On 11 October, I was proud to celebrate ten years as Ombudsman. The office is a very different place to what it was in 1999. It is now the fifth largest Ombudsman service in Britain, and one of the largest specialist Ombudsman services anywhere in the world. Our remit is now much wider. And one of the most interesting changes has been to the make-up of our complaints caseload.

When I was first appointed, I could only accept complaints from prisoners. Today, probation complaints represent almost 10 per cent of our workload. Complaints from those held in immigration detention have also been added - thus extending the safeguard of independent investigation to detainees in immigration removal centres as well as those several hundred still held in prisons. There are important synergies between the prison and probation work (notably in respect to OASys and offender management) and between prisons and immigration detention (not least because so many detainees are time-served former prisoners).

It is striking how the pattern of prison complaints has altered over the decade. In the 1990s, property complaints and appeals against prison disciplinary hearings (adjudications) represented over 40 per cent of all our investigations. That proportion is now down to below one-in-six.

Here, for example, is a flavour of one week's completed investigations from the summer of 2009. There were just two adjudications in the sample. Property featured seven times, but the greatest number focussed on aspects of regimes, sentence planning and categorisation. There were also more challenges to the content of reports - a reflection of the more structured nature of imprisonment and the growth of indeterminate sentencing.

Some old favourites recurred. Differences in facility lists (the possessions to which prisoners are entitled) continue to generate grievances - what is a threat to security in one jail is perfectly okay in another. Visitors are banned or Visiting Orders go missing. And regrettably, legal and other confidential correspondence is still opened improperly in busy prison mailrooms. But much more of our time is now devoted to issues directly relevant to offending behaviour and the reduction of risk and reconviction.

The PPO office’s response to the changing nature of our complaints workload has included an increase this year in the proportion of formal reports we issue. The default position remains that investigators seek to resolve matters restoratively, but the number of recommendations we are making to NOMS is also on an upward trend. While there will be no return to the position in the 1990s when every single complaint resulted in a formal report, there is now a better balance in the way we conclude our investigations.

Stephen Shaw
All three deaths were self inflicted and occurred very soon after sentencing. One man hanged himself, a second swallowed a substance he had brought into court and the third case was due to the effects of alcohol and cocaine (although no substances had been found when the men were searched). The checks required of escort staff were, in the most part, carried out properly but unfortunately did not prevent the suicides.

We found that none of the deaths could have been foreseen. There were no similarities amongst their offences, their sentences, or whether they had been in custody before – which suggest that some prisoners are at greater risk. Sadly, a friend of the second man knew of the risk but did not share the information with court staff.

Newly-sentenced prisoners are not allowed a visit before they leave the court. It may be that early contact with the family would provide reassurance to a prisoner facing a long sentence. Having said that, the first man did not seem to have expected a prison sentence and had come to court alone.

We found examples of good practice – including staff trained to notice and act on risks of suicide or self harm. Staff responded promptly on each occasion and medical assistance was obtained. Escort staff managed to persuade one of the men to accept treatment, but it was unsuccessful.

Although escort and court staff are unaccustomed to such tragedies, the investigators have always been given full cooperation. I am pleased that the escort providers and Court Service have accepted my recommendations and produced action plans to address them. As a result, prisoners may no longer take their own refreshment into the dock – it is provided by court staff. Escort staff must ensure that prisoners are checked during the staff lunch breaks, and consideration should be given to equipping them with small first aid packs.

Jane Webb
Mr W complained that the Governor would not grant him regular Release on Temporary Licence (ROTL) to attend his 14 year old daughter’s psychology appointments.

Mr W had been granted special licences on an ad hoc basis to attend the psychology sessions since August 2008. He wanted ROTL each Monday in order to continue his attendance. However, he was advised that his attendance would continue to be approved by monthly special licence until March 2009 and that he would then need to use Resettlement Day Release (RDR). Mr W considered that it was unfair to be asked to choose between attending his daughter’s appointments and his Saturday RDR.

The Investigator obtained copies of letters to the prison from Mr W’s daughter’s General Practitioner and Clinical Psychologist. It was the professional opinion of both that Mr W’s attendance at his daughter’s counselling sessions had been of benefit to her. The Investigator also discussed the complaint with the Governor. He felt it was not appropriate to be issuing regular special purpose licences for an open-ended activity. He considered that Mr W had to make a choice, albeit a difficult one, in how to use his RDR.

The Ombudsman was sympathetic to Mr W’s desire to offer as much support as possible to his daughter. However, having examined Prison Service Order (PSO) 6300 on ROTL, the Ombudsman was satisfied that it was not appropriate to continue to issue regular special purpose licences indefinitely. The PSO makes it clear that regular activities should be dealt with by RDR. The Ombudsman was also satisfied that, by providing Mr W with a monthly special purpose licence until March 2009, the prison had acted sympathetically towards him. It had given him time to make arrangements with his family to spread his contact with them as best he could. The Ombudsman did not therefore believe that it was unreasonable that Mr W was now asked to make a choice between spending his RDR with his daughter at her appointments or with other members of his family. The Ombudsman did not uphold this complaint.

Mr S arrived at the prison on 20 January 2009, his property arrived on 4 February, and he was supplied with it ten days later on 14 February. Whilst the Ombudsman would not normally consider such a delay reasonable, the Ombudsman was satisfied that, on this particular occasion, the prison had dealt with Mr S’s property as early as circumstances allowed after they had received it.

However, the fundamental issue was whether Mr S had access to a change of clothing. Unless the prisoner arrived in Reception without suitable clothing, the onus was on the prisoner to request a change of clothing once they had been placed on a wing. At the time of Mr S’s arrival, this would have taken five to seven days after completing a change of clothing form, which the Ombudsman considered to be too lengthy a procedure. However, the Ombudsman noted this had since been changed and that requests for a change of clothing were now entered onto a computer and the clothing was usually ready within two to three working days.

There was some discrepancy as to when Mr S’s prison issue clothing had been ordered. However, whatever the reason for this discrepancy, it was clear that Mr S only had one set of clothing from his arrival on 20 January until he was provided prison issue clothing on 13 February – a total of 24 days. The Ombudsman considered that this was unacceptable. The Ombudsman also considered that the complaint which Mr S submitted at the prison on 10 February should have alerted staff to the problem, and he should have been given prison issue clothing immediately.

In view of the changes already implemented, the Ombudsman made no recommendations for speeding up the process for issuing prison clothing. However, he recommended that the Governor should issue Mr S with a letter of apology for the delay in providing him with prison issue clothing, which was accepted.
A nurse conducted a first reception healthscreen, during which Mr A said he had been addicted to heroin for ten years. She referred him to the newly-opened detoxification unit. When the nurse was given the suicide warning form, she spoke to Mr A about the court staff’s observations. He assured her that he was not thinking of harming himself. Despite noticing red marks around Mr A’s neck and considering other risk factors, the nurse did not start suicide prevention measures. She filed the warning form in a later section of the clinical record and made no note of it elsewhere.

An officer escorted Mr A to the drug treatment unit. They arrived as medication was being distributed, so all staff from the unit were busy. The officer was asked to put Mr A in an empty cell. The hatch on the cell door was very high, obscuring the view into the cell. There was also a nail affixed to the wall that served no discernible purpose. Failed to load the image.

Later that evening, the doctor assessed Mr A and prescribed a low dose of methadone. During his mental health assessment, he did not assess Mr A as at risk of suicide. The doctor did not see the suicide warning form, although he did have the clinical record, and he did not recall any red marks on Mr A’s neck.

Less than an hour later, staff discovered Mr A hanging in his cell from a ligature attached to the nail in the wall. Following resuscitation attempts, Mr A was taken from the prison in an ambulance. Sadly, he died before reaching the hospital.

The Ombudsman made several recommendations covering record keeping, staff training, and the physical environment and procedures in the detoxification unit.

Mr A was sentenced to two years imprisonment – his first time in prison. At court, staff found him in his cell with red marks around his neck. They completed a suicide warning form and put him on constant supervision. In prison, the reception officer acknowledged receipt of the suicide warning form, but did not think Mr A was at risk of self harm.
PPO Stakeholder Feedback Survey 2009

We have recently sent out a questionnaire for our Stakeholder Feedback survey. If you haven’t yet completed your questionnaire, please do so as soon as possible. The deadline is 23 November and we would really like to hear your views. If you haven’t received a questionnaire from us and would like to complete one, please either go to our website www.ppo.gov.uk, or email mail@ppo.gsi.gov.uk to get the link to the on-line survey – or call 020 7035 2834 for a paper copy. We are looking forward to hearing what you think about us.

New Deputy Ombudsmen

Elizabeth Moody and Penny Snow joined the Ombudsman’s office on 12 October as Deputy Ombudsmen with overall responsibility for our work on investigating complaints. Elizabeth and Penny work as a job-share and will both cover the full range of the work. (They have been job-sharing together for nearly five years.) Before joining PPO, they jointly headed the Mental Health Unit in the National Offender Management Service where they were responsible for policy and casework on restricted patients.

PPO Tube

Hot on the heels of the launch of the two new PPO promotional films (see issue 30), the PPO now has a You Tube Channel dedicated to the office. It’s the first time that the PPO have used a user-generated content website to raise awareness of the office, however it has already proved to be a success as many people from the general public have viewed the two promotional films on the net. “It is of great importance for the PPO to utilise new media to raise awareness of the great work we do” says Ries-William Lamont, Communications Officer at the PPO. He continued “The wider world can benefit from a deeper understanding of how complaints and deaths in custody are handled by our office, the central message is the need for effective independent investigations and the two promotional films on You Tube do this perfectly”.

To view the PPO promotional films on You Tube simply visit www.youtube.com/user/PPOmbudsman
Mr C complained that he had been denied category D status in May 2009 because he had only recently completed a detoxification programme and the prison felt that he needed a longer drug-free period. The prison also considered that his detox showed that he had not previously complied with prison rules, which they viewed as a breach of trust.

The Investigator established that Mr C was a long-term drug addict who had been on a methadone maintenance regime. In late 2008, he had decided to wean himself off drugs entirely and was ‘clean’ by February 2009. Confirmation was obtained from two category D prisons that they had no problems accepting recently de-toxed prisoners, providing they had no on-going associated medical problems.

The Ombudsman upheld the complaint because he considered that Mr C’s detox should be viewed as a positive achievement rather than evidence of non-compliance. The prison acknowledged that, because he had only recently arrived, they had not been aware of the full circumstances of Mr C’s detox. The prison therefore reviewed Mr C’s security category early and downgraded him to category D status.

Ms D had a very difficult time during the two months she spent in prison before she died from a severe asthma attack. She was particularly disappointed that she died in custody several days after she could potentially have been released on HDC, seemingly because the relevant forms had not been completed on time. Nevertheless, the Ombudsman was unable to say that Ms D’s death would have been prevented had she received the further support that could have been provided.

Mr F complained that his stereo had been damaged in transit between two prisons. He requested to be reimbursed by £155 in order to buy a replacement.

Mr F’s property cards showed that the stereo had arrived at the prison in November 2008 in a badly damaged condition. Mr F said that he had purchased the stereo. However, the Investigator established that when he had been at a previous prison some four years ago in 2004, Mr F had signed a loan agreement for the stereo. This agreement stated the stereo had been loaned to him at no charge, that any loss or damage would be his responsibility and that the cost to replace the item would be £25. The agreement requested that the stereo should not be taken from the prison.

The Ombudsman did not uphold Mr F’s complaint because he had sought compensation for an item that he had not purchased and that he should not have taken from his previous prison.

Mr K complained about being refused a transfer to a prison closer to home.

The Investigator established that Mr K had been transferred to another prison for a court hearing. Unfortunately, the sending prison had failed to make the necessary arrangements for his return once the court case had finished. Mr K therefore ended up in a prison some considerable distance from his immediate family.

The prison in which Mr K found himself had an internal policy which required prisoners to have been there for a period of three months before an application for transfer could be considered. The Ombudsman upheld Mr K’s complaint because it was clear that he had lost his place at his previous prison for reasons that were beyond his control, and this was counter to the assurances he had been given at the time.

Mr K’s current prison agreed that they would arrange to transfer him back to his previous prison or another one nearer his home.

Mr R was an American citizen serving an eight-year sentence. In 2008 he was diagnosed with cancer and received chemotherapy in hospital. As an inpatient, Mr R was released on temporary licence. Non-uniform officers stayed with him to offer support, as his relatives were in America. The Governor allowed a prisoner, one of his friends, to be escorted to the hospital to visit Mr R.

Mr R was later transferred to a prison healthcare unit for palliative care during the final weeks of his life. The prison arranged for his next of kin to fly to the UK. They were met at the airport by a prison family liaison officer and taken to see their brother. They visited him daily in the healthcare unit and were offered assistance while in this country. Sadly Mr R died several days after they returned home, but his family appreciated the support of prison and healthcare staff.

The Ombudsman commended the above arrangements as examples of good practice.