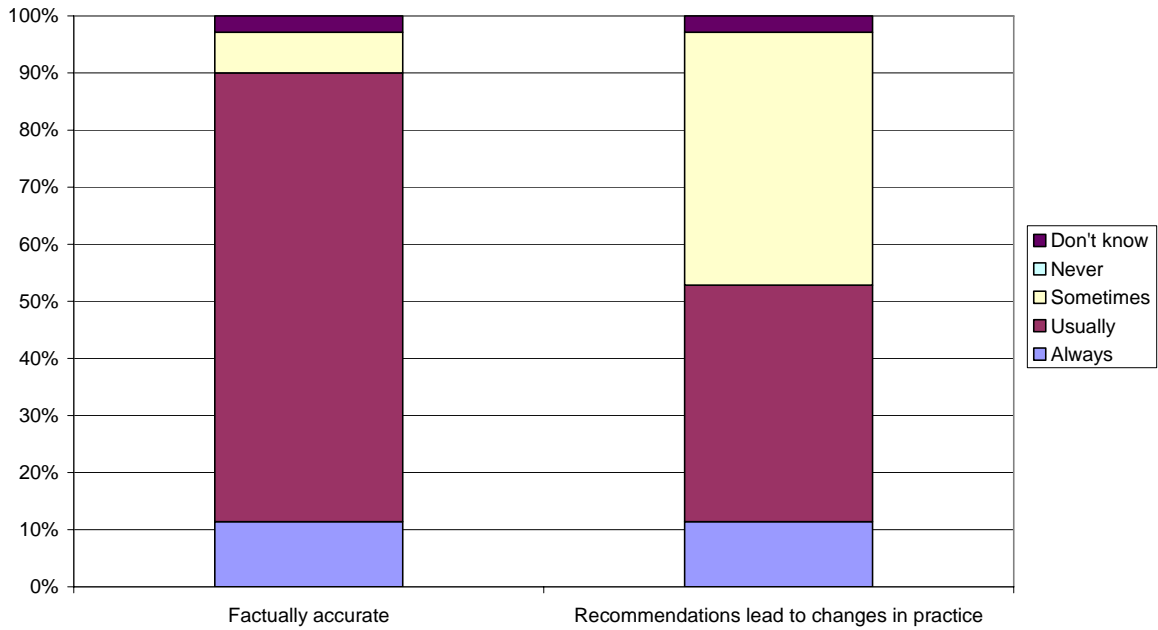


Over 50% of respondents felt that the recommendations are *always* clear, rising to 93% who thought they were *always* or *usually* clear. Whether the recommendations are realistic was the question which received the lowest rating, with only 24% thinking they were *always* realistic. Even so, there were still 78% who felt that the recommendations were *always* or *usually* realistic. One person commented that, *'some establishments are more complex than others and reports need to reflect this.'*

Comments were divided between those who felt the reports were *'clear, concise and fully understandable'* and those who thought they could be written more clearly. One suggested that a short summary of the complaint and the outcome could be provided at the front of the report. Someone pointed out that the reports/letters *'can be difficult to read for a detainee in an Immigration Removal Centre.'*

Only Governors were asked whether the reports were factually accurate and whether the recommendations lead to changes in practice. Fig 4.4 shows that only just over 10% thought reports were *always* factually accurate and *always* lead to changes in practice. Although 90% thought reports were *always* or *usually* factually accurate, only just over 50% thought that they *always* or *usually* lead to changes in practice.

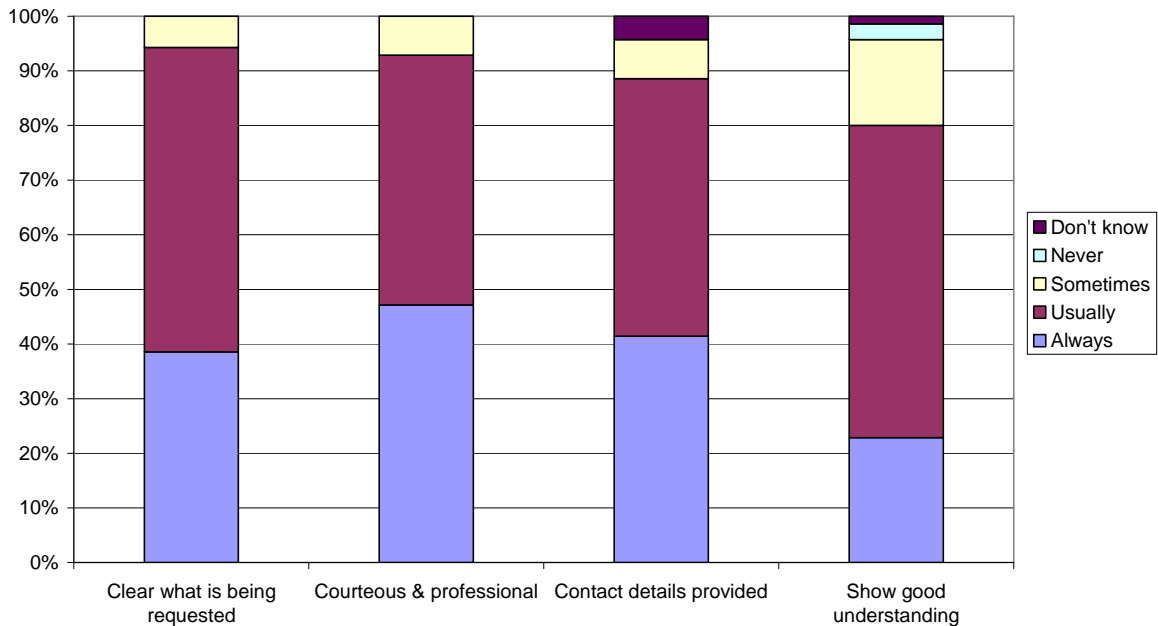
Fig 4.4 Governors' views of complaints reports (N=70)



Assessment Team

Of the 98 Complaints Clerks who fully or partly completed the survey, 18 were not aware of any complaints having been sent to the PPO whilst they had been in post. There were 70 who remembered being contacted by the PPO Assessment Team. Fig 4.5 shows how the Complaints Clerks rated their experiences of dealing with the PPO Assessment Team.

Fig 4.5 Complaints clerks' views of the Assessment Team (N=70)



Nearly 50% of Complaints Clerks felt that the Assessment Team were *always* courteous and professional, rising to 93% who felt that this was *always* or *usually* the case. Only 23% felt that the Assessment Team always show a good understanding of the system and issues involved, although this rose to 80% who felt this was *always* or *usually* the case.

The majority (41 out of 70) had never been contacted by different people from PPO on the same day, asking about different complaints, although three said this happened often and 26 occasionally.

Very few additional comments were received regarding the assessment team. One felt that the team did not always appreciate how busy Complaints Clerks are: *'I don't feel the assessment team fully understand the volume of work that comes in via the complaints system on a daily basis, they do not always understand the timescales involved to be able to reply to their queries.'*

4.2 Fatal Incidents

Fatal Incident Investigations

There were 158 respondents who had been in post in their establishment when there had been a fatal incident investigated by the PPO. These were 47 Governors, 35 Safer Custody Officers, 8 Approved Premises Managers and 68 Family Liaison Officers.

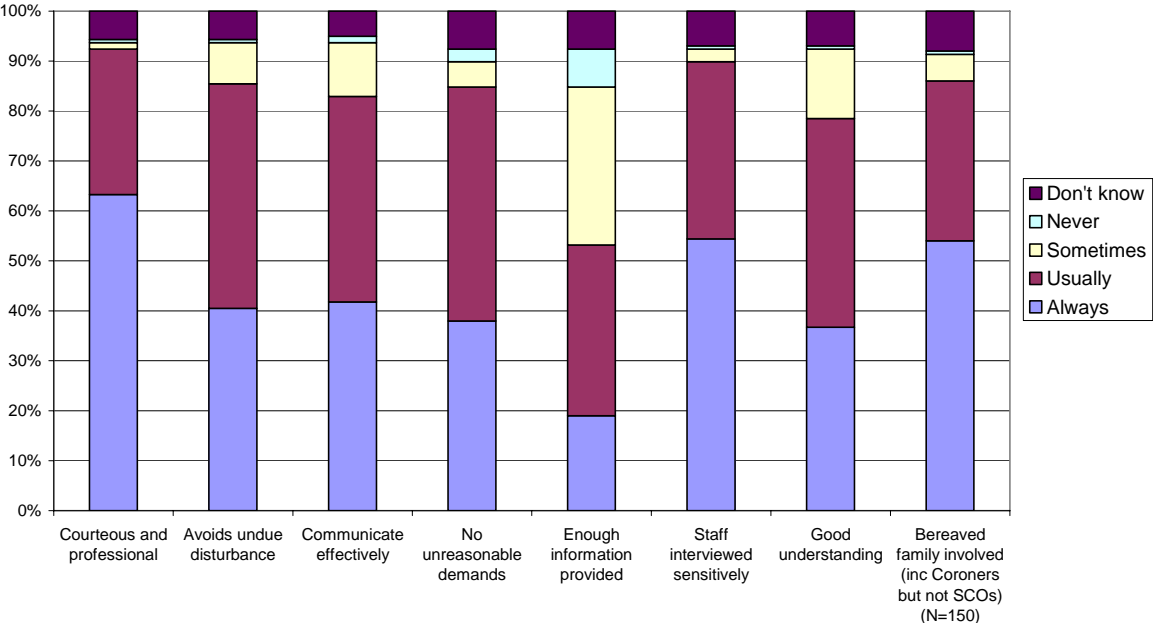
Whilst some respondents had seen several fatal incident investigations, some had only limited experience. Nevertheless there was much praise for the investigations, for example:

'The process is excellent.'

'Our investigator was thorough, courteous, knowledgeable and inclusive. I cannot fault the investigation process and how it was conducted.'

Fig 4.6 shows how these staff rated their experiences of PPO investigations. (The question relating to whether the bereaved family was involved was accidentally omitted from the Safer Custody Officer version of the questionnaire, but was included on the Coroner version. The answers to this question include responses from 27 Coroners.)

Fig 4.6 Views of parties involved in fatal incidents investigations (N=158)



The question with the highest rating was, as for complaints investigations, whether investigations are conducted in a courteous and professional manner. Over 60% thought this was *always* the case for fatal incident investigations, rising to over 90% including those who felt it was *usually* the case. These scores, and those for the other matching questions, are

slightly higher than for the complaints investigations. There were many comments on the professionalism of the staff, such as:

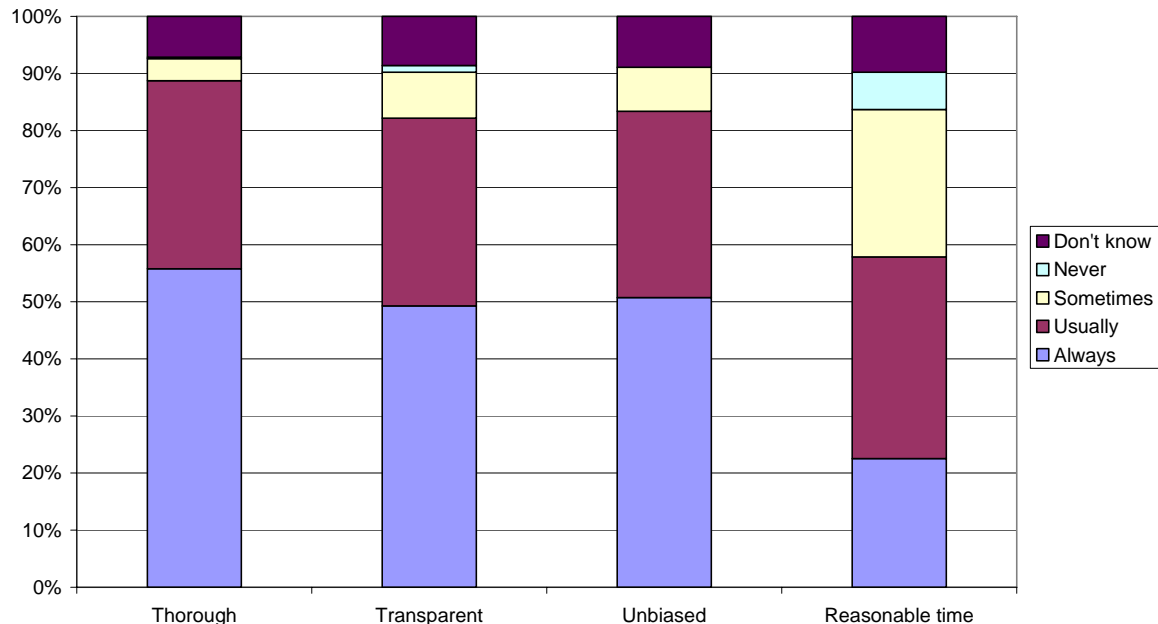
'From personal experience I have found all fatal incident investigators to operate in a truly professional manner at all times.'

It is clear from the survey that many respondents feel that not enough information is provided about the progress of the investigation. Less than 20% reported that enough information was *always* provided and only just over 50% that it was *always* or *usually* provided. This was felt most strongly by Safer Custody and Family Liaison Officers. For example, one said, *'In the investigations I have been involved in, until the draft or final report is disclosed, I have never known at what stage the investigation was at.'*

Respondents appear to think fatal incidents investigators have a better understanding of the systems than complaints investigators, with 78% reporting that fatal incident investigators *always* or *usually* show a good understanding compared to 64% for complaints investigators. One Governor said the investigators are *'astute people who do understand how prison's operate and are responsive to family concerns and feelings and indeed those of staff.'* There were still a few comments suggesting that *'there is a lack of consistency with investigators' knowledge of procedures.'*

In addition to the detailed questions referred to above, more general questions were asked of all respondents who said they knew anything about fatal incident investigations. These questions were answered by the 158 staff plus 27 Coroners, 56 IMB chairs and 96 assorted other respondents. Their responses are shown in Fig 4.7.

Fig 4.7 All respondents' views of fatal incidents investigations (N=337)



Around 50% of respondents felt that fatal incident investigations were *always* thorough, transparent and unbiased. These figures are slightly higher than the ratings for complaints investigations. Over 80% felt that fatal incident investigations were *always* or *usually* thorough, transparent, and unbiased. There were a number of comments on the objectivity of fatal incidents investigations, although these comments did not suggest bias in the same direction. A representative from the third sector said they felt that investigations are *'getting increasingly biased in favour of the Prison Service'*, whereas a Coroner felt investigators *'seem to want to criticise Prison Service more than praise it when due.'*

Timeliness, or lack of it, received by far the most comments. As with complaints investigations, just over 20% of respondents thought that investigations were *always*

completed in a reasonable time. However, only just over half thought this *always* or *usually*, compared to 66% for complaints. Also, 10% of respondents (33 people) felt that fatal incidents investigations *never* take a reasonable time, whilst only 2% thought this about complaints investigations.

Many respondents felt that the *'investigations always take too long'* and that *'straightforward cases should be dealt with more quickly'*. Some appreciated the reasons behind the delays and thought that there should be *'more resources to allow them to be investigated quicker'*. An IMB chair commented that, *'it is understood that there may be a number of contributory factors to delays, not least the length of time taken by some PCTs to conduct clinical reviews as part of the process.'*

Concern was expressed about the anxiety that is caused to staff and bereaved families when investigations take a long time. A Family Liaison Officer noted that, *'it can be difficult trying to make the family understand that the investigation is important even though the length of time may make it seem otherwise.'*

Some mentioned the interviews as another source of anxiety for staff: *'members of staff on occasions display a real apprehension prior to being interviewed. Some members of staff, due to their lack of knowledge of PPO, see the PPO as there to "trip them up" and criticise the job that they do.'* There was, however, recognition that *'staff who were interviewed were put at their ease'* and that *'the investigator was compassionate and very sensitive with staff'*.

The clinical review process elicited a number of comments. A number felt that clinical reviews should be independent and should *'not use the same PCT [as the prison healthcare] for the medical opinion.'* A few suggested that the *'PPO should commission and pay for independent medical reviews'* or that *'a group of clinical investigators should form part of the team, perhaps seconded from DoH.'* Someone in HMPS/NOMS suggested that a *'dedicated clinical review team to support the Ombudsman could be used instead of asking whoever is free to do the job at random.'* It was also suggested that PPO investigators could have training in forensic skills.

Those involved in the clinical reviews also had something to say on the matter. One representative said clinical reviews *'always take longer than time allowed for: PCTs are not resourced to do this and it impacts on our work.'* Another thought that if *'the transcripts from interviews were turned around quicker [it] would enable PCT to complete clinical review in a more timely fashion.'*

Communication during investigations was mentioned by a number of respondents. Several Family Liaison Officers indicated that they would like more contact with PPO during investigations. One said that, *'occasionally I am asked to provide a contact address for a family but never any more.'* A couple of others felt that PPO *'contact with the families could on occasions be speedier, and that the fact that the contact has taken place should be relayed to the establishment's FLO as a courtesy.'*

The IMB chairs also felt that they should be contacted by PPO during investigations and some thought they should be interviewed as they *'attend all DICs [deaths in custody] and serious incidents and write a report as independent observers.'*

Someone in the Probation Service wondered *'whether there is enough area involvement in the investigation process.'* Coroners felt that investigators should liaise with them during the investigation, *'to check that all issues have been covered'* as they felt that otherwise *'important witnesses can be lost if the PPO ultimately do not speak to them (such as inmates who leave the prison system).'*

One Safer Custody Officer was unable to answer any of the questions as they said that all liaison during fatal incident investigations was with the Family Liaison Officer and that *'safer custody is excluded from the process [in this prison].'*

Fatal incident reports

There were 299 respondents who had read a PPO fatal incident investigation report. This included all the staff as before (except two FLOs who did not complete the rest of the survey), all 27 Coroners, plus 37 IMB chairs and 79 other stakeholders.

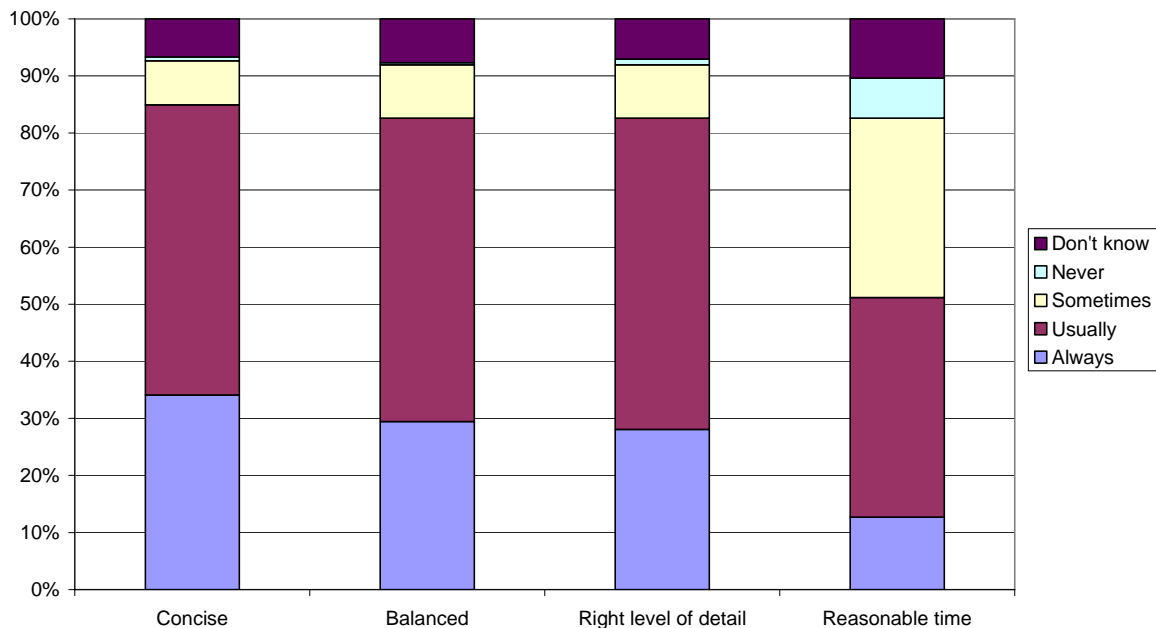
General comments about the reports were positive, such as:

'The presentation of the report is excellent and easy for the families to follow,' and

'The last report I read I felt was very fair.'

Fig 4.8 summarises how they rated the fatal incident reports they had read.

Fig 4.8 All respondents' views of fatal incidents reports (N=299)



Around 30% of respondents thought the fatal incident reports are *always* concise, balanced and with the right level of detail, rising to 80% who thought this was *always* or *usually* the case. These ratings are slightly lower than for complaints reports.

A couple of respondents felt the reports were too long, *'often caused by repetition from one section to another'*, and suggested that they could be shorter for most natural causes deaths. There were a number of comments suggesting that the reports should be standardised, possibly by using a template, which would make it easier to find particular information and to compare cases.

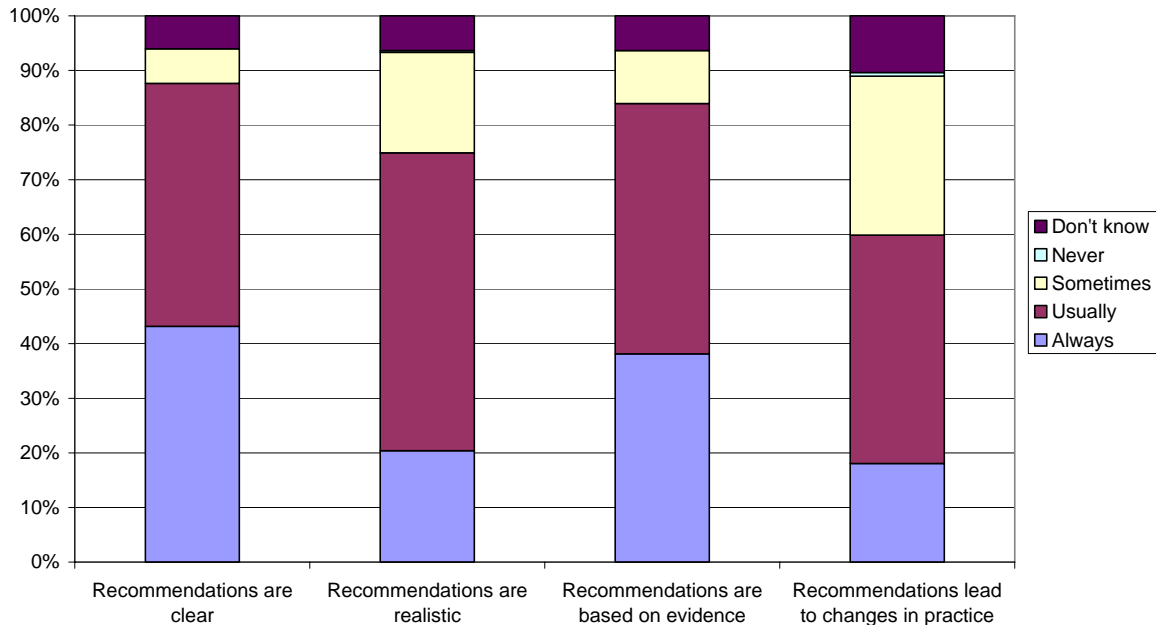
As with timeliness of investigations, the length of time for reports to be produced was a cause for concern. Only 13% felt that the reports are *always* completed in a reasonable time and 7% (21 people) thought this was *never* the case. There were a great many comments that the reports take far too long.

Concern was expressed that *'the delay in the PPO report and the inquest together can cause a high level of anxiety [for staff] - some of which could be reduced.'*

Coroners were particularly concerned by the late production of reports. One thought, *'delays well in excess of a year are really not acceptable.'* Another said, *'the inquest process cannot proceed without the PPO report – the longer the report is delayed the longer the inquest process.'*

Fig 4.9 shows what the respondents thought about PPO fatal incident recommendations. Only 20% felt that the fatal incidents recommendations are *always* realistic. Nearly 60% thought that they *always* or *usually* lead to changes in practice, higher than for complaints recommendations (53%).

Fig 4.9 All respondents' views on fatal incidents recommendations (N=299)



Someone from the Probation Service said *'I think recommendations are usually well thought out and relevant, they do result in changes in practice and procedures.'* One thought the PPO should have the *'ability to force through change rather than simply recommend.'* Someone else suggested that recommended changes should be mandatory if the report provided evidence that the change would reduce the number of deaths.

There were a couple of respondents who were concerned how recommendations were followed up. Some felt the recommendations may be *'unachievable in resource constraints'* or may not be *'within the gift of the individual establishments to action'*. There was some concern that sometimes recommendations were made which would have made *'no difference regarding the circumstances of the death'*. One person thought *'recommendations need to be more clear in terms of PCT/prison responsibility.'*

There were a number of comments which suggested that by the time the report is published the recommendations are *'largely out of date'*, either because they have already been implemented or because other things have changed.

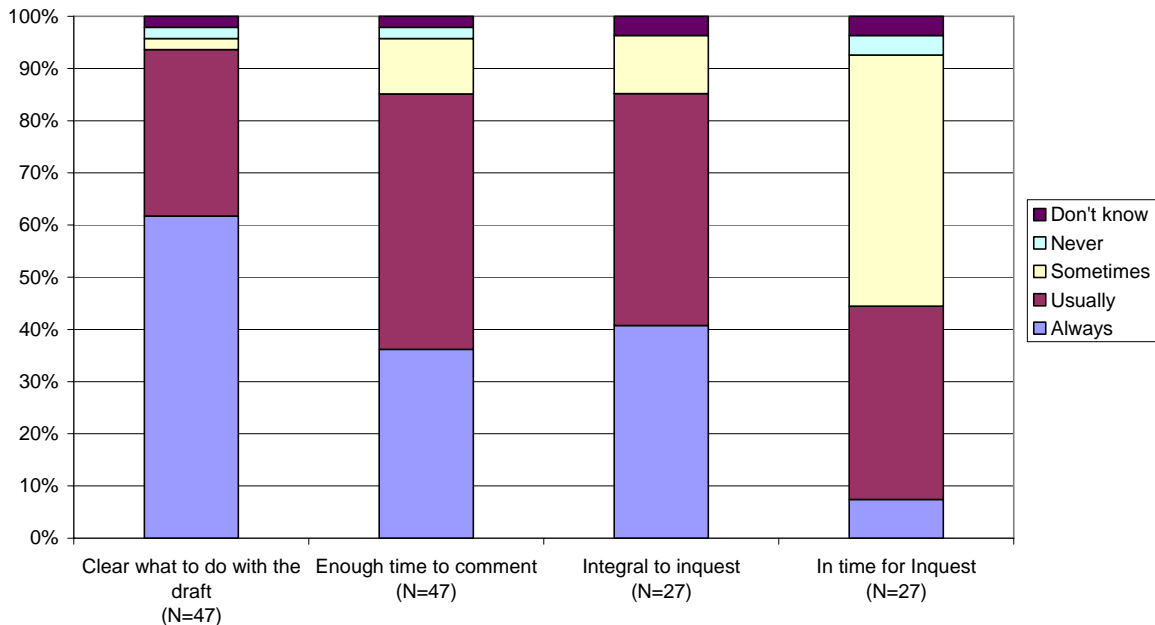
Governors were asked a couple of questions about what they are expected to do with the draft fatal incident reports. Their responses are shown in Fig 4.10. Over 60% (29 Governors) thought it was *always* clear what they were supposed to do with the draft report and over 90% thought it was *always* or *usually* clear. Only 36% (17 Governors) thought they were always given enough time to comment, although over 80% thought they *always* or *usually* had enough time. Only one person answered never to these two questions.

One respondent felt that the *'establishment should be able to challenge, confirm/seek clarification of any draft report before it is disclosed to the family of the deceased'*, as *'when things [in the draft report] are disputed and changed this raises suspicion with the family.'*

Fig 4.10 also shows what the 27 Coroners think about PPO fatal incident reports in relation to inquests. The majority (23) feel that the reports are *always* or *usually* integral to the inquest and eleven of these think this is *always* true. However, less than half (twelve

Coroners) think that the reports are *always or usually* received in time for the inquest, and only two Coroners think they are *always* in time.

Fig 4.10 Governors' views on draft reports & Coroners' view on Inquests



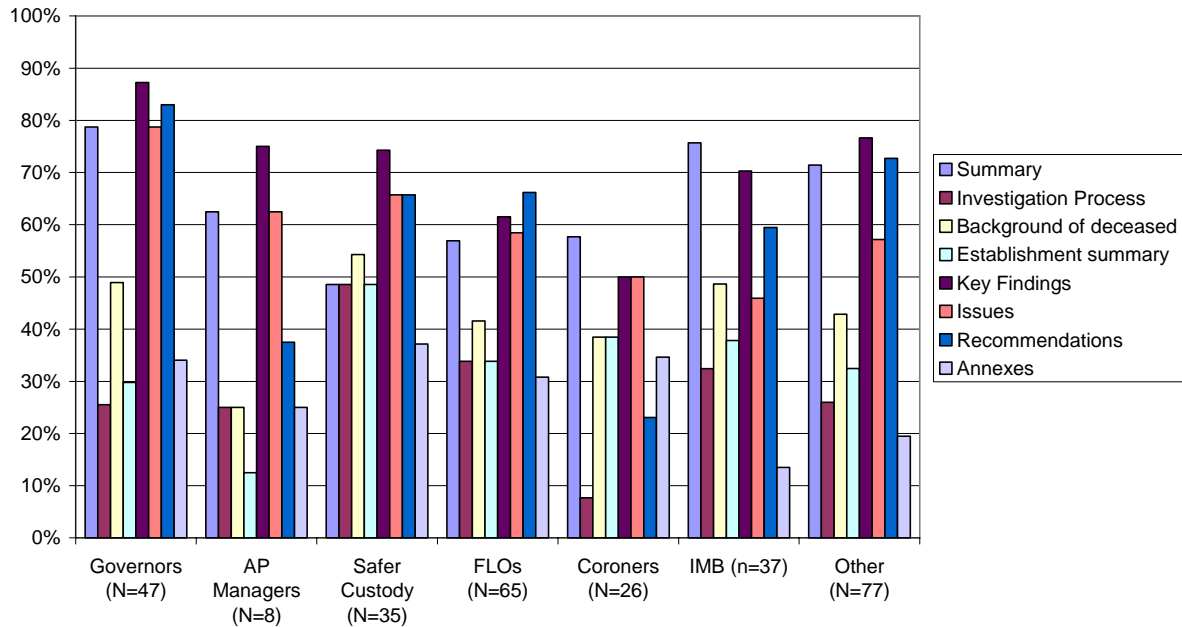
Coroners were asked how they use fatal incidents reports. They said they were most likely to use them to identify witnesses, establish key issues and help to understand the concerns of the bereaved family. They were less likely to refer to them as evidence. One stated that they found them useful to identify the timelines in the case. One thought that *'sometimes the report is a précis of the evidence and lacks detail, rather than the evidence itself. This can cause difficulty in squaring the conclusions with the evidence.'*

Only a third of Coroners (8) said they usually call the PPO investigator as a witness. Of those who had called an investigator, over 80% of them rated their performance as *very good or good*. None was rated as *poor*. Feeling that the investigator would not be able to add anything was the most cited reason for not calling them as a witness.

Respondents were asked how useful they found each part of the fatal incidents reports. Fig 4.11 summarises their responses. 'Key findings' is the section most likely to be rated as *very useful* by Governors, AP managers, Safer Custody Officers and general stakeholders. Family Liaison Officers were most likely to rate the 'Recommendations' section as *very useful*, while Coroners and IMB chairs are most likely to rate the 'Summary' section as *very useful*. Coroners are least likely to rate the 'Investigation Process' section as *very useful*.

One academic commented that *'different sections are useful for different purposes and audiences - so I think it is all necessary.'* This was illustrated by someone from NOMS/HMPS who said *'I already know lots about the prisons and rarely have time to read the annexes'* and a Coroner who said *'sometimes, the annexes are very useful'*.

Fig 4.11 Proportion of respondents rating each part of the report as 'very useful'



Access to the reports

Governors were asked which other members of staff see the reports. Of the 47 Governors who replied, 44 reported that other Governors see them, followed closely by Family Liaison Officers (42). Only 33 out of 47 Governors said that staff involved in the custody or care of the deceased would see the report.

Around half the Governors (28 out of 47) said they *always* notify all staff when the report is received, but two said they *never* do. Three Safer Custody Officers (out of 35) and seven Family Liaison Officers (out of 64) said that staff are *never* notified when the reports are received. The majority (58%) of respondents said staff have to make a request to access the report. All Approved Premises Manager said the reports were stored in their offices. The Governor's office was the most common response from respondents based in prison.

There were a number of comments suggesting they would like the reports to be more easily accessible. Some felt that the reports should be '*available to all involved*' and, at the very least, individuals named in the report should be informed that it had been issued, rather than relying on the Governor to do so locally.

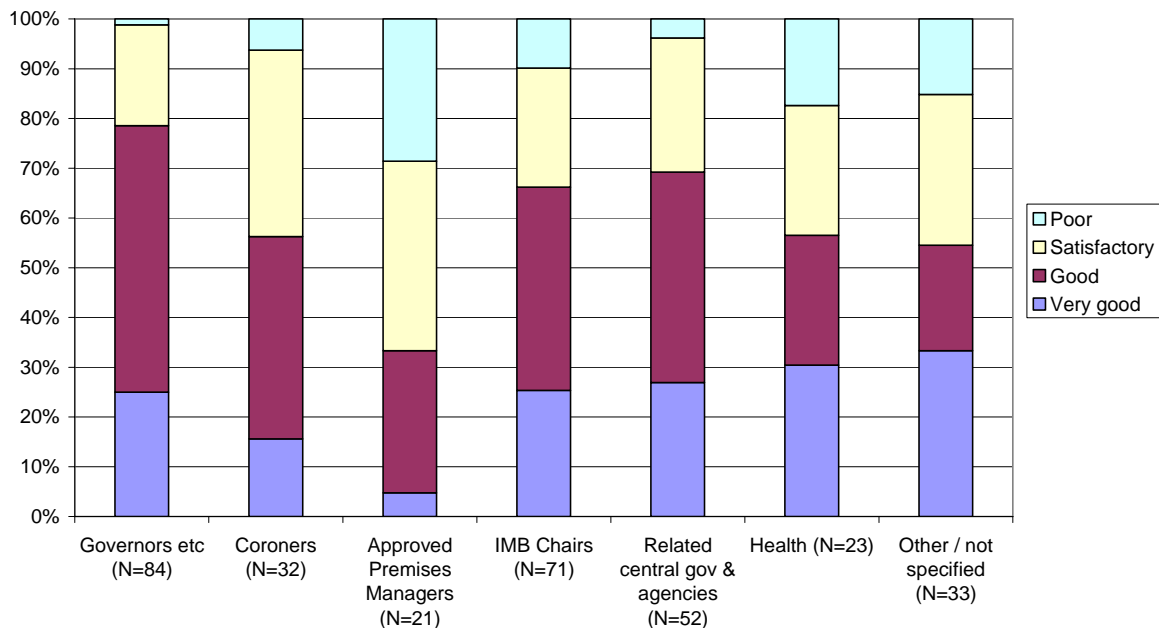
Several Family Liaison Officers commented that they had not been given access to any PPO reports. One said, '*as a FLO, I do not usually see the report unless a family let me have access to theirs. I would find [having a copy] useful as it would better prepare me for questions from the family and what to expect at the inquest.*'

Overall, just over half the respondents (57%) were aware that anonymised reports are published on the PPO website. Safer Custody Officers and Family Liaison Officers were least likely to be aware of them, with the majority of Safer Custody Officers not knowing. Despite most being aware, the majority of every type of respondent had never looked at the anonymised reports. Only 13 Governors out of 47 tell staff about the anonymised reports.

4.3 Communications

Stakeholders were asked how they regard their current communications with PPO. An administrative error meant that this question was not asked of Complaints Clerks, Safer Custody Officers and Family Liaison Officers. The results are shown in Fig 4.12.

Fig 4.12 Stakeholders' views on their communications with PPO



Overall, 64% of respondents regard their communications with PPO as *good* or *very good*. With the exception of Approved Premises Managers, the majority of each type of stakeholder regards communications as either *good* or *very good*. Although the sample was small, only a third (7) of Approved Premises managers regard their communications with PPO as *good* or *very good* and nearly as many (29%, 6 managers) regard them as *poor*. Surprisingly, the stakeholders who were most likely to regard their communications with PPO as *very good* were those not directly affected by our services.

Governors were asked whether they would like more face to face contact with PPO fatal incidents staff. Of the 43 who answered the question, 20 (46%) would like an annual meeting to discuss themes. Thirteen (30%) would like more face to face contact during investigations, but sixteen (37%) thought they have enough face to face contact with fatal incidents staff. One Governor said *'the suggestion of tailored, themed feedback on an annual basis is a positive one and would be useful.'*

The majority of Governors (66%) and Coroners (53%) would like to have a named individual in PPO as their main contact, excluding investigations.

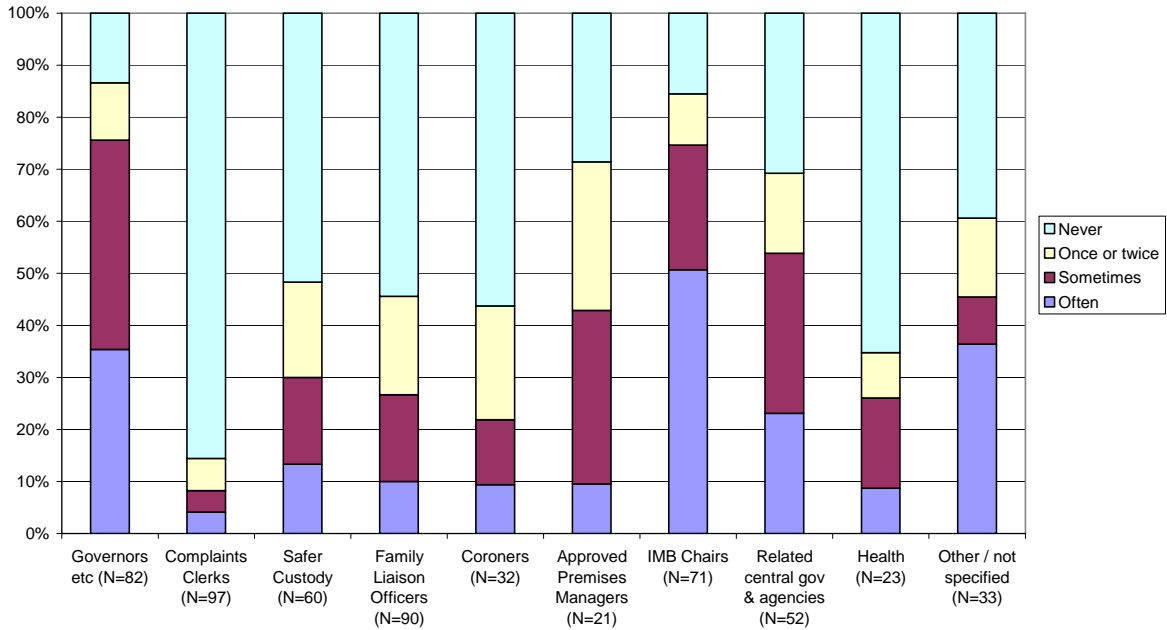
Lack of communication about the progress of investigations was the source of most comments in this area: *'Regular updates, to say how an awaited report is progressing, would be helpful.'* There were also a few who thought *'visits to establishments by PPO staff would be beneficial to raise prison staff awareness and also PPO staff's understanding of how individual establishments work.'*

Some of the respondents who had not had much contact with PPO thought it would be a good idea to have *'better marketing of the services it can provide'*.

4.4 Publications

Overall, 41% of respondents said they had seen the PPO Newsletter *'On the Case'* more than *once or twice*. Fig 4.13 shows there was considerable variation between the different types of stakeholders. Governors and IMB chairs were the most likely to say they see on the *'On the Case'* either *often* or *sometimes*. However, 80% of Complaints Clerks had *never* seen it.

Fig 4.13 How frequently respondents see 'On the Case'

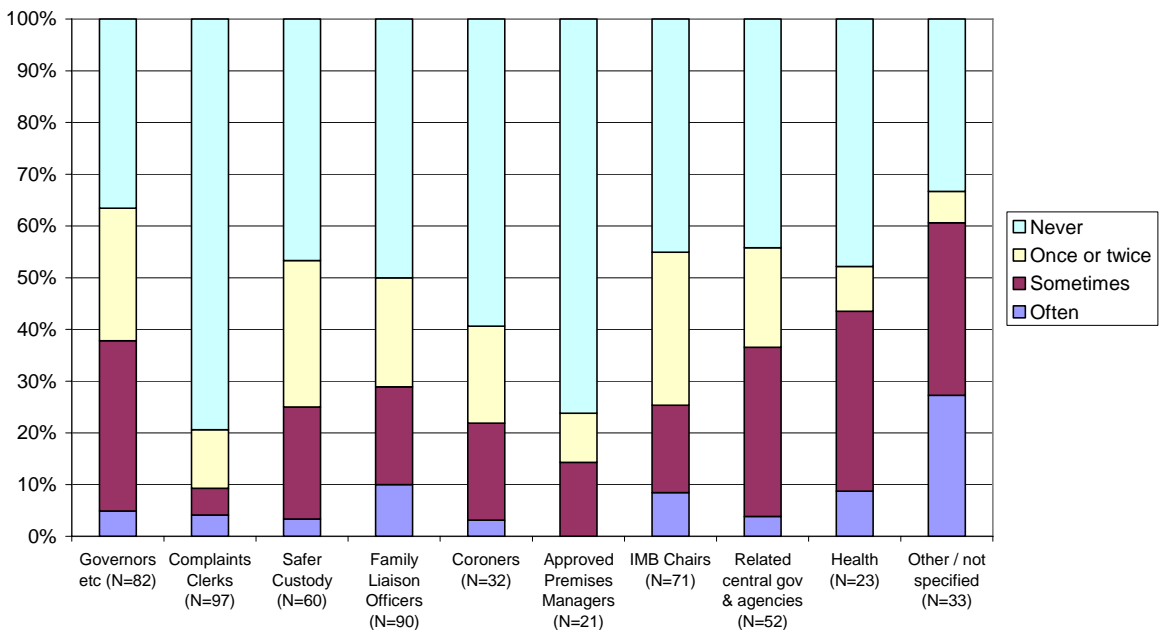


All together, slightly more people (43%) had seen the Annual Report more than *one or twice* than had seen 'On the Case'. The pattern is very similar for the Annual Report, reflecting the fact that they are sent via the same distribution list. The only notable difference is for Coroners where nearly 40% (12 Coroners) said they see the Annual Report *often* or *sometimes*, while only 22% (7 Coroners) see 'On the Case' this frequently.

When it comes to the PPO website the pattern is different (see Fig 4.14). Overall only 28% have visited the website more than *once or twice*. Very few (7%) had looked at it *often* and the majority (52%) had never visited the website at all. External stakeholders tended to report visiting the website more frequently than operational ones.

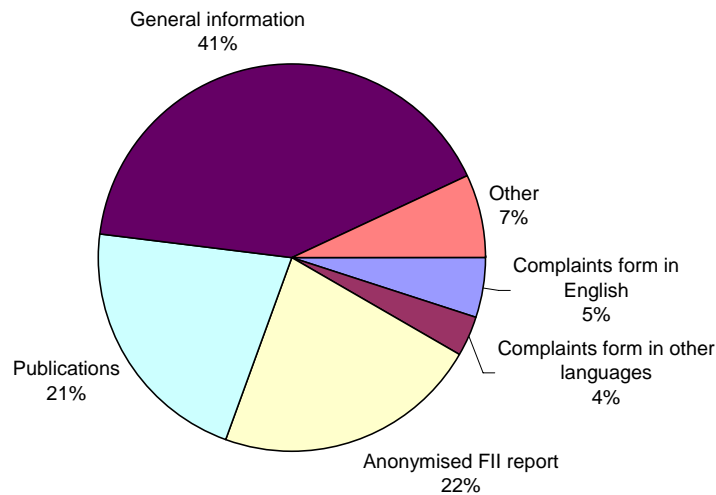
All three publications (Annual Report, 'On the Case' and the website) were rated as *good* or *very good* by over 85% of those respondents who had seen them.

Fig 4.14 How frequently respondents visit the PPO website



Respondents were asked what they were looking for when they visited the PPO website. Fig 4.15 shows how their responses were distributed. General information was the most common reason given. Publications and anonymised fatal incidents reports were also common reasons for visiting the website.

Fig 4.15 Why respondents visit the PPO website (N=523)



The most common suggestion for how PPO publications or website could be improved was *'by making potential users aware of [the website's] existence'*. Someone else said that it *'would have been useful if I knew of these publications/websites.'* Several people suggested having a link from the HMPS intranet to the PPO website and publishing news of fatal incidents reports on the HMPS intranet too. One person wondered why the anonymised report *'never names the deceased individual, I've never understood this as inquests always take place which name the person and often its therefore difficult to marry up the PPO report and inquest.'*

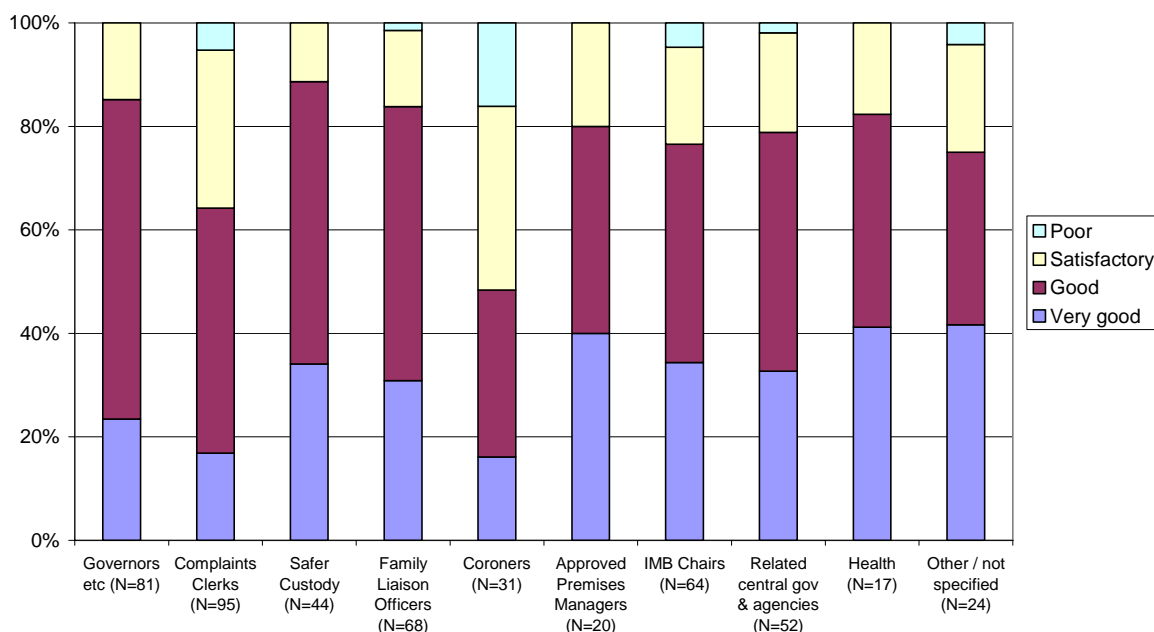
Suggestions for other publications included best practice as identified during investigations; something focussing on immigration removal centres and leaflets for staff explaining what the PPO does.

4.5 General

Quality of service

A quarter of respondents said they had had no contact with the PPO in the last year. Some of these chose not to answer questions relating to general issues. Of the 496 who answered the question on quality of PPO services, 76% rated PPO services as *good* or *very good*. Fig 4.16 shows that Complaints Clerks and Coroners gave lower ratings than other stakeholders. Less than 50% of Coroners (15 out of 31) rated PPO services as *good* or *very good* and 16% (5) rated them as *poor*. Overall only 3% (16 people) rated the services as *poor*.

Fig 4.16 How respondents rate the quality of PPO services



When asked how their experience of dealing with the PPO compares with their experience of other public bodies, more than half of the respondents (56%) thought we were *about the same* and a further 40% thought we were *better*. Only 4% (19 people) thought we were *worse* than other public bodies they deal with. One remarked that *'the PPO is refreshing in that it doesn't behave like a typical public body.'*

What works

As well as rating the quality of PPO services, respondents were asked what in particular works well and less well. These questions produced a wide range of answers but there were some topics which were frequently mentioned. Good communication was the most popular example of what works well. Comments ranged from the Complaints Clerk who liked it when *'someone expresses clearly what information they require and do not use jargon'* to the Governor who felt *'face to face meeting re DIC investigations is always best and updates for me personally on progress/issues particularly helpful. Not all investigators do this and they should.'*

Many respondents mentioned PPO staff in general. Typical comments received included: *'All the PPO staff I have encountered have been knowledgeable and helpful'*; *'the professionalism of the staff'*; *'investigators are always polite and well mannered'*.

Other aspects which were thought to work well included having investigators who *'know what they are talking about with regard prison regimes/facilities'*; being *'able to contact a named caseworker'*; being *'non-adversarial'*; and having *'good personal relationships'*.

There was praise for the work carried out by the PPO Family Liaison Officers. One prison FLO said, *'the Family Liaison Officer that assists the investigator is a good point as the information flow can work two ways, meaning we provide a better service on the whole.'*

IMB chairs were particularly pleased with *the 'considered response'* that the Ombudsman personally sends to their Annual Reports.

There were far fewer examples of what works less well, with delays in investigations being the most common. One said, *'my only criticism is timeliness of draft report on some cases but not all.'* Some felt they would have liked more information on the role of the PPO and one clinical reviewer felt the *'communication networks are haphazard'*.

Ratings

All stakeholders except Complaints Clerks were asked to rate the PPO on the following characteristics: *influential, impartial, professional, effective, and efficient*. The ratings received from all respondents are combined in Table 4.1.

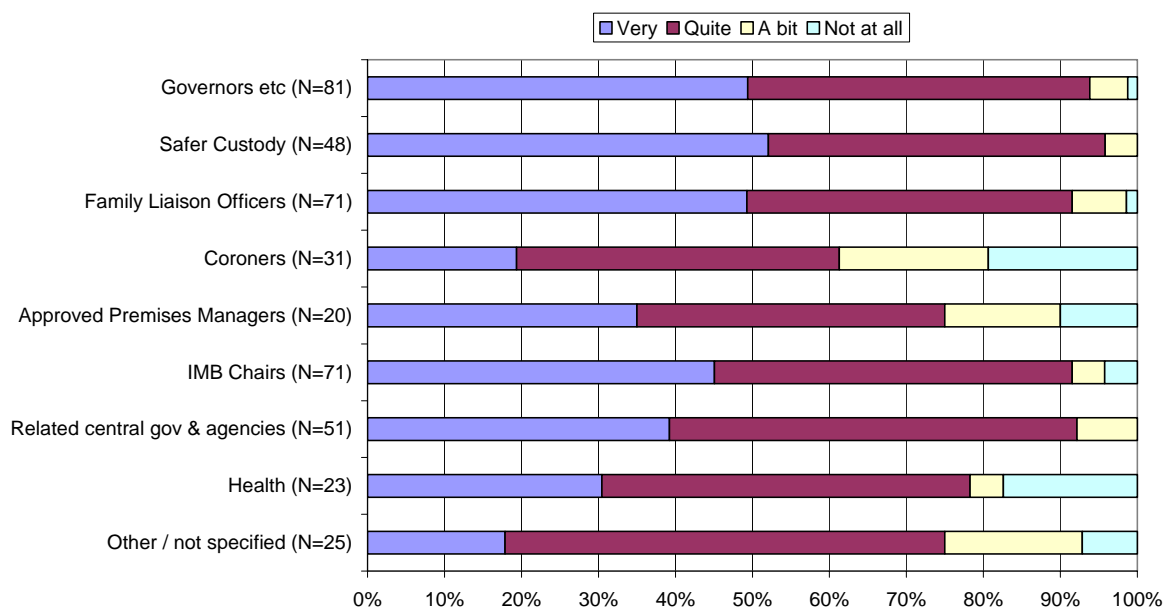
Table 4.1 Overall PPO ratings

	Influential (N=424)		Impartial (N=422)		Professional (N=425)		Effective (N=423)		Efficient (N=424)	
Very	177	42%	221	52%	297	70%	171	40%	148	35%
Quite	195	46%	158	37%	104	24%	211	50%	220	52%
A bit	33	8%	27	6%	7	2%	25	6%	37	9%
Not at all	19	4%	16	4%	17	4%	16	4%	19	4%
	424	100%	422	100%	425	100%	423	100%	424	100%

Table 4.1 shows that the highest proportion of 'very' ratings was on the 'professional' scale. A total of 70% of respondents rated the PPO as 'very professional'. Over 50% of respondents rated PPO as 'very impartial'. Efficiency is the characteristic with the lowest proportion of 'very' ratings, with only 35% of all respondents rating PPO as 'very efficient'.

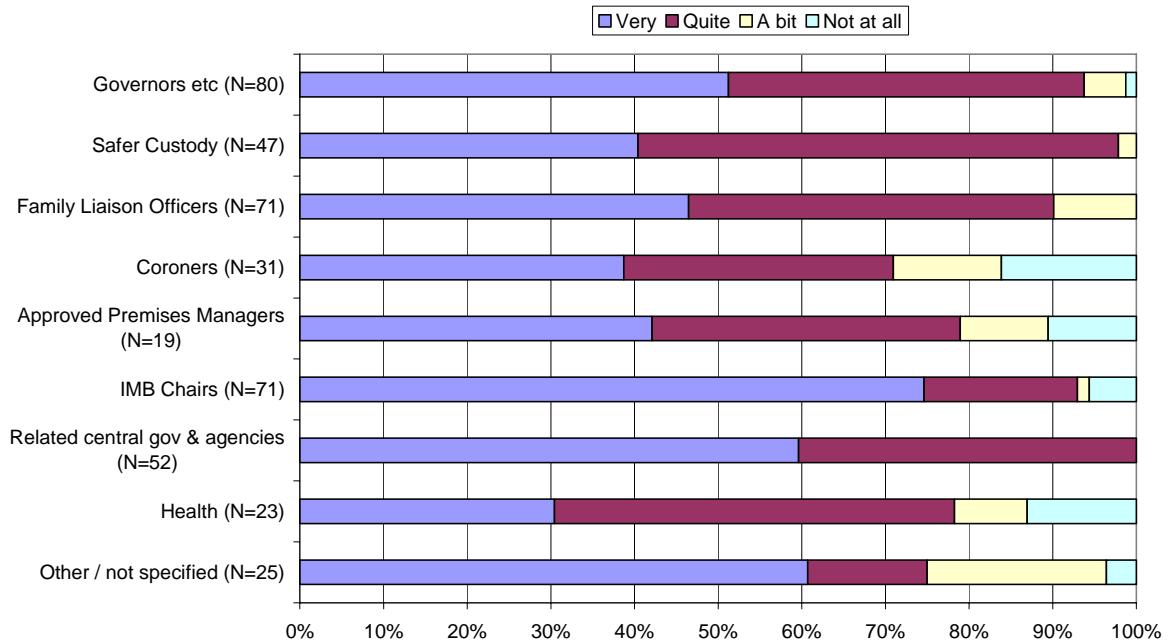
There were differences between respondent types in the ratings they gave on these scales. Fig 4.17 shows the ratings for *influence*. Governors, Safer Custody Advisors and Family Liaison Officers were most likely to rate PPO as 'very influential' (around 50% of each type). Conversely, 19% of Coroners (6 people) and 17% of health respondents (4 people) thought PPO was 'not at all influential'. One person from NOMS/HMPS who rated PPO as 'a bit influential' thought 'Ministers and senior MoJ officials pay less attention to the Ombudsman than they should,' and a Coroner who gave the same rating questioned 'whether the prison service take note of reports from the PPO or the HM Inspectors, or indeed Coroners.'

Fig 4.17 How influential is PPO?



More respondents (52%) rated PPO as 'very impartial' than 'very influential' (42%) (see Fig 4.18). At least 30% of all stakeholder types gave a 'very impartial' rating. IMB chairs were most likely (75%) to rate PPO as 'very impartial' with general stakeholders next most likely to do so (60%). Health-related stakeholders were least likely to rate PPO as 'very impartial' (30%). As with *influential*, only 4% rated PPO as 'not at all impartial'. An IMB chair who rated PPO as 'not at all impartial' said, 'unless you take and accept evidence from both complainant and prison staff you will not be or be seen by those whom the service is for - the prisoner, to be exercising a balanced impartial view.'

Fig 4.18 How impartial is PPO?



Even more respondents rated PPO as *'very professional'* (see Fig 4.19). Overall 70% thought PPO is *'very professional'* and only Coroners, Approved Premises Managers and health-related stakeholders had less than 70% giving this rating. Coroners were the least likely to give a *'very professional'* rating, but over 30% did so. Again, only 4% gave a *'not at all'* rating. One IMB chair who gave a *'quite professional'* rating was concerned that *'the boundaries of confidentiality were not clear'* when an IMB member had spoken to an investigator about a fatal incident.

Fig 4.19 How professional is PPO?

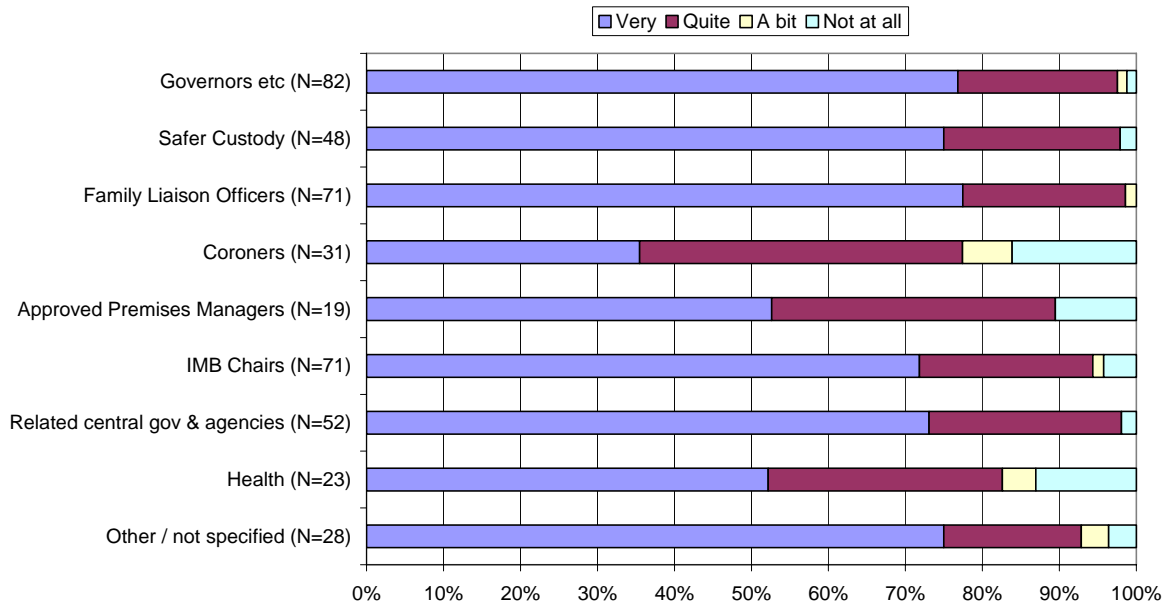
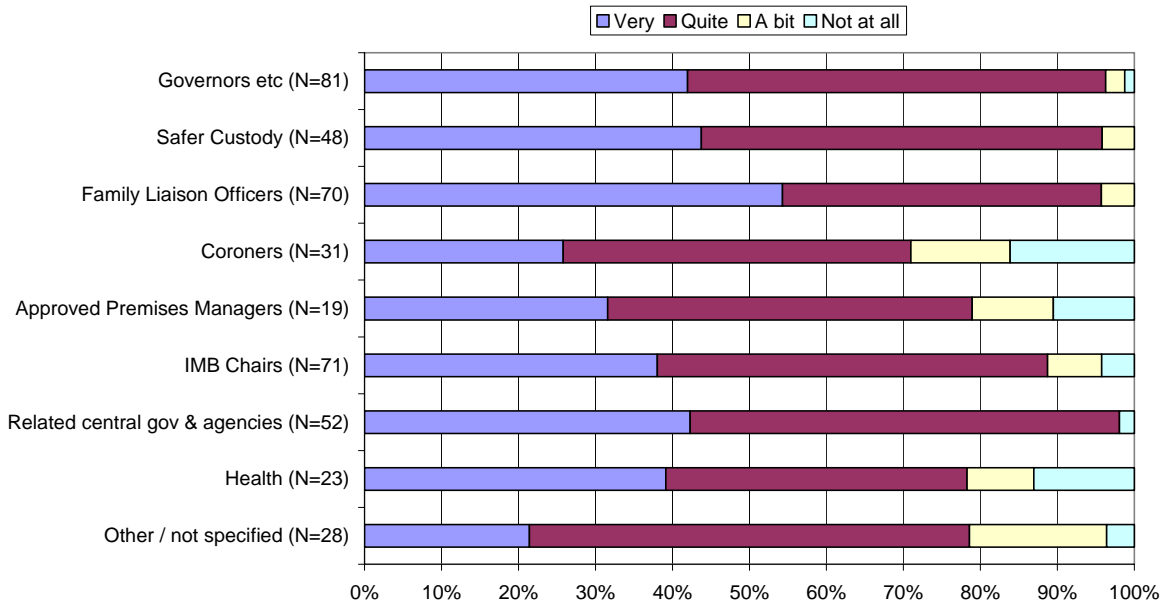


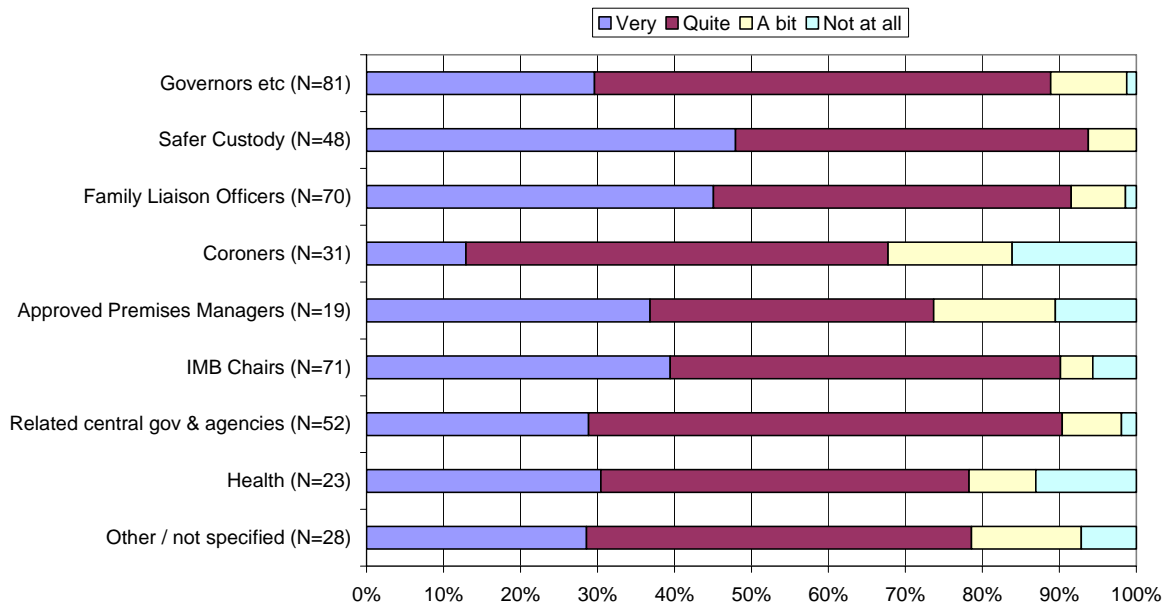
Fig 4.20 shows that fewer respondents, only 40%, rated PPO as *'very effective'*. Only Family Liaison Officers had more than half (54%) giving this rating. Again only 4% rated as *'not at all effective'*.

Fig 4.20 How effective is PPO?



Efficiency gained the lowest ratings of all the scales (see Fig 4.21). Safer Custody Officers and Family Liaison Officers had the highest proportions of respondents giving ‘very efficient’ ratings but both were less than 50%. Coroners gave the lowest rating with only 13% thinking PPO is ‘very efficient’. One Governor explained that their rating was ‘affected solely by the failure to report on a DIC [death in custody] in a timely manner’, and it is likely that the lower ratings for efficiency are generally due to lack of timeliness in completing investigations.

Fig 4.21 How efficient is PPO?



Improvements

After rating the PPO on the various scales, respondents were asked whether they could suggest any improvements. Not surprisingly given their earlier comments, there were many who wanted ‘increased timeliness’. Several thought that ‘more regular contact’ would be helpful. One Family Liaison Officer thought PPO should ‘try to develop a “real” interface

between the service and PPO, not in order to influence but to collaborate and develop professional standards.'

A lot of suggested improvements concerned staff awareness. One said *'I think the PPO should give a presentation at local level to improve the knowledge of staff on its responsibilities'*, and another would like *'literature to understand how I could assist in working closely with the Ombudsman.'*

Communications also came up as an area for improvement. Direct communication was mentioned by IMB chairs, Family Liaison Officers, PCTs and Safer Custody Officers. As before, more information about progress of investigations was also requested.

There were several respondents who suggested improvements such as *'place on statutory footing'*, *'move away from the MoJ'* or *'establish as an NDPB to ensure independence'*. One also suggested *'more resources, bigger offices, more staff' as well as 'statutory independence'*.

Other suggestions included: *'greater visual impact in establishments'*, *'respond to letters from solicitors'* and *'involve ex-offenders in your work'*. One Family Liaison Officer would like the PPO *'to devise and publish some "expectations" like HMCIP do, to clarify the FLO role.'* Someone from UKBA said they *'would like to see a willingness to investigate near misses in the Immigration estate.'*

There were a number of respondents who were unable to suggest any improvements as they felt that there was *'none needed'* and they were *'satisfied with the way it is currently run'*.

Finally, respondents were asked if they would like to add anything else. Most of the comments repeated sentiments that had been expressed elsewhere in the survey or were clarifying that they had had little contact with the PPO on which to form an opinion. The majority who did have something to say praised the work and staff of the PPO. A typical comment was: *'they do an excellent and difficult job with limited resources.'*

Appendix I: Summary of issues raised by the stakeholder feedback

1. Investigations

All Investigations

- Conduct investigations more quickly
- Complete reports more promptly
- Keep interested parties informed of progress and produce interim reports where appropriate
- Ensure investigators are well informed of the systems and regimes in all types of establishments, via training; visits or shadowing
- Say hello to Governor when on visits
- Make more contact with IMBs and be considerate to the fact that they are not in establishments all the time
- Consider relative complexity of the establishment when writing reports
- Beware of bias

Complaints investigations

- Keep IMB informed. Consider copying in to letters and reports and provide summary of cases at end of year
- More visits
- Be sensitive when asking for information that the staff have other things to do
- Make sure letters to detainees will be understandable to them

Fatal Incidents Investigations

- Consider ways to increase the independence of the clinical reviews
- Get transcripts to reviewers more quickly
- Forensic training for investigators
- Interview IMB chairs
- Make contact with the bereaved family more quickly and let prison FLO know contact has been made
- More liaison with FLOs
- Encourage all establishments to involve Safer Custody Officer in the investigation
- Increase staff awareness of PPO so they are more prepared for what happens during an investigation, how they can help and what happens in an interview and afterwards
- More liaison with Coroners during the investigation to check that everything is covered
- More contact with Probation Area Offices
- Avoid repetition in reports
- Make natural causes reports shorter
- Use a template for reports so it is easier to compare cases
- Make responsibility for recommendations more clear between prison healthcare and PCTs
- Provide follow up of recommendations
- Consider asking establishments to fact check reports before disclosing to families
- Recommend that Governors tell all staff the report has been produced
- Recommend that Governors provide copies of the report for FLOs and SCOs
- Send letters to all staff interviewed and IMB chairs telling them the report has been sent to the Governor
- Increase awareness of anonymised reports

2. Communications

- Improve communications so that overall rating is better next time
- Provide progress reports
- Consider face to face meetings with Governors or during investigations
- Provide named contact
- Have more direct contact with FLOs, SCOs, Coroners, IMB chairs & PCTs
- Leaflets and visits to increase staff awareness
- Greater visual impact in establishments

3. Publications

- Increase awareness of publications & website
- Set up link from HMPS/NPS/UKBA intranet to PPO website
- Publish news of reports on PPO website and HMPS/NPS/UKBA intranets
- Other suggested publications –
 - Best practice based on findings from investigations
 - Something on IRCs
 - Leaflets for staff

4. General

- Improve working practices so that ratings are better next time
 - Influential, Professional, Effective, Impartial, Efficient
- Continue to work towards statutory independence
- More resources & more staff

Appendix II. Methodology

- A survey was chosen as the most appropriate method for this strand, as it would allow feedback from different groups each with a large number of people. This would also have the advantage of acting as a mini promotional exercise and should in itself increase the PPO's profile. For this reason, it was decided to send the survey to all stakeholders rather than a sample.
- As this was the first time feedback had been collected from stakeholders, it was felt that it would be better to send a one-hit mailing to all stakeholders rather than a questionnaire after each investigation. This would enable feedback to be collected from all establishments at the same time as other stakeholders, rather than waiting until there was a complaint or death in a given location. This method had the added benefit of minimising the risk of identifying individual investigators. A short evaluation form could be developed in the future to be sent with final reports.
- Seven different versions of the questionnaire were developed to cater for the varying needs of the groups of stakeholders. The questionnaires covered all aspects of PPO work, including investigations and reports.
 - Three versions covered both complaints and fatal incident investigations (FII):
 - Governors / Directors / Centre Managers
 - Approved Premises Managers
 - General stakeholders
 - The other three questionnaires concentrated on either FII or complaints:
 - Safer Custody Officers (FII only)
 - Family Liaison Officers (FII only)
 - Coroners (FII only)
 - Complaints clerks (complaints only)
- All versions also had sections about communications and general impressions of PPO. Only Approved Premises Managers and Complaints Clerks were asked questions about PPO posters and leaflets.
- SurveyMonkey.com was used to design an on-line survey in order to maximise the response rate. This required the addition of the SurveyMonkey website to the NOMS approved list. Printed versions of the survey were also produced for those stakeholders who were not accessible via email.
- Links to the appropriate on-line survey were sent direct to Complaints Clerks, Family Liaison Officers, Approved Premises Managers, Area Managers and to selected other stakeholders. Governors were contacted via NOMS Communications, HM Coroners via the Coroners Society and PCTs via Offender Health. Respondents were given a three week deadline for completion of the questionnaire and a reminder email was sent after two weeks.
- Questionnaires were sent by post to IMB chairs, Safer Custody Officers, Immigration Removal Centre managers and others for whom an email address was not available.
- A short piece promoting the stakeholder survey appeared in the August edition of the PPO newsletter '*On the Case*'.
- Although some money could have been saved by sending the questionnaires with '*On the Case*', it was decided that this could introduce an unintentional bias into the results. The timings were instead worked out to avoid sending at the same time as other PPO mailings and to use '*On the Case*' to send a reminder instead.

- The risk of getting a low response rate was identified as the most severe risk. Steps taken to mitigate this risk included:
 - Piloting the questionnaire
 - Making sure it was clear, understandable & not too long
 - Having a good covering letter
 - Using an on-line survey where possible
 - Sending emails via gatekeepers such as NOMS Communications, Offender Health and the Coroners Society
 - Providing a prepaid envelope for those receiving the questionnaire by post
 - Having return address on the questionnaire as well as envelope
 - Planning a reminder in '*One the Case*' and sending a reminder email.

- There were concerns about the possibility of individual investigators being identified in the questionnaires. This risk was less likely in a questionnaire asking about PPO investigations in general rather than evaluation form following each investigation. It was made clear to respondents that the survey was for research purposes but that comments about individual staff would be passed to line managers.