

Annual Report 2008–2009

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at HMP Norwich and HMP Send



Prisons and Probation Ombudsman
for England and Wales

Annual Report 2008–2009

Presented to Parliament
by the Lord Chancellor and Secretary of State for Justice
by Command of Her Majesty
July 2009

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A PROFESSIONAL ORGANISATION

This Annual Report differs in one important respect from the predecessor reports for which I have been responsible since 1999. At the heart of the report there remain the many stories of complaints and fatal incident investigations that we have conducted, and the lessons that may be derived from them. That is how it should be. Indeed, I am proud of what people tell me is the readability and humane tone that distinguishes this report from so many emanating from public bodies. However, I have also felt for some time that there was a need for a greater focus on outcomes, use of resources, and the business side of running an Ombudsman's office.



This is not to say that I much like the business metaphor. One of the reasons Ombudsman's offices regularly encounter backlogs of work is that, unlike most commercial businesses, an increase in demand for our services does not improve the revenue stream and thus enable a speedy increase in output. There are no market mechanisms to bring supply and demand back into balance.

However, it is arguable that had we placed more emphasis upon so-called business outcomes it might have persuaded the Home Office and Ministry of Justice to take more seriously my concerns about the under-funding to which we have been subject. We might also have encountered more understanding of our need for day-to-day operational freedoms. At the same time, the extent to which the Prisons and Probation Ombudsman's office has been insufficiently accountable might also have been more obvious. Be that as it may, my colleagues and I have set out this year with the express goal of creating a more professional (and business-like) organisation.

I would like to outline some of the ways in which we have gone about this in the paragraphs that follow. But before doing so I must repeat what has been manifest throughout my time as Ombudsman – that our status as a non-statutory body cannot be justified given the public significance of our role. Indeed, as I have also pointed out repeatedly, the absence of legislation undermines the extent to which we may be considered sufficiently independent in terms of Article 2 of the European Convention on Human Rights. That view has been buttressed by the decision of the Court of Appeal in *Brooke* in respect of the independence of the Parole Board.¹ It is true

that the decision in regard to the Parole Board was with reference to a different Article of the European Convention. However, at least the Parole Board has had the benefit of operating as a non-departmental public body, a model I believe would be exactly right for my office but which has been rejected thus far by the Government.

Legislation remains this office's aim, and we have continued to press that view on every occasion. There remains a Government commitment to that end, but that cannot be a reason to put everything else on hold. Instead, we have been working very hard to enhance our independent professionalism in other ways. Proper investment in our staff has been critical in that endeavour. This year, we have developed bespoke training courses for our investigators – a step-change both to improve skills and to reinforce the message that ours is a profession apart. We have also looked at the support we offer to our staff, given the emotionally demanding nature of much of their work. We are not like any other 'unit' in the Ministry of Justice. We are a specialist organisation whose whole purpose is to conduct comprehensive, professional investigations that command public respect.

We have also been looking at the way in which we communicate the learning from our reports. I am especially keen to develop our knowledge management (another term imported from business schools), although this will never be as it should be until we are free to invest in the IT that suits our needs rather than what we are obliged to accept within the terms of a Department-wide contract.

Given the serious ill health of three of the most senior members of my office – one of my Deputy Ombudsmen, Rhian Evans, has

¹ [2008] EWCA Civ 29.



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been obliged to take early retirement due to ill health, while another, David Barnes, died in service – we have not been able to make as much progress during 2008–09 as I would have liked. In particular, plans to deliver a comprehensive performance management framework covering the elements of timeliness, quality, customer feedback and organisational performance have had to be bounced forward. Nevertheless, as I record later in this report, our achievements in regard to the development activities that I set out in our published business plan have been very encouraging.

In any casework operation, it is the front-line work that must always take priority. But given that we do not have the luxury of designated staff who can take the change agenda forward, I think that we can be pretty proud of what we have done so far. As I have said, we have invested heavily in training. We have revised our website and internal meetings structure. We have conducted customer and stakeholder feedback initiatives. We have carried out a major review of the complaints function. We have refreshed our relationships (the title of the essay I wrote introducing last year's Annual Report) with key stakeholders – in particular, with the Department of Health, the Coroners Society and the National Offender Management Service (NOMS).

Beyond all this, the initiative that has been of most significance has been that to revise our Terms of Reference and to establish a framework document and supporting protocols to set out the office's freedoms and accountabilities. Unfortunately, the framework document became bound up in the Ministry of Justice's own initiative to set out a Regulatory Framework Review,

and has not been progressed to the extent I had hoped. It was particularly disappointing not to achieve the target of 1 April 2009 for a framework document – to be supported in due course by protocols and memoranda of understanding over functions such as accommodation, HR and IT. However, I anticipate that we will be able to finalise the document soon.

Progress on the new Terms of Reference was even more disappointing. Although we ourselves submitted a draft in the early autumn, we learned in March that a further consultation might take months to complete. In fact, the new Terms of Reference are largely a tidying up and amalgamation of those terms that had developed since the office was founded in 1994. The new responsibilities we have sought – a light-touch 'guardianship' role in respect of the complaints system as a whole, a limited 'own volition' power, and a responsibility for the complaints of offenders' relatives as well as the offenders themselves – did little more than regularise arrangements that were already in place informally. (Indeed, I do not have the resources to extend these roles.) I have found the labyrinthine procedures deemed necessary to deliver modestly updated Terms of Reference extremely frustrating. However, this was all of a piece with other difficulties we have faced in our relationship with the Ministry of Justice – in particular with regard to the provision of adequate accommodation.

I must now turn to say something about the complaints we have investigated and the fatal incident investigations we have carried out. It has been a year of great pressure on staff at all levels given the mismatch between the tasks with which we

have been entrusted and the resources at our disposal. I am concerned about stress levels and over-working.

We have changed the way in which we record complaints with the consequence that the figures for 2008–09 cannot sensibly be compared with those for past years. The headline figure is that the number of complaints received fell by 470 (10 per cent), the first year it has fallen since I became Ombudsman in 1999 (indeed, I think it is the first fall ever). However, this is almost certainly the result of the new recording practice that no longer separates out multiple complaints. Because of an increase in the eligibility rate (that is, the proportion of complaints received that come within my Terms of Reference), the number of complaints that I could investigate rose to 1,828 (an increase of 10 per cent). This is the best index of the rising workload faced by colleagues on the complaints side of the office.

Of those complaints received, 3,818 were prison complaints, 388 were probation complaints and 99 were immigration complaints.

In line with our greater professionalism, we have begun to differentiate more effectively between complaints in terms of the depth of investigation required. Of course, no complaint is trivial to the complainant (not least when you are in custody and have so little autonomy over your life). And what may appear to be straightforward at the outset of an investigation can become far more complex once you start digging around. However, I have been concerned that we were not investing sufficiently in the most serious complaints (those alleging assault, or racism, or other misuse of power). And in a world of limited

resources, that inevitably raised questions as to where compensatory savings could be made. In fact, the watchwords of this office – proportionality and reason – have proved as good a guide to resource allocation as they are to the determination of issues. I think we can identify complaints where it is both proportionate and reasonable to devote fewer resources – and thus allow more time and effort to be put into matters that are objectively more significant.

In respect of fatal incidents, the total number of deaths investigated was 181 compared with the figure of 204 that I reported in 2007–08 (a fall of 11 per cent). The headline figure, the number of apparently self-inflicted deaths in prison, fell by 24 per cent from 83 in 2007–08 to 63 in 2008–09. However, because work on an investigation does not conclude until after the inquest, the number of ‘active’ cases has grown rather than fallen.

Given the pressures on staff, I took the decision in the latter part of the year not to open any more discretionary post-release investigations. I will review this policy monthly.

Every self-inflicted death necessarily occasions great sadness, and the fall in the number of such deaths in prison is a matter for quiet celebration. I hope that the lessons from my office’s investigations are one of the reasons why this reduction has occurred. My reports have emphasised the centrality of treating prisoners decently and as individuals, as well as ensuring that policies and procedures designed to reduce distress are implemented properly. Nevertheless, while the trend in self-inflicted prison deaths is now down significantly, I must caution against over-interpreting one year’s figures. And

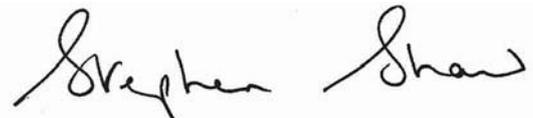
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it is important that the momentum is not lost. It is a matter of regret that the words suicide and self-harm feature nowhere in the NOMS Strategic and Business Plans published in February 2009.

The circumstances giving rise to a death in custody and those that lead to a near death (where resuscitation has been successful) are self-evidently closely aligned. And during the reporting year, I published my report into the first Article 2-compliant investigation into a near death in this country in the case of D.² In conducting the D inquiry, I became increasingly concerned that the procedures that had been ordered by the courts were time consuming, costly and disproportionate. The D inquiry cost in excess of £0.5 million (made up in large part by the parties' legal bills), and in my report I wrote as follows: "I believe this was disproportionate to the facts of this case. In any event, such a sum would prove ruinous were it to apply to all future inquiries into near deaths in custody." (More positively, I do think that the non-adversarial approach to D – what I called in the report "an inquiry conducted by an Ombudsman in a manner consonant with an Ombudsman's approach to dispute resolution" – was entirely right. I regret the degree to which Coroner's inquests have become increasingly adversarial, with grandstanding by barristers more accustomed to the different ways of the criminal courts.)

Because of my concerns in respect of the D inquiry, I have taken a particular interest in the decision of the House of Lords in respect of a third near death, that of a young man known as JL.³ The Law Lords concluded that the Article 2 investigative obligation would be triggered by some cases of near suicide, but did not give a definitive description of what cases would require independent investigation. However, the form of such an investigation would usually be significantly more modest than that ordered in D. The Law Lords appeared to indicate that my office would be sufficiently independent for the purpose, and I have no doubt that the most sensible way of delivering such investigations would be by extending my office's Terms of Reference.

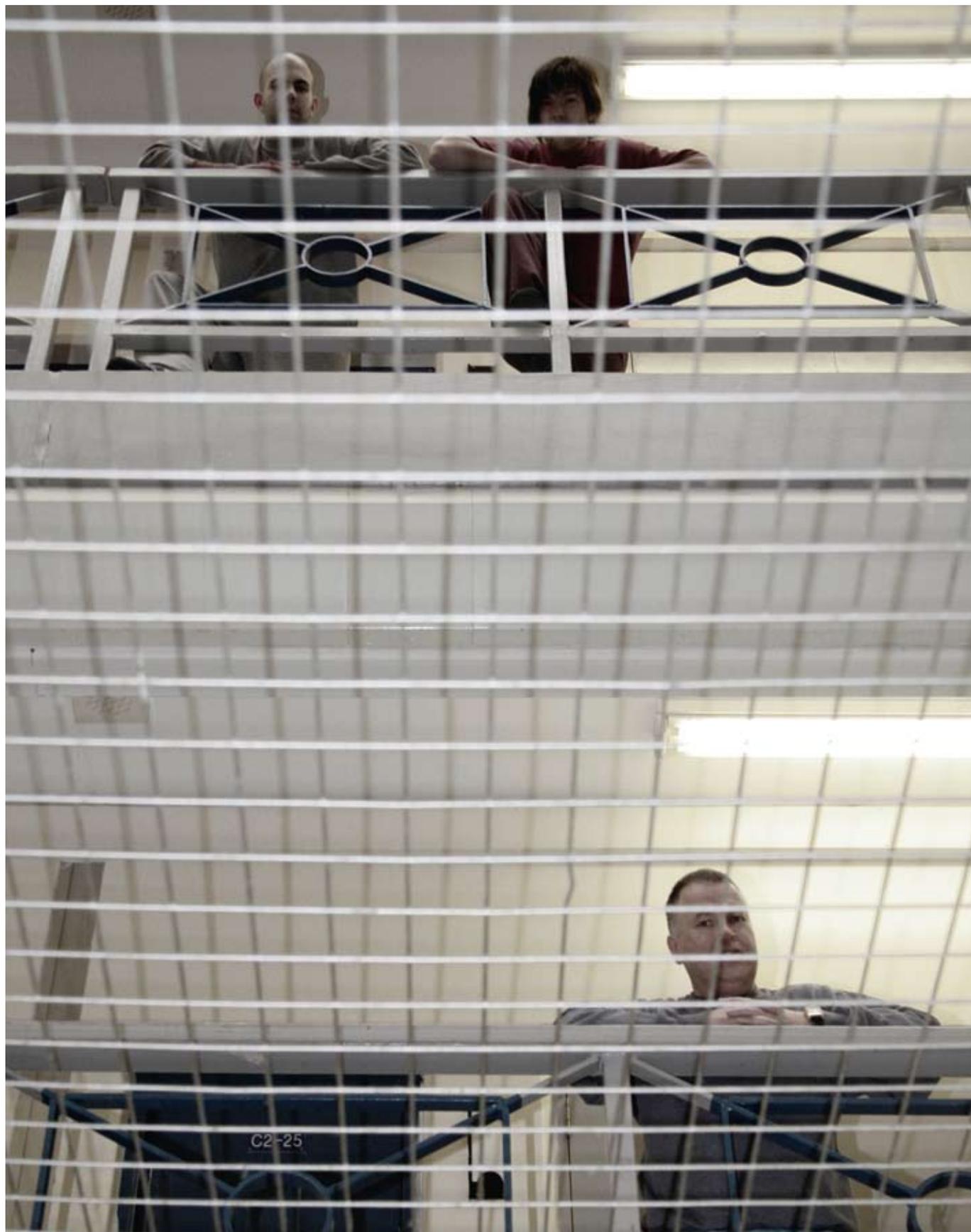
I am pleased to conclude this introduction by paying a public tribute to my colleagues. Under very trying circumstances, it is they who have made a reality of the Mission Statement and Statement of Values that are reproduced elsewhere in this document. It is they who are responsible for the achievements that are represented so admirably in this Annual Report. It is they who have made us a more professional organisation.



Stephen Shaw CBE
Prisons and Probation Ombudsman for
England and Wales

² Full details on my website (www.ppo.gov.uk). I was also asked to chair a second Article 2-compliant inquiry in the case of a young woman known as SP who repeatedly self-harmed in custody. I resigned from that inquiry in June 2008 for reasons that were widely reported in the press.

³ R (JL) v Secretary of State for Justice [2008] UKHL 68.



INVESTIGATING FATAL INCIDENTS

March 31 2009 marked five years since I first began investigating deaths in prisons and Immigration Removal Centres (IRCs), and the deaths of residents of probation Approved Premises. (I also investigate deaths in other places where there are prisoners, such as escort vehicles and court cells.) In that time nearly 1,000 investigations have been opened, 831 draft reports issued, 762 final reports published and over 5,000 recommendations made.



I wrote last year about the number of vacancies in the Fatal Incident Investigations (FII) management team. Filling the last position in June 2008 brought much needed focus and purpose to our death in custody work. Managers have taken great strides in addressing a range of issues: in particular, more consistent evaluation and validation of investigations, prompt advice on feedback to draft reports, and increased recognition of workload stress and keeping safe when away from the office.

Re-establishing a full FII management team has also meant we can liaise and communicate more actively with our stakeholders. I am especially pleased that we have been able to speak to regional Offender Health teams about their role in fatal incident investigations, and I have been glad of the opportunity to support initiatives that should increase the independence and quality of clinical reviews. The management team has also built upon the already good working relationships we enjoy with the UK Border Agency (UKBA) and HM Courts Service by establishing more formal liaison arrangements. And throughout the reporting year, we have continued to have fruitful discussions with established stakeholders such as the National Offender Management Service (NOMS), Safer Custody and Offender Policy Group, the NOMS Public Protection Team, and with Offender Health. In the coming year I hope to introduce regular liaison arrangements with each establishment, area and region. I will also be working with Offender Health and the National Patient Safety Agency, which has agreed to receive our reports. In this way our recommendations will go

to a wider audience and carry even greater weight for healthcare providers.

So far as my reporting of fatal incidents is concerned, I must begin by acknowledging that, while the timeliness of my reports is continuing to improve, it remains below the standards that I expect. I am very aware of the impact that reporting delays have on bereaved families as well as on prison, probation and immigration staff and the relevant Coroner. That said, the reasons for many of the delays do not rest within my office. For example, it has been necessary to suspend a small number of investigations to ensure that the work of the police and the Crown Prosecution Service is not jeopardised. (I hope that proposals for extending our Memorandum of Understanding with the Association of Chief Police Officers, and the initiative to develop a similar memorandum with the Crown Prosecution Service, will help keep any consequent delays to my investigations to a minimum.) And by far the most significant factor in delays is my dependence on local Primary Care Trusts to provide a review of the clinical care that the deceased received. I recently surveyed 40 cases and was pleased that most reviewers were suitably qualified and reasonably independent, but I was perturbed by the time they took to produce their reviews. Of the 69 reports that were overdue at the end of the reporting year, 51 were still awaiting the clinical review. In some cases, the delay in supplying the clinical review has been almost a year.

This is not to try to pass the buck. I am aware that the responsibility for some other overdue reports is entirely our own. We have not been helped by the fact that it takes so long to fill vacancies (the FII team ran with seven vacancies for most of the year).



INVESTIGATING FATAL INCIDENTS

During 2008–09, 164 people died in prison. I finalised 174 reports on prison cases and made almost 700 recommendations. The themes that arose most often were the need for improvements to healthcare, the need to ensure the proper implementation of policies and procedures, and the need to improve healthcare record keeping. One other theme deserves a special mention. That is the number of staff whose positive actions exceeded normal expectations and led me to commend them for their work.



Many of my recommendations concern the practice of individual prisons and I make them directly to the Governor where the death took place. However, throughout the reporting year I have also made recommendations of national significance. In particular, I have been concerned about the treatment of foreign national prisoners and welcome the revised Prison Service Order (PSO) that requires all prisons to establish and implement a policy for meeting their needs. In addition, a number of my investigations have highlighted the differing expectations for dealing with any prisoner who is found not breathing. I have been pleased to learn that NOMS and Offender Health are considering issuing further guidance on the actions to be taken in respect of resuscitation. I hope that this will result in a more consistent approach throughout the prison estate.

Regrettably, I have found the arrangements for sharing and implementing national recommendations to have been rather insubstantial and I have taken action to improve them. I now routinely share my recommendations with HM Chief Inspector of Prisons and am in consultation with NOMS about their own systems for disseminating the learning from investigations.

Once more I have been grateful to Offender Health for undertaking an analysis of my reports. This year they looked at 130 deaths from natural causes and found a number of common factors:

- The average age of the deceased was worryingly low at 52 years for the men and just 44 years for the women.
- The most common causes of the deaths were heart attacks and cancer.

- In 14 per cent of the investigations the care provided was found to be less than satisfactory. (I variously found lack of continuity of care, failure to refer to specialist secondary healthcare, inadequate reception health screening and poor emergency responses.)

Turning now to other deaths in remit, I am pleased to report that the number of people who have died in Approved Premises remains low. I should also say that probation areas and trusts continue to respond positively to my reports, and a Probation Circular is planned which will extend my recommendations across the estate. NOMS is currently considering introducing a national arrangement for monitoring and supporting hostel residents who are at risk of suicide or self-harm, rather as Assessment, Care in Custody and Teamwork (ACCT) monitors and supports prisoners who are at risk. Another development which originated from my work in prisons is that hostel residents, like prisoners, will now be allowed to hold their own medication in possession unless there is good reason not to do so.

No death occurred in immigration detention, but I conducted one discretionary investigation following the death of a man recently released from immigration detention and one investigation following a death in court cells. Although the inquest has yet to be held, this latter death appeared to be the result of deliberate self-poisoning and raised questions about search procedures at court.

The following sections of this report provide examples of the work undertaken by my FII team throughout the year.

Natural deaths

The majority of fatal incident investigations that I conduct each year are deaths resulting from natural causes. As the average age of the prison population increases (the outcome of longer sentences, not least in respect of sexual offences), it seems reasonable to assume that the trend in natural cause deaths will be upwards.

Most of these deaths are unavoidable, and I see many instances of staff treating prisoners suffering from terminal illnesses with great respect and compassion. However, I also believe that on too many occasions decision-making – particularly in the use of restraints when a prisoner is taken to outside hospital – is excessively risk averse. I question how far this is consistent with the Prison Service's own 'decency agenda'. The use of restraints can be upsetting for families and hospital staff, and is not dignified for prisoners approaching the end of their lives.

Mr A was already in his seventies when given a long custodial sentence for sexual offences. It was established on reception in prison that he had several chronic diseases, including arthritis and lung disease. He was later diagnosed in hospital as having cancer, and was told that his condition was terminal.

Although he returned from hospital to prison, soon afterwards Mr A experienced breathing difficulties and was readmitted to the hospital. Two officers accompanied him and conducted a bedwatch. A risk assessment was carried out, and it was

decided that Mr A posed a high risk to the public and that handcuffs were required.

Mr A was in hospital for just two days. His condition deteriorated. The duty governor agreed that handcuffs should no longer be applied an hour after he had been given the last rites. He died shortly afterwards.

In this case, I judged that the restraints should have been removed earlier. Mr A was elderly, his prognosis was very poor, and there were two officers with him. I recommended that the prison review its bedwatch and escort instructions, and offer further guidance to staff.

A safe place

The prison population has increased steeply in recent years, from around 61,000 in 2000 to its current level of around 83,000. (The absolute peak of 83,810 occurred in August 2008.) As a result, despite significant investment to create additional places, the prison estate remains under great pressure. A mismatch between population and the available accommodation has a number of destabilising effects. Not least, it often means that prisoners are transferred on 'overcrowding drafts'. Although the prisoners are selected according to agreed criteria, the result is often that they are moved from jails that they know, and where they are known, to other busy prisons where they may feel less safe. A number of my investigations have drawn attention to potentially tragic consequences.

From October 2006, an initiative known as Operation Safeguard enabled prisoners from court to be held overnight in police cells if there was insufficient space in the

prisons. The intention was that prisoners should be returned to the discharging jail the following day. The Prison Service Instruction providing guidance on the use of Operation Safeguard advised that every effort should be made to avoid the use of police cells for particular groups of vulnerable prisoners, such as those at risk of self-harm on open ACCT plans and those with significant healthcare problems.

Mr B had served a lengthy sentence for a violent offence and had previously been diagnosed as suffering from schizophrenia. While on licence, he was recalled to prison following allegations of further offending. Mr B was taken to a local prison where he remained for just over a month until a scheduled appearance at a magistrates' court. By the time Mr B departed from court, the prison he had left that morning had no places available and, as part of Operation Safeguard, he was taken to a police station in another county. After spending the night in the police station, Mr B was taken to a prison in yet another county. Ten days after his arrival at the second prison, Mr B was found hanging from the window bars in his cell.

Prisoner Escort Records (PERs) are used to share information about risk or vulnerability between agencies responsible for prisoners as they move around the criminal justice system. My investigation found that Mr B's PER was not endorsed with details of his mental health condition and did not ask that he should be returned to his discharging prison.

Mr B was seen by nurses from the mental health in-reach team at the second prison and was prescribed anti-psychotic medication. However, the investigation found that he had not collected it for four days. It was also found that nursing staff had not contacted their colleagues in the prison where Mr B had been held previously to obtain information about his condition and treatment.

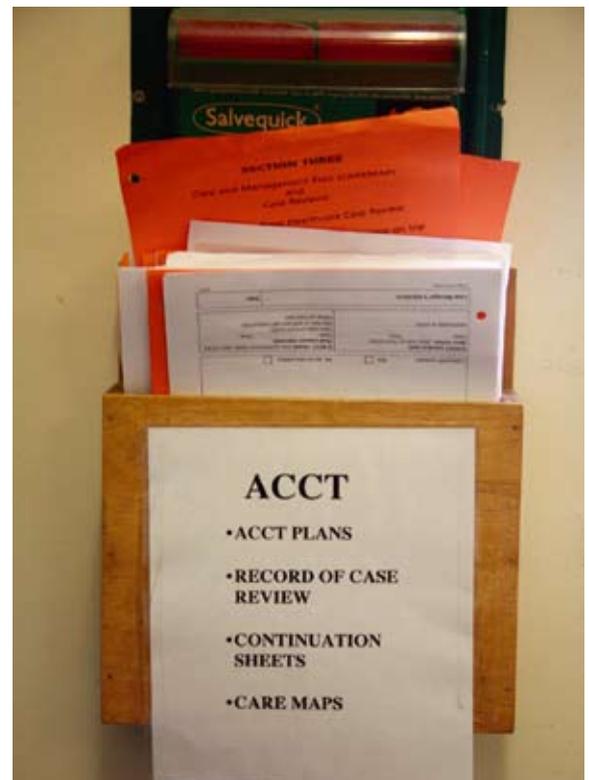
The lessons from this sad affair speak for themselves. When Mr B was first recalled to prison he was settled and was receiving appropriate medication. He was then relocated twice within a short space of time. With the benefit of hindsight, it is apparent that the disruption to his care caused by overcrowding substantially increased Mr B's risk of self-harm.

The malign effects of overcrowding are also experienced by prisoners who have not passed through Operation Safeguard. Prisons in the South East are among the most overcrowded, and it is commonplace for groups of prisoners to be transferred to jails in the Midlands. They may then be transferred even further from home. The effect of such movements may be seen in the case of Mr C.

Mr C was a young man who had come to England with his mother while still a teenager. They settled in the South East and Mr C went to college. There he met his partner, with whom he had two children. Mr C breached the conditions of a 120 days suspended sentence and the sentence was activated. It was Mr C's first time in custody. As prisons in London and the South

East were full, Mr C was sent to a prison in the West Midlands. He remained there for almost two weeks before he was further transferred to a prison in the North West. After less than a month in this third prison, Mr C was found hanging.

Mr C's partner told my investigators that he was a very shy and timid person, embarrassed by his relatively poor command of English. Her mother said that Mr C had sounded extremely upset when he last telephoned from the prison in the West Midlands. He had told her that he was happy there and did not want to be moved to a different prison. Whatever the reasons for the second transfer, the consequence was that Mr C was held about as far from his home and family in the South East as it was possible to be. Staff and prisoners at the





prison were not aware that Mr C had any major concerns. His temperament may have proved a barrier to seeking help and he left no note in his cell to explain his actions.

Mr C's death came when he had less than three weeks of his sentence still to serve. However, my investigation found that he had received no visits at the prison where he died and had made no telephone calls. I cannot say categorically that the severance of family ties contributed to Mr C's death (the only other apparent trigger was that he had recently been placed on the basic regime under the Incentives and Earned Privileges scheme). But it is self-evidently destructive of family relationships if prisoners are held so far from home that no personal

contact with loved ones can be maintained. This too is not consistent with decency.

Warning signs

In my report on the near death of D (see footnote 2 on page 8), I recommended that the Prison Service should conduct a formal review of the ACCT system to ensure that it remains fresh, properly implemented and attuned to individual circumstances. However, there is no doubt but that the introduction of ACCT has reduced the risks of suicide and self-harm. Indeed, it may have other benefits too in bringing staff from all disciplines together. It may not be perfect, but when done well ACCT is a world-class system.

Nevertheless, when prisoners give no outward indication to staff or their peers that they are feeling low or depressed, it becomes very much more difficult to identify warning signs. Many prisoners choose to hide their real feelings from staff (and often from other prisoners), and wish to keep their personal circumstances private. Furthermore, prisoners' personal circumstances may change dramatically in a day. If prisoners learn during a visit or over the telephone that their partner intends to end the relationship, or that a close relative has died, prison staff may well not be aware of the bad news. In that situation the prison self-evidently cannot offer the additional support or monitoring that is available when a prisoner is known to be vulnerable and at risk. Deaths can therefore occur completely unexpectedly and are perhaps even more shocking for those involved.

Mr E was a troubled young man who had been in young offender institutions (YOIs) on a number of occasions. While growing up, Mr E had been in contact with various services and had been assessed as suffering from anxiety and depression. He was found hanging in his cell shortly before Christmas.

Less than a month after being released from a custodial sentence, Mr E had been remanded in custody and sent to another YOI. He had hoped to be given bail so that he could spend the Christmas period with his family. The following day, Mr E wrote to his mother expressing his frustration at being in custody and missing the festive celebrations. However, he also said that it did not matter as the following Christmas would be "the big one".

Two of Mr E's friends told my investigator that he was generally chatty and chirpy and played pool during the association period, showing no signs of depression.

My investigation found that, during the afternoon of the same day, Mr E made seven telephone calls over the space of an hour or so to his mother and his girlfriend. The tone of the calls was confused, expressing both anger and love in swift succession. Finally, Mr E told his girlfriend that he would speak with her the following week. He asked her to tell his mother that he would not be able to call her until the next week as he had no more telephone credit. No members of staff were aware of these conversations as only a small proportion of telephone calls are monitored contemporaneously.

Later that day, Mr E wrote to his mother and expressed his disappointment at missing Christmas. He also wrote to his girlfriend, saying he was sorry for his behaviour towards her in the past and that he was sorry it had to end like this. Quite rightly, most prisoners' mail is not routinely scrutinised and staff had no reason to see Mr E's letters.

That evening, Mr E had a conversation with an officer who knew him from a previous sentence. The officer subsequently told my investigator that Mr E seemed in good spirits and was joking with other prisoners. The officer knew Mr E had been refused bail and asked him how he felt about this. Mr E did not appear too upset and told the officer that he hoped to get bail later.

Mr E was not seen again until the following morning's roll check when he was found hanging in his cell. It was clear that he had died some time previously. He had

left a letter on his bed, indicating that he intended to take his own life. It gave no reasons. It would seem that once Mr E had made up his mind to kill himself he took pains to ensure that he hid it from all those around him.

I may add that Mr E was not unusual in appearing calm, perhaps even happy, in the immediate period before his death. This is a phenomenon I have noted in many of my reports, and it seems that some people may achieve a form of emotional release once they have decided to commit suicide. However, while this becomes clear retrospectively, it need hardly be said that appearing cheerful is not a credible predictor of increased risk.

Bullying

The Prison Service has a manifest responsibility to provide a safe environment for prisoners and staff alike, and to promote conditions that reduce the use or threat of violence. Bullying undermines prisoners' sense of safety, and causes physical and emotional harm. Preventing such abuse requires constant vigilance and challenge.

Bullying has featured in a number of my fatal incident investigations. Although one might assume that bullying is more common among younger prisoners, my investigations have identified it in all types of prison. In each case where bullying has featured, my investigations have considered a number of questions. Did staff know about the bullying? If not, was it reasonable that they did not know? If they did know, did they take reasonable steps to challenge the bully or bullies and make the victim safe?

Prisoners may be vulnerable to bullying for many reasons; for example through drugs,

or debt, or family loyalties. But perhaps the most at risk are those who have committed offences regarded as particularly abhorrent by other prisoners.

Mr F was accused of sex offences against children and was transferred to a local prison before his court appearance. The prison had a unit to hold sex offenders but this was full, and Mr F was therefore placed in a shared cell on a normal wing with another alleged sex offender. The cell was on the fourth landing and offered poor observation from the staff office. Over the next five days, Mr F was subject to threats and intimidation from other prisoners. An insulting word was written on his door and a piece of burning paper was pushed under it. Mr F also believed that urine was poured under his cell door. He was too fearful to come out of his cell at meal times. Staff investigated, but their best efforts failed to identify the perpetrators. Mr F was anxious and not eating. He was moved to the healthcare centre but took his life a few days later.

My investigation found considerable population pressures within the establishment. Given these circumstances, and although far from ideal, I was satisfied that setting up an overflow area for alleged sex offenders was the right thing to have done. However, I found that the cells used were in an area that could not be easily monitored. As a consequence, staff observation was limited. I suggested that overflow cells should be relocated to an area that allowed staff to be properly vigilant.

Mr G reported to staff that he and another prisoner had been threatened with a bladed weapon by a number of prisoners in the showers. Mr G said he and the other prisoner had “fought their way out”, and he named the assailants. Staff placed Mr G and the other prisoner in a cell together until they could be moved to another wing. The next day, Mr G and the other man were moved to the vulnerable prisoners unit. The following day, Mr G took his life.

My investigation found a number of factors that could have caused Mr G to have felt particularly depressed, and I could not say with certainty that

his death was a direct result of the intimidation. However, I also found that the prison had not handled the situation effectively. They had not investigated the allegation of bullying, despite having the names of the alleged perpetrators. Instead the victims were moved, but offered no further support.

I was not satisfied that wing managers were aware of their responsibilities to conduct investigations in such circumstances. I was also concerned that bullying could take place without being challenged. I asked the Governor to look into the matter and to remind all wing managers of their responsibilities. Nevertheless, by the time the Governor’s investigation was completed, the alleged perpetrators had been moved to other prisons.



Approved Premises

There was a welcome decrease in deaths of Approved Premises residents from 17 in 2007–08 to 10 in 2008–09. Of these 10, three were apparently self-inflicted, six were as a result of natural causes, and one followed a road traffic accident.

Given the small numbers, it is not surprising that no major themes have emerged from the investigations completed so far. However, in one case my investigator found that insufficient staff had received suitable first aid training. In another investigation, we found that there was no policy in place to advise staff when to attempt resuscitation.



Mr H had served a sentence for sexual offences. He was assessed as being at high risk of re-offending and was monitored under Multi Agency Public Protection Arrangements (MAPPA) level 3. Mr H was subsequently remanded in custody for a further offence before being convicted and given a suspended prison sentence. His release from custody was unexpected. The local probation area acted quickly to house him in an Approved Premises, but his case was highlighted in the local media and it was decided that he should be moved out of the area for a short time. Mr H was transferred to a different Approved Premises, some distance away. Five days after he arrived at the new hostel, Mr H did not return for the evening curfew. Shortly afterwards, staff were contacted by the police who said that he had been found dead some distance away.

Soon after arriving at the second Approved Premises, Mr H had told staff that he was having thoughts of self-harm and re-offending. Although the staff tried to support him, he was not allocated a key worker as his stay in the hostel was expected to be temporary. Staff were also concerned that they had not received full information about him and his history from the other probation area.

I was concerned that staff at the Approved Premises had responsibility for Mr H without having sufficient information about him and the risks he might pose to himself and others. As a result of my investigation, I made two recommendations. The first

was that all residents should be allocated a key worker regardless of the anticipated length of stay. The second was that staff should be reminded of the Probation Circular setting out how transfers between areas should be conducted.

Discretionary investigations

My Terms of Reference provide a discretionary power to enable the investigation of deaths of those who have been released from prison or IRCs where the circumstances raise issues about the care provided before release. (Although I am not aware of any test cases, it seems to me that the Article 2 investigative obligation may also be triggered in some post-release deaths.) However, as I have said elsewhere in this report, as a consequence of staff shortages and workload pressures I have had to limit the number of discretionary cases I take on. Indeed, by the end of the reporting year, no such investigations were being initiated. However, earlier in 2008–09 the office was investigating some discretionary cases, albeit I exercised my discretion only where I considered there might be crucial lessons to be learned.

The way I receive information about post-release deaths can be haphazard as the information can come from a variety of sources. The Prison Service, UKBA, Primary Care Trusts and individual Coroners have all brought such deaths to my attention at various times. I did not learn of the following case until some 18 months after the death occurred.

Mr J had served a sentence for serious sex offences that required him to sign the Sex Offenders

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Register for an indefinite period. He was also subject to a deportation order and, after his release from prison, he was immediately detained in an IRC. Some 18 months later, Mr J reported that he was losing weight but, for religious reasons, he initially refused medication or medical tests. A month later, Mr J agreed to a chest x-ray and tuberculosis was diagnosed. A few weeks after Mr J's diagnosis, the Asylum and Immigration Tribunal granted him bail. Consequently, he was released on temporary licence and moved to a National Asylum

Support Service (NASS) supported flat. Around six weeks later, a neighbour found Mr J unconscious and paramedics who attended confirmed that he was dead.

When Mr J was first diagnosed with tuberculosis, he was placed in isolation for approximately two weeks. After this period, he was overseen by the outpatient department of a local hospital. I found some evidence to suggest that he had tried to register with a community doctor to obtain his medication.

My investigation found that, as a result of good links between the IRC healthcare centre and the local hospital, Mr J's



symptoms were treated in a timely and appropriate manner before his release. However, I was advised by UKBA that detainees are only entitled to minimum emergency treatment and not the full range of NHS services in the community. I consider that the state retains a duty of care to those it releases from immigration detention (there are also obvious public health considerations), and that former detainees should be assisted to access care and medication in the community. Accordingly, I recommended that the Department of Health should review its policy regarding access to medical care in the community, particularly in respect of those with a notifiable disease. I am aware that the Court of Appeal recently ruled that failed asylum seekers are not entitled to free medical healthcare for chronic conditions, but hospitals have the discretion to provide such care. I await a response from the Department of Health.

Aside from the handling and care of Mr J, I also discovered serious shortcomings in the public protection process. Mr J had reported twice weekly to a reporting centre in compliance with his licence conditions, but I found that he had not signed the Sex Offenders Register. Although the documents prepared for the Asylum and Immigration Tribunal gave details of the offences for which he had been convicted, the papers did not indicate that he was expected to sign the Register, and the police were therefore unaware of his whereabouts.

In light of these findings, I made two recommendations. First, UKBA should ensure that detainees required to sign the Sex Offenders Register are reminded to do so on release, and second that caseworkers

and managers dealing with convicted detainees should understand the MAPPA and check that detainees comply with the conditions of their release. UKBA and NOMS have agreed to look at what more can be done to increase detainees' understanding of the conditions of their release and the consequences of failure to comply.

I mentioned above the haphazard way in which post-release deaths are reported, and in the coming year I intend to review the notification procedures with a view to achieving greater consistency. I hope this will also enable me to be more consistent and transparent about my own decisions on which cases to investigate.

Liaising with families

In the first nine months of the reporting year, my team of five Family Liaison Officers (FLOs) was involved in 142 new investigations. The team contacted 139 families (I use that definition to include friends) to inform them of my investigation and offer the opportunity to be involved. Sadly, in the remaining three cases, the FLOs could not identify any next of kin.

Additionally, my FLOs have continued to work with families in cases where my final report has not been completed or where inquests have not yet taken place. The FLOs' individual caseloads are very high, and I am conscious of the demands that are placed on them.

The team prefers to make first contact with the family by telephone. However, there are a number of reasons why this may not be possible. We may have been told that telephone contact is likely to be too distressing, or the family may not have English as its first language. In those cases,

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the team makes contact by letter, using translation services when necessary. At the family's request, contact may also be made via their legal representative.

My policy is to be as inclusive as possible. Consequently, if they are made aware of more than one set of family members, FLOs will offer contact to them all. I recognise that this may be difficult for those who are estranged or where family relationships are strained, especially when tensions are exacerbated by grief. Nevertheless, my aim is to offer a service to all family members

even when the involvement of some may be distressing to others. In 45 of the 139 cases, an FLO has worked with more than one set of family members, and they are trained to be alert to difficulties and to handle them as sensitively as possible. The FLOs will also contact the Coroner to confirm that they are dealing with all those whom the Coroner considers properly interested persons.

When Mr K died in custody, his parents were happy with the support they were given by the prison's own FLO who dealt with matters quickly, sensitively, appropriately and in accordance with PSO 2710. However, the prison's FLO did not know that Mr K had been married and separated until his wife telephoned the Governor, explaining that she had been in recent contact with the deceased.



When my FLO learned of the wife's existence, she contacted her offering the opportunity to be involved in my investigation. The Coroner also had not known about the wife, but deemed her to be a properly interested person in the inquest process because she and the deceased had remained married. With the wife's permission, her details were passed to the Coroner.

Mr K's parents did not want his wife to be involved and told my FLO that they did not want my office to have any contact with her. The FLO listened to their objections and acknowledged the parents' concerns, but explained my policy and my wish to be fair to all those affected by the prisoner's death. Although the parents were not

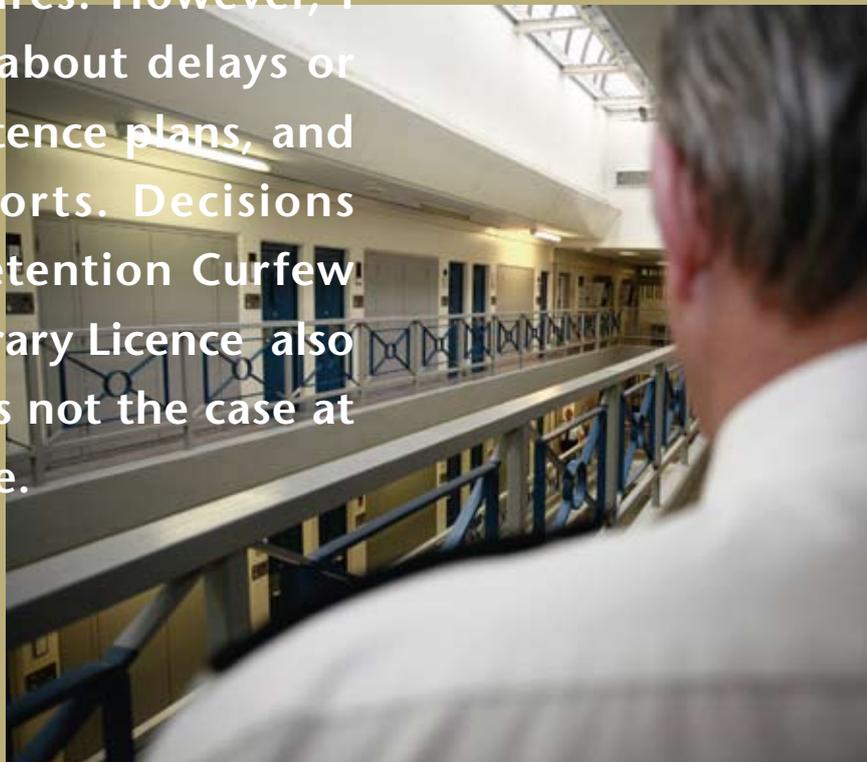


happy about the wife's involvement, they nevertheless appreciated the reasons for my policy, acknowledging how they might feel if they had been excluded.

Although I have received various indications that the work of the FLOs has a significantly positive impact for bereaved families, I am constantly seeking to improve the practice of my office. One initiative this year was a review of the initial information that FLOs provide to families, to ensure that it is informative and written in plain language. I have also introduced a number of changes to ensure that there is a consistent approach by FLOs in dealing with requests from families. The work that began last year on developing a system to obtain structured feedback from bereaved relatives is ongoing.

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The rising trend in the prison population, together with changes in its structure (many more prisoners are now serving long sentences), has affected the nature of complaints that reach my office. Of course, prisoners still complain about loss or damage to property and what they consider to be unfair disciplinary procedures. However, I now see more complaints about delays or omissions in delivering sentence plans, and about the content of reports. Decisions about release on Home Detention Curfew (HDC) or Release on Temporary Licence also feature to a degree that was not the case at the beginning of the decade.



The following cases illustrate the changing face of my office's complaints work, although I also cite examples of more traditional subjects of complaint.

A mother's concerns

Although most people supervised by the Probation Service are relatively young, they suffer a death rate much higher than among their peers. My remit does not normally include investigating the circumstances surrounding deaths of those subject to probation supervision unless they happen to be residents of Approved Premises. Nevertheless, exercising my discretion it is possible for a complaint about other deaths to come within my Terms of Reference.

Mr L was a young man under the age of 21 who died from a drug overdose at a time when he was being supervised by the Probation Service and had been attending an Offender Substance Abuse Programme (OSAP). Mr L's mother complained about the way in which her son had been supervised. In particular, she said that he should not have been placed on a programme with a group of older, regular users of hard drugs.

The probation area had commissioned an independent consultant to consider the mother's complaint, and he had prepared a report based upon a number of interviews with key personnel. As there had been no appeal hearing, strictly speaking the Probation Service's internal complaints system had not been exhausted when I agreed to take on the investigation.

Nevertheless, I judged that it would not have been kind to Mrs L or her son's memory to insist upon the completion of all the procedures, and I was grateful to the probation area for agreeing with me about this.

Mr L had pleaded guilty to a number of offences, including robbery. In asking for a pre-sentence report (PSR), the sentencing judge indicated that the seriousness of the offences meant that he must consider a custodial sentence. The author of the PSR assessed that Mr L's offending was directly related to his use of illegal drugs and alcohol. After further assessment, Mr L was found suitable for a community order with a condition to participate in an OSAP. In sentencing Mr L, the judge said that normally a sentence of several years would apply. However, in view of Mr L's age and absence of previous convictions, supervision could provide the best opportunity for him to change his ways.

For the next two months, Mr L kept appointments with his offender manager, admitting that he had been using cocaine every day and owed a significant amount of money. He also attended pre-group motivation sessions where his behaviour was disruptive. Course tutors considered excluding him from the group, but Mr L asked them to allow him to attend and gave an undertaking to co-operate. He attended three OSAP sessions over the next month and admitted that, on occasions, he had continued to use both cocaine and heroin. Mr L left the last session in the company of an older group member. He was found at the man's flat the following morning, having died from an overdose of heroin.

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My investigation looked at the criteria for admission to an OSAP. The programmes are intended for those whose offending is linked to any kind of substance misuse and who pose a risk of re-offending. They inevitably involve offenders of different age groups as probation areas are unable to sustain programmes for different age groups. Mr L was a vulnerable young drug user whose offending was not at the most serious end of the scale. However, he fitted the criteria for admission to the OSAPs that were in use at the time and the Probation Service had not placed him inappropriately.

Had he been sent to prison, Mr L might have found it a most difficult experience (and there is evidence that young people entering custody can be more not less likely to revert to drugs and crime after release). Likewise, had he been placed in a drugs programme in the community with others of a similar age, he could also have been

influenced for the worse. Although I could not entirely rule out such a possibility, it was not evident that the age of the other man had influenced Mr L to take a lead from him.

Nevertheless, I shared the opinion of the original investigator that the Probation Service should always ensure that the potential vulnerability of offenders under the age of 21 is taken into consideration when assessing them for OSAPs. I also proposed that NOMS should investigate any alternative programme that might be more suitable for offenders under the age of 21.

In addition, I suggested that there should be a further examination of those recommended for an OSAP. It may be possible to separate those for whom heroin is almost a way of life from other substance abusers where drug-taking plays an important, but not predominant, part in their activities.



Getting it right

In my introduction to this report, I refer to the professionalism of the staff group and the measures I have taken during the year to improve both training and delivery. I am proud that my office treats all complainants with respect as individuals. I expect no less from the services in remit and, on the whole, the same standards apply. However, there are times when complaints from those who believe they have genuine grievances are not given the attention they merit.

Mr M complained about a delay in receiving special delivery mail sent to him in prison. He was concerned as the letter contained much needed money for canteen purchases. Mr M's partner had paid extra postal charges to ensure that the letter reached Mr M quickly.

My investigation found that the letter had been received in the prison the day after posting but it had not been issued to Mr M until two days later. Although a delay of two days may not have been unacceptable, I found that the reasons given for the delay at stages one and two of the complaints procedure were contradictory. The PSO dealing with complaints requires that each stage should be handled by a different officer and that the appeal stage should be considered by a Governing Governor or designated representative. My investigation found that the same officer had dealt with all three stages of the complaint, and thus that it had not been dealt with in accordance with Prison Service guidelines. Not only that, but the officer's responses appeared both unhelpful and contradictory. The prison agreed to compensate Mr M by reimbursing the cost of postage.

Mr N said that he had complained about an officer's bullying, harassment and victimisation, saying that he would take legal action if the behaviour did not stop. He said that his complaint form had been returned unanswered and, when he submitted a second complaint asking why the earlier one had not been dealt with, he was told that staff had considered the complaint to be "threatening".

Mr N had complained that it was inappropriate for prison staff to refuse to answer his complaint and I agreed. I accept that it may be irritating for a prisoner to refer to the possibility of taking legal action, but it cannot be said to be threatening. It may show a lack of confidence that problems will be resolved, and to return such complaints unanswered only serves further to undermine that confidence. I was also concerned that, in refusing to address Mr N's complaint about a member of staff, the prison did not meet the mandatory requirement of the PSO that says any written allegation about a member of staff must be investigated. The prison accepted my recommendations that Mr N's original complaint should be investigated and he should receive an apology for the mishandling of the matter.

Mr P complained about the handling of the complaints procedure at the prison where he was placed. He said complaint forms submitted over the weekend were being returned and appeals were being dealt with as separate complaints. Mr P also said that the prison operated a

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blanket ruling that prisoners could submit only one complaint a day, irrespective of whether they were regarded as persistent complainants.

I understand that an informal rule adopted by many prisons is that any prisoner identified as a persistent complainant should be allowed to submit only one complaint per day, including weekends. However, this approach does not and must not apply to those who have not been warned that they will be treated as such. The prison agreed that appeals were treated as separate complaints as “each response requires time to go through the process”. I found this to be a clear breach of the requirements of the relevant PSO, as was the decision to allow only one complaint per day from all prisoners.

Consequently, I found that the prison’s local procedure was not in line with national policy. I am glad to say that the prison immediately acknowledged previous errors and agreed to amend its policy. The prison now imposes no restrictions on prisoners not identified as persistent complainants. The prison also agreed to consider each complaint, irrespective of the stage of appeal, as one complaint.

Ms R is a transsexual prisoner who complained that she had not been allowed to keep certain items of her property. She suggested that she had been bullied and suffered discrimination.

My investigation found that the items in question were not on the prison’s facilities list and it was appropriate for the prison to confiscate them. I also found no evidence

of bullying or discrimination. On the contrary, because of Ms R’s concerns, staff had taken particular care over her property, providing Ms R with bags and seals to organise her belongings. However, I found it was a feature of complaints about bullying and discrimination at the prison for the Diversity Manager and the Anti-Bullying Co-ordinator to be made aware of complaints only after they had been answered. In Ms R’s case, both were satisfied that the complaints had been properly addressed, but they had not been given the opportunity to consider if it was appropriate for them to have investigated the complaints themselves. Clearly it is neither fair nor cost-effective for specially designated officers to be prevented from considering the very issues they have been trained for. The Performance Manager accepted that this was an error and it has now been put right.

I also noted that two of Ms R’s complaints were answered at the final stage by a junior governor, with no indication that they had been seen by the Governing Governor. I was concerned that, if this was routine practice, the spirit of the PSO was not being followed. Treating appeals in this way could give prisoners the impression that their complaints are not being taken seriously. I suggested to the Governor that, when his colleagues respond to final appeals, they should make it clear that they have been delegated to do so. Otherwise, the Governing Governor should countersign the response to indicate that it has been seen.

Discipline and sanctions

I understand that in excess of 100,000 adjudications take place each year, and

many of them of course result in findings of guilt. The most serious allegations are now heard by independent adjudicators – district judges – and consequently the number of prisoners who appeal to me has decreased somewhat. Nevertheless, my office remains the appellate body for prisoners who believe they have been treated unfairly in most disciplinary hearings.

Adjudicators are invested with considerable powers and the punishments that follow findings of guilt may have a substantial effect upon prisoners' lives. It is therefore incumbent upon adjudicators to enquire fully into the circumstances of an alleged offence, and be satisfied that guilt is proved beyond reasonable doubt. I can review the record of hearing and assess if there have been procedural flaws that could render a conviction unsafe.



Mr S was found guilty of inciting other prisoners on his wing to commit offences. It was alleged that a number of prisoners were intoxicated and, when officers were restraining one of them, Mr S was heard to shout words of encouragement (to the effect that, whatever happened, he was completely behind the other prisoner and would help him resist). Mr S said he was simply attempting to calm the other prisoner who was being restrained.

The adjudication had been a lengthy process involving a number of witnesses. Several prisoners confirmed that Mr S had been trying to calm another prisoner. Evidence from two officers was inconclusive and contradictory, but all witnesses agreed that the incident ended when Mr S succeeded in calming the other prisoner and getting him back to his cell. The officers suggested that Mr S must have had second thoughts about inciting trouble when he realised the seriousness of the situation. Although I acknowledged that the officers were dealing with a potentially explosive incident in noisy, chaotic surroundings, I believed that a finding of guilt was unsafe given the considerable uncertainty as to what had happened. The evidence could not be said to point to proof beyond a reasonable doubt and I judged the ruling to be unsafe. The Area Manager agreed to quash the finding of guilt.

Mr T was an enhanced prisoner who had no previous adjudication findings against him. He pleaded guilty to being in possession of an unauthorised article, namely an improvised stabbing tool (known

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as a 'shank') that he had secreted in his cell. He said this was for his own protection. Mr T complained that his punishment of total loss of earnings for 82 days was excessively severe.

Mr T said he could not have money sent in to him. The total loss of pay meant he could not speak to his family on the telephone and thus could not maintain contact with them. Mr T suggested that he had the implement only because he had

been stabbed three times in custody and been threatened by another prisoner. He suggested that he would not have used the weapon on staff or other prisoners, but had forgotten to dispose of it after the prisoner who had threatened him was transferred.

The prison's guidelines stated that the most serious incidents of a prisoner possessing an unauthorised article could be punished in various ways, including 82 days stoppage of earnings. Although I accepted that Mr T would have been extremely concerned for



his safety, I could not agree that there is any occasion where it is right for a prisoner to take matters into their own hands and have in their possession a very dangerous weapon. The risks associated with the possession of such a weapon are among the most serious imaginable, and I did not judge that the punishment in itself was disproportionate. Consequently, I found no reason to recommend that all or part of Mr T's wages should be reimbursed.

However, the Prison Service had argued that more was expected of Mr T as an enhanced prisoner on the Incentives and Earned Privileges (IEP) scheme, and that the penalty was higher than he might have received on the standard or basic level. In contrast, the Service's own adjudication policy makes it clear that the IEP scheme and disciplinary arrangements should be kept separate, and I did not see any correlation between the penalty necessary to mark the seriousness of Mr T's offence and his incentives level. Consequently, I asked the Prison Service to take the necessary steps to ensure that prisoners' incentives levels play no part in adjudication decisions.

Mr V was found guilty of failing to comply with a rule or regulation in that he was found to be touching his visitor in an intimate and wholly inappropriate way on a family visit day.

In the visits room an officer was concerned that he could not see one of Mr V's hands and asked for the camera to be trained on him. Mr V's hand could not be seen as a child was in the way, but when the child moved the officer said he could clearly see Mr V's hand on his visitor in an intimate manner. At the

adjudication hearing it was noted that the video evidence was not available as it had been retained for only three days after the alleged offence. Nevertheless, the officer's evidence was that Mr V was touching his visitor intimately and inappropriately. Mr V said that, as family visits were more liberal and relaxed than normal visits, he did not realise he had been doing anything wrong.

I was critical that the video evidence had been wiped before the adjudication. Although the officer involved had decided it was inconclusive, Mr V and the adjudicator might have thought otherwise. I considered that, in the interests of transparency and conspicuous fairness, Mr V should have had the opportunity to view the recording. I was also concerned that the adjudicator did not explore whether different rules applied on family days and whether it was reasonable for Mr V to believe that his behaviour was acceptable. However, given that the evidence was that Mr V was touching his visitor intimately, I did not consider this to be a fatal flaw.

More importantly, the charge had been laid outside the 48 hours required by the PSO ("failure to charge within 48 hours renders any hearing void unless there are exceptional circumstances"). I could find no circumstances to account for the late laying of the charge and consequently I judged that the hearing was void.

I recommended that the finding of guilt should be quashed and Mr V's lost earnings restored to him. I also recommended that, where a recording is made of any incident leading to a charge, it should be retained for use at the ensuing hearing and any subsequent appeal.



Immigration removal

Those held in IRCs are normally refused permission to remain in the United Kingdom, and the expectation is that they will be returned to their countries of origin. In some cases, the desire to remain is so strong that the removal may be traumatic for all those involved.

Ms W was removed from an IRC and escorted to her country of origin via Southampton and Paris. She complained about her treatment by the escort service used by the UKBA during her removal, and made serious allegations of assault. In particular, Ms W alleged that on arrival at Southampton she had

been handcuffed and shackled because of her refusal to take medication. Ms W also said she was dragged onto a plane and at the airport in Paris had been beaten and kicked. She said that, as a result of the beating, when she reached her destination she was in pain and collapsed.

The investigation was assisted by CCTV footage taken inside the van showing that Ms W had been asleep for much of the journey. It also indicated that there was a substantial gap between Ms W's refusal to take her medication and the time when a struggle took place after Ms W became agitated and unco-operative, refusing to travel. Restraints were applied as a result of Ms W's behaviour.

However, the CCTV footage was obscured in places and did not show all that happened. I commented that it was unfortunate that there was no sound recording in the escort vehicle as this would have established more readily what happened when the CCTV was unclear. I am pleased to report that, in response to my recommendation, sound recording equipment is to be installed in all escort vehicles. This should be an added protection for detainees and staff alike.

My investigation found that Ms W's leg restraints were removed to enable her to walk to the aircraft. The handcuffs were removed after the plane took off and she calmed down. The evidence I obtained from a medical officer who had been present when Ms W was transferred from the van to the aircraft, and from others who witnessed events, gave no indication that she had been dragged or beaten. Witnesses agreed that Ms W had walked onto the aircraft with a member of the escorting staff on either side.

The events that occurred on arrival at Paris had been witnessed by French police, security staff, staff from Air France – including the captain of the aircraft – and various others. I found no evidence of inappropriate force being used. By all accounts, Ms W panicked when she saw French police waiting and tried to run away, chased by police and escort staff. She was tackled to the ground and leg restraints were again applied at the request of French police. The medical officer confirmed that Ms W was supported as she fell, to prevent serious injury. The only injury reported at the time was a graze to Ms W's knee.

All the evidence I obtained suggested that this was a frightening and traumatic

episode both for staff and, self-evidently, for Ms W herself. However, I found nothing to suggest that Ms W was restrained inappropriately or that she was assaulted. There is a fine line between what constitutes restraint and what is an assault but I was satisfied that the line had not been crossed in this instance. That said, the use of reasonable force may be both lawful and proportionate but no one would readily elect to be on the receiving end.

I was critical of two issues arising from the complaint lodged by Ms W. There was evidence that Ms W had spent a protracted period with her hands restrained behind her while waiting for the aircraft to take her on the second leg of her journey home from Paris. It is very uncomfortable to be restrained in this way and it must have caused considerable distress to Ms W. Although the Use of Force Manual provides for restraint with arms behind the back, it gives no specific guidance on the circumstances when this is justified, nor the length of time for which it should be applied. I recommended that UKBA should conduct a thorough review of the use of restraints and issue more detailed guidance.

I was also concerned that a female escort officer had reported that she had escorted Ms W to the lavatory during the flight and had helped her because Ms W was handcuffed. This was degrading for both parties and should never have occurred. Guidelines on the use of restraints provide for escort chains to be used when handcuffs have been authorised and the detainee needs to use the toilet. I recommended that all escort staff should carry escort chains with them, and they should be instructed to use them whenever decency would otherwise be compromised.

Sentence planning

The aim of most prisoners is to move through their sentence as quickly as possible. But unless prisoners make progress by demonstrating good behaviour and a commitment to working on their offending behaviour, they stand little chance of achieving early release on licence. There are key points in sentences when the Parole Board needs clear, timely information about prisoners' achievements and risk. Delays in the provision of such information have a knock-on effect and can leave prisoners feeling frustrated and uninformed. In one of the cases I outline below, the prisoner was so distressed by delays that prison staff became concerned he could harm himself and opened an ACCT document to monitor the risk.

A number of prisoners who have had their licences revoked and been recalled to prison have complained about delays in the system for providing information and the opportunity to appeal. Although it is outside my remit to examine the Parole Board's decisions about recall, I am able to look at any administrative delays that may have occurred.

Mr Y complained that he did not receive his recall pack until nine weeks after his return to custody. Mr Y said he was told that the prison had notified the Release and Recall Section (RRS) of the Ministry of Justice of his return to prison, as it was required to do, and they had no control over how or when the RRS responded.

My investigation confirmed that Mr Y was recalled on an out-of-hours basis

from an Approved Premises and that his supervising probation officer had sent the completed recall paperwork to the RRS the following day. A representative of the RRS confirmed that both the probation office and the prison had submitted the required documentation within the necessary timescale, but he could provide no explanation for the delay in providing Mr Y with his recall dossier. I found nothing to suggest that Mr Y's dossier or his representations against recall were in any way intentionally suppressed or hindered. Nevertheless, I judged that his case could have been handled more efficiently and the delay he experienced was avoidable. I asked the RRS to take whatever remedial action was necessary to make delays like the one Mr Y experienced less likely to occur in the future.

Mr Z complained about delays in submitting information required for his assessment by the Parole Board. The Board had issued written instructions that reports on Mr Z should be submitted to them by March 2008 but they were still outstanding some five months later.

Mr Z had been sentenced to an Indeterminate Sentence for Public Protection and consequently was classed as a life sentence prisoner. This meant that he could not be released until the Parole Board considered that his risk had been reduced to a manageable level. Without the necessary information, the Board could not know what risks Mr Z posed nor what he had done to reduce them. Consequently, Mr Z could not move forward. He had completed a course necessary for his Structured Assessment of Risk and Need

report in 2006, and been informed that the report would be completed within a few months. He had enquired about the report since March 2007 and had been told that he was one of many caught in a backlog. When he answered Mr Z's complaint, the Governor said he did not have the resources to complete reports but the psychology department had prioritised their work and Mr Z was on a waiting list.

My investigation found that there were just two chartered senior psychologists at the prison to cover all reports for all programmes, when the workload required six. Although trainee psychologists could undertake assessments and prepare reports, a senior psychologist was required to approve them and sign them off. On advice from Prison Service HQ and Treasury Solicitors, prioritisation criteria had been implemented and all outstanding reports had been placed in a queue. This was a lamentable situation and I was concerned that it had left Mr Z feeling distressed and even suicidal. Nevertheless, I was satisfied that the criteria used to prioritise cases were appropriate and that the prison was taking active steps to increase its capacity for completing reports. I upheld Mr Z's complaint but in the circumstances, despite my serious concerns, there were no practical recommendations I could make.

Mr AA complained that a report for the Parole Board prepared by the prison's former Lifer Manager contained a number of false statements that wrongly influenced the Board's decision for him to remain in closed conditions. Mr AA also suggested that the Manager's actions contained an element of racism.

My investigation found that the Manager's report was compiled using information from wing history sheets that were based on the observations of staff who had contact with Mr AA on a daily basis. I also noted that neither Mr AA nor his solicitor had challenged the information when given the opportunity to do so at an earlier Parole Board oral hearing. Consequently, I did not uphold Mr AA's complaint. However, it was evident that Mr AA's allegations of racism had not been followed up and I asked the Governor to investigate them at the earliest opportunity.



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Mr BB complained that, when he was transferred, the receiving prison had failed to provide a sentence plan or an OASys assessment and that these failures delayed his parole review.

Mr BB was a life sentence prisoner who had been refused transfer to open conditions until he could demonstrate that he had learned from offending behaviour work in category C conditions. It was clear that the main objective of his transfer on this occasion was to consolidate what he had already learned, and complete any outstanding work, to enable the Parole Board to reconsider his suitability for open conditions. Without a sentence plan he could not achieve that objective. Mr BB's OASys report had been completed 18 months late and in turn this delayed his parole review by more than eight months.

My investigation found that there had been severe staffing shortages in the lifer department of the receiving prison and that this had led to delays in the preparation of some plans and reports. However, reports on some other prisoners who were transferred to the prison around the same time as Mr BB were completed on time, and I could find nothing to account for why he had been missed. It is a prison's responsibility to ensure that prisoners receive their induction and subsequent assessments to provide the framework within which they must reduce their risk. Clearly, Mr BB's needs were overlooked and he experienced considerable frustration. While I accepted that the establishment had not deliberately overlooked Mr BB, staff could have done more to assist him.

I asked the Governor to apologise to Mr BB for the failures. I also recommended a review of staffing levels and performance to ensure that sentence planning and parole documentation is completed properly and on time.

Mr CC complained that the probation area and his offender manager had failed in their responsibilities towards him. He alleged that the area had not told him about a forthcoming visit, or that his previous offender manager had retired. They had also failed to inform him that the probation office had moved to a new address, and the absence of a home probation report had led to a delay in his recategorisation.

Mr CC was a long-serving prisoner whose outside probation officer had left the probation area in 2004. On her last visit to Mr CC, she had said that the probation office would be moving and that she would write to him with the new address. However, she failed to do so and Mr CC received no contact from the office between 2004 and 2007. When the area received a request for a progress report on Mr CC in 2007, two probation officers arranged to visit but did not tell him of their intention. In the prison, Mr CC was told he had a legal visit but, as he was not expecting one and did not know who the visitor was, he declined to attend. Consequently, no progress report was prepared. The probation officers later said they had thought there had been no need to inform Mr CC of their visit as the prison would tell him. The prison took the view – and I agreed – that it was not their responsibility to tell prisoners who was visiting.

The probation officers did not write to Mr CC after the failed visit and made no further attempt to contact him. He did not discover the misunderstanding until he was told that no report was forthcoming. The probation area acknowledged that Mr CC had not been informed of the office's change of address, and accepted that there had been a considerable gap in contact. However, the area's internal investigation into Mr CC's complaint considered the omissions to be reasonable in the light of severe staff shortages and restructuring.

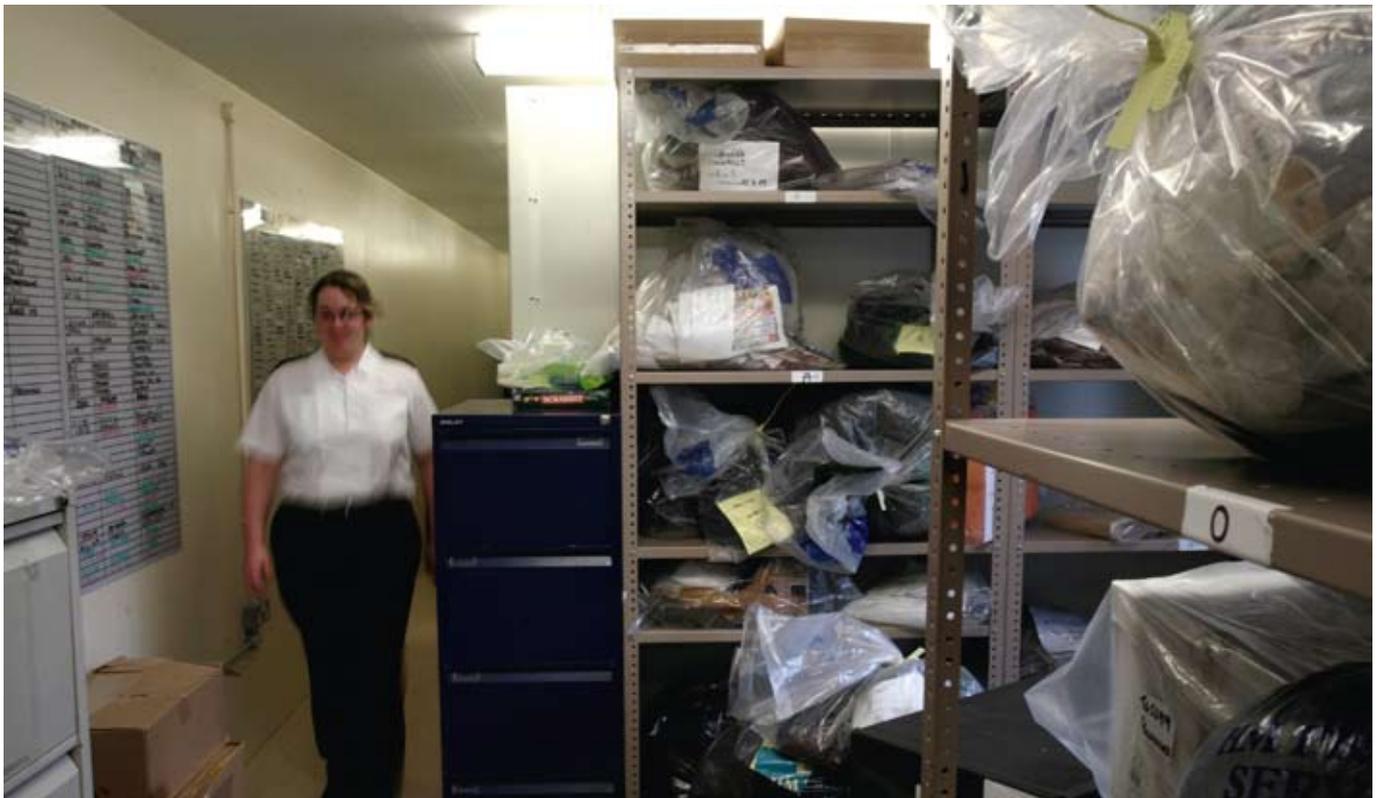
I did not agree. I considered that such a lengthy gap in contact was unacceptable in any circumstances and I asked the area to apologise to Mr CC for the delay. I was satisfied that the previous probation officer had had ample opportunity to have informed Mr CC of the new office address. It would also have been common

courtesy and good practice for the visiting officers to have given Mr CC notice of their impending visit. However, given information from other sources, I did not find that the lack of a progress report had impeded Mr CC substantively.

The probation area advised that from now on there would always be written contact with Mr CC prior to any planned visits. The area also accepted my recommendation to issue a practice direction that all offender managers should write to serving prisoners in advance of visits.

Property matters

Mr DD complained that a number of items of clothing were lost during his transfer from one prison to another and were not forwarded on to him at his new location.



INVESTIGATING COMPLAINTS

My investigation discovered that, on the day he was transferred, Mr DD was wearing several of the alleged missing items. I also found that he had been involved in a dirty protest that day and the clothing had been soiled with faeces. As a consequence, it had to be cut off him. In the circumstances, it was plainly unreasonable for a prisoner to expect compensation for clothing that he had soiled with human waste. I rejected Mr DD's claim.

Mr EE was serving a prison sentence for breaching the conditions of his parole licence. He said that, after his return to prison, his estranged wife had packed his belongings into a number of plastic bags and left them on the doorstep of the local probation office.

Mr EE said his offender manager had told him that one split bag of belongings found in the car park had been identified

as belonging to him because of the photographs it contained. Mr EE was told that the bag contained various articles but only two items of clothing. The offender manager laundered the clothing and arranged for it to be sent to Mr EE. The probation area's investigation omitted to contact Mr EE's previous partner and found no evidence of any other property belonging to Mr EE. The investigation concluded that only one bag had been left at the office, the contents of which had been returned to Mr EE.

However, it transpired that the area had failed to conduct a thorough search for Mr EE's property. During the course of my own investigation a number of further bags were found in the basement of the probation office. Unfortunately, by the time the property was located, many of the contents were mouldy and useless. I was obviously pleased that more of Mr EE's property had been found, but remained concerned about the time taken



to locate it and the shoddiness of the area's original investigation. Given that the probation office had accepted responsibility for the property by taking it in, I judged that the area was obliged to compensate Mr EE for the items that remained unaccounted for. I further recommended that the probation area should send a letter of apology to Mr EE for failing properly to investigate his complaint.

Mr FF complained that his trousers had been damaged by paint smears when he had used the lavatory on his wing landing over a weekend. He said the prison should take responsibility for the damage as it had happened when the lavatory was being painted and no warning 'wet paint' signs were displayed. Mr FF recognised that, as he could not provide a receipt for the trousers, he would not be eligible for compensation. Nevertheless, he wanted the issue investigated.

The prison had repeatedly told Mr FF that his account could not be accurate as painting did not take place at weekends. My investigation ascertained that usual procedures at the prison required painting to take place only between Monday and Friday. However, I discovered that – unknown to staff – a prisoner who was not a designated painter had been painting at the weekend without authorisation. I could not say for certain if warning signs were displayed, but as the painting was not authorised it seemed reasonable to assume that this was unlikely. Although there was only minor damage to Mr FF's trousers, the prison agreed to apologise to him.

Outside contact

Keeping in touch with family or friends – whether by phone, letter, or through visits – minimises isolation and can be crucial both to a prisoner's well being and to successful resettlement following release. For these reasons, the Prison Service has a responsibility to do all it can to ensure that prisoners are able to stay in contact with those they have left behind. I receive many complaints when things run less smoothly.

Mr GG was in prison awaiting a retrial. His son could only visit at weekends and had done so on each alternate weekend until, on one visit, Mr GG and his son were verbally threatened and intimidated by other prisoners in the visits room. Mr GG complained that his son was so upset by the experience that he could not visit again unless alternative arrangements were made.

The prison had dealt with the incident promptly by issuing the main bully with an IEP warning, but regretted that there was no room to offer separate visits to vulnerable prisoners. (During my investigation, the prison exceptionally arranged a pastoral visit for Mr GG and his son through the chaplaincy although such visits could not be used regularly.) A senior officer also offered personally to supervise the visits to ensure that other prisoners did not cause a nuisance to Mr GG or his son. Unfortunately, the son was not prepared to accept the offer.

The Prison Service advised that there was no central policy guidance as to arrangements for visits to vulnerable



prisoners and, despite the best efforts of my investigator together with the willingness of prison staff to assist, it was not possible to resolve the matter. The prison could not guarantee that a closed visits facility would be available when Mr GG's son visited, no additional staff were available to monitor the visits area at the weekend, and the ongoing use of pastoral visit facilities was not appropriate.

Although the incident appeared to be isolated, and unlikely to recur, it was not difficult to understand the anxieties of Mr GG's son. I acknowledged the constraints that the prison had to work within, and I appreciated the efforts of staff to facilitate more closely supervised visits, but all prisoners are entitled to receive visits free from bullying and intimidation. Despite discussions with staff at the prison

and with Prison Service HQ, no acceptable alternative to the main visits room could be immediately identified. Nevertheless, I recommended that the Governor should continue to try to find a solution acceptable to all parties.

Mr HH complained that his incoming mail and certain prison records had been confused with those of another prisoner who shared the same forenames and surname. The other prisoner, Mr JJ, also complained about the same issue. Mr HH had received mail containing cheques intended for Mr JJ and Mr JJ said he had routinely received mail for Mr HH. In addition, a report on Mr JJ's offending behaviour work – including personal details of

victims – had been read aloud at Mr HH’s sentence planning review, and Mr JJ had been refused employment due to erroneous security information.

My investigation found that, although prison files were clearly marked with a warning that there were two prisoners with the same name, some documents contained information about the wrong man. The prison accepted that mail had been misdirected. However, there had been occasions when there was no prison number on the envelope to identify either prisoner and I appreciated the difficulties this had caused. Nevertheless, I was concerned about the potential risk to correspondents if their personal details were wrongly shared (as it seemed likely had been the case). I was also concerned about the apparent breach of data protection each time the details of Mr HH and Mr JJ were used in respect of each other.

I recommended that the Governor should appoint a named person to be responsible for checking all Mr HH’s prison records and to confirm to him that the records were correct. I also recommended that the current process of identifying and delivering mail should be reviewed as soon as possible and replaced with a more robust system. Finally, I recommended that when mail for either man was not clearly identifiable it should be opened by staff in the presence of one or other of them.

Mr KK was a prisoner with a heart complaint who said that procedures in place for outside escorts were adversely affecting his access to medical treatment. Mr KK complained that a number

of hospital appointments had been cancelled as the prison provided escorts for only two outside appointments on any given day. He said that such procedures were inappropriate as prison officers were obliged to decide the clinical priorities of prisoners with hospital appointments.

My investigation found that, in a period of eight months, five of Mr KK’s eight scheduled hospital appointments had been cancelled – including a pre-operative scan. The prison confirmed that it could allocate only two escorting officers each morning and two each afternoon and, as a consequence, appointments that required urgent attention – such as those for prisoners suffering with cancer – took precedence. As the prison had a high proportion of elderly and disabled prisoners, the number of outside appointments could not be met and many of the more routine appointments were cancelled.

I understood that the nature of the prison’s population placed a considerable pressure on operational staff to manage escorts, and that managers were doing all they could to address the problem. However, hospital appointments are not made frivolously and, if a prisoner needs expert opinion or diagnostic procedures requiring hospital attendance, last minute cancellations are not only upsetting for the prisoner but also a considerable waste of hospital resources. I asked the Governor to ensure that proposed improvements to the prison’s system of escorts be implemented as a matter of urgency.

Cell sharing

The murder of Zahid Mubarek, the young man killed by a racist prisoner sharing his cell in March 2000 in HMYOI Feltham, was both a grievous personal tragedy and a critical moment in the history of the Prison Service. I was therefore deeply disappointed and concerned when I received a complaint indicating that the lessons of successive inquiries into Zahid Mubarek's death had not been fully taken on board.

Mr LL complained that prison staff were negligent and had placed him at risk by putting him in a cell with a known racist. Mr LL said that on arrival at the prison he had been placed in a cell with two other prisoners, one of whom had threatened him by implying he would not last the night if he remained in the cell. That prisoner had said he would not share a cell with a black person.

Frightened for his safety, Mr LL pressed the emergency bell and staff removed him immediately. Mr LL's complaint was investigated by the prison's race equality officer who confirmed that the other prisoner had made the threatening remarks (although he said he intended them to mean that he and Mr LL would not be spending the night in the same cell). The race equality officer apologised to Mr LL for the anguish he had suffered.

During my investigation I considered the PSO that was introduced following the murder of Zahid Mubarek. The PSO requires that all prisoners should have a cell sharing risk assessment carried out to identify any potential risks they might pose

to themselves or others when cell sharing is unavoidable. These assessments must take place before any prisoner is allocated to a shared cell and any identified risks should be clearly recorded.

My investigator examined the copies of the cell sharing risk assessment undertaken on the racist prisoner when he arrived at the prison. The record clearly stated that he had grown up in South Africa during apartheid, considered himself to be a racist, and was only happy to share a cell with white Europeans. The assessment noted that the prisoner was to be classified as high risk for cell sharing. The information was also noted on the prisoner's history sheet, but a subsequent entry noted that his risk had been revised to 'medium'. My investigation could find no reason for the revision.

Aspects of this complaint were of self-evident concern. The first and most obvious was why Mr LL had been placed in a cell with a self-confessed racist. The second was why the racist prisoner's cell sharing risk had been reduced to medium when there was no evidence to indicate that his attitude to black people had changed. Third, there appeared to have been no inquiry by the prison as to how any of this had occurred or what was required to ensure that it would not happen again.

In placing him in shared accommodation without first having checked the risk assessments of the other prisoners in the cell, the prison failed in its duty of care to Mr LL. Although the consequences on this occasion did not include any physical violence, the potential dangers need no further elucidation. I recommended that the Governor review the cell sharing risk assessment process as a matter of urgency

and make such improvements as were necessary. I also sent a copy of my report to the Prison Service's Race Adviser and to the Chief Operating Officer of NOMS for their consideration. I further asked the prison's Governor to send Mr LL a written apology for the unnecessary distress he had suffered.

Moving along

Save for that tiny number of life sentence prisoners with whole life tariffs, all prisoners expect to regain their freedom at some point. During the year I have received a number of complaints about adverse transfers, and about decisions related to release.

Mr MM was a category D prisoner who complained that he had been unfairly downgraded to category C prior to his transfer out of an open prison. Mr MM said he had been transferred from the open prison for his own protection as he had previously been employed by the Prison Service as an Operational Support Grade. He said he had encountered no problems until he had intervened to support a young black prisoner he believed was being bullied. The change of category prevented Mr MM from having a period of temporary release to prepare for his release.

My investigation found that, because of overcrowding, no other category D prison could be found for Mr MM and it was necessary to transfer him to a category C prison. Nevertheless, there had been no change in Mr MM's risk factors and, consequently, no reason to recategorise

him before the transfer. I readily understood why staff wished to move Mr MM for his personal protection, and they had acted with commendable speed. However, I was surprised that they had thought it necessary for him to revert to category C before he could be transferred. Had they been in any doubt, they could have settled the matter by a telephone call to the category C prison. It was also very regrettable that, as a result of the decision to transfer him, Mr MM was prevented from taking his resettlement leave.

Mr MM's category D status was reinstated as a result of my investigation, and he was able to resume the process of preparing for his resettlement.

Mr NN was a life sentence prisoner who complained about the delay in transferring him after the Parole Board had recommended a move to open conditions. He had to wait more than six months for the transfer.

When Mr NN's solicitors complained to the Prison Service on his behalf, they were told that the delay had been caused by population pressures and the reduction in open prison places following the closure of another prison in the area. During my investigation, prison staff initially maintained this explanation but subsequently acknowledged that, as a lifer, Mr NN's transfer was subject to a different process. I found evidence to suggest that most of the delay was caused by the length of time taken by the NOMS Public Protection Unit (PPU) to approve the Parole Board's recommendation. Instead of taking about a month as usual, it had taken four months for the recommendation to be approved –



a delay that I felt was unacceptable and which could have been avoided. Although some of the delay was due to a backlog of work caused by staff sickness, the Head of Casework at PPU agreed to apologise to Mr NN for what had happened.

Mr PP complained that he had been refused early release on HDC on the basis that his index offence involved the possession of an offensive weapon – a knife – which automatically excluded him from consideration.

The relevant Prison Service Instruction says that offenders serving sentences for certain types of offences must be considered unsuitable for release on HDC unless there are exceptional circumstances. Possession of offensive weapons is included in the list of 'considered unsuitable' offences but there is no mention of wounding.

Mr PP said that he needed to return home to care for his wife and new-born son. While I had considerable sympathy with his request, I could not say that his circumstances were exceptional and I could not support his application. However, I could also understand Mr PP's sense of grievance that possessing a knife made him unsuitable for early release whereas, if he had been convicted of using the knife – in many respects a far more serious offence – he might well have been granted HDC.

I was concerned about the anomaly. I understand the political imperative underpinning the presumption of unsuitability for those convicted of certain offences. However, it surely cannot have been the intention that those convicted of possessing weapons should potentially be disadvantaged in comparison with those convicted of using them.

I recommended that the policy should be made more consistent to avoid prisoners convicted of possessing offensive weapons being treated less favourably in terms of HDC than those convicted of wounding.

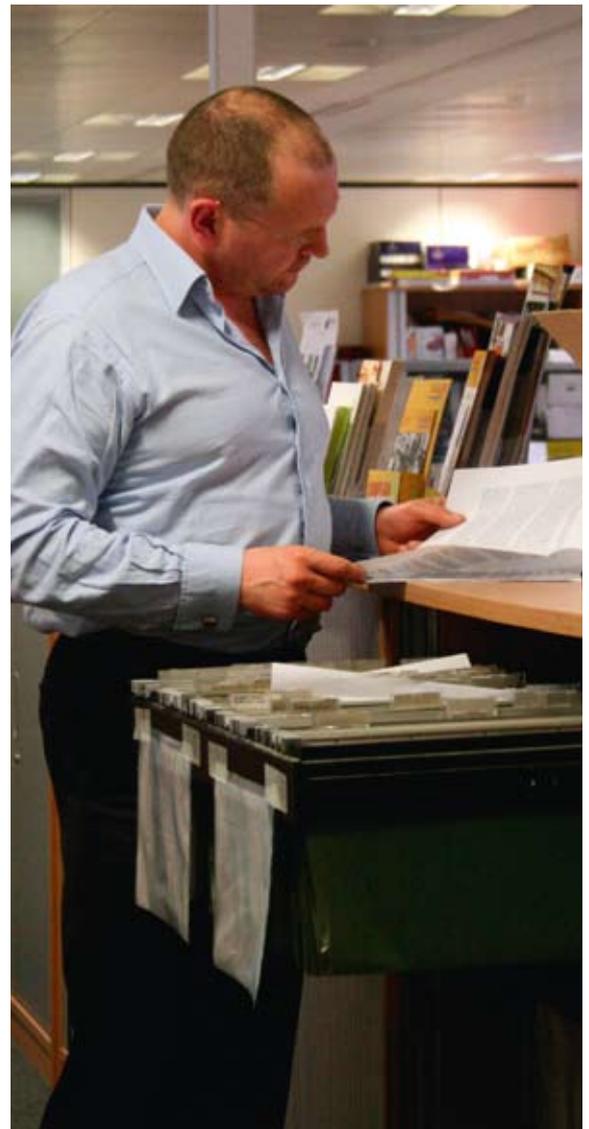
Mr RR complained about the probation area's management of his resettlement arrangements. He questioned the decision to place him in Approved Premises on release when he had been offered a home with a woman friend.

Mr RR's complaint shared features in common with others I have received about probation. Other prisoners too have either been refused permission to live in their areas of choice or required to reside in Approved Premises on release. Indeed, it is entirely understandable that prisoners who say they could return to their homes and families feel aggrieved if they are not allowed to do so. Nevertheless, probation areas and trusts have a duty to take whatever steps they deem necessary to prevent re-offending and, in making such decisions, the protection of the public takes precedence over the needs and wishes of the offender.

In Mr RR's case, his supervision was the responsibility of a probation area in the North of England but he wished to move to the South East to live with his girlfriend. He was told that his offence and sentence brought him within MAPPA and that a move away from the area would not necessarily be approved by the MAPPA panel.

My investigation found that the MAPPA panel had refused Mr RR's request as he had not previously lived with his girlfriend

and their relationship had not been tested. Additionally, he was being released from a closed prison due to his lack of co-operation and poor behaviour, and he had not been approved for resettlement leave. In those circumstances the panel considered that there was no evidence to indicate that Mr RR's risk had been reduced sufficiently for him to move into independent accommodation immediately on release. I was satisfied that the probation area's decision was reasonable and justified by the overriding requirement to protect the public.



THE YEAR IN FIGURES

In 2008–09, I received 4,288 complaints. At first sight, this is almost 500 fewer than in 2007–08. However, as I have said in the introduction to this report, I have made changes to the way in which my office records the number of complaints received and, unfortunately, this means that the figures cannot be directly compared with those from past years.



Complaints

Most of the complaints I received – 3,818 (89 per cent) – were about the Prison Service while 388 (9 per cent) were about the Probation Service. In addition, I received a total of 99 complaints (2 per cent) from immigration detainees of which 93 were about IRCs. Of the remainder, four complaints were about short-term holding facilities, one was about escort services, and one concerned the UKBA as a whole.

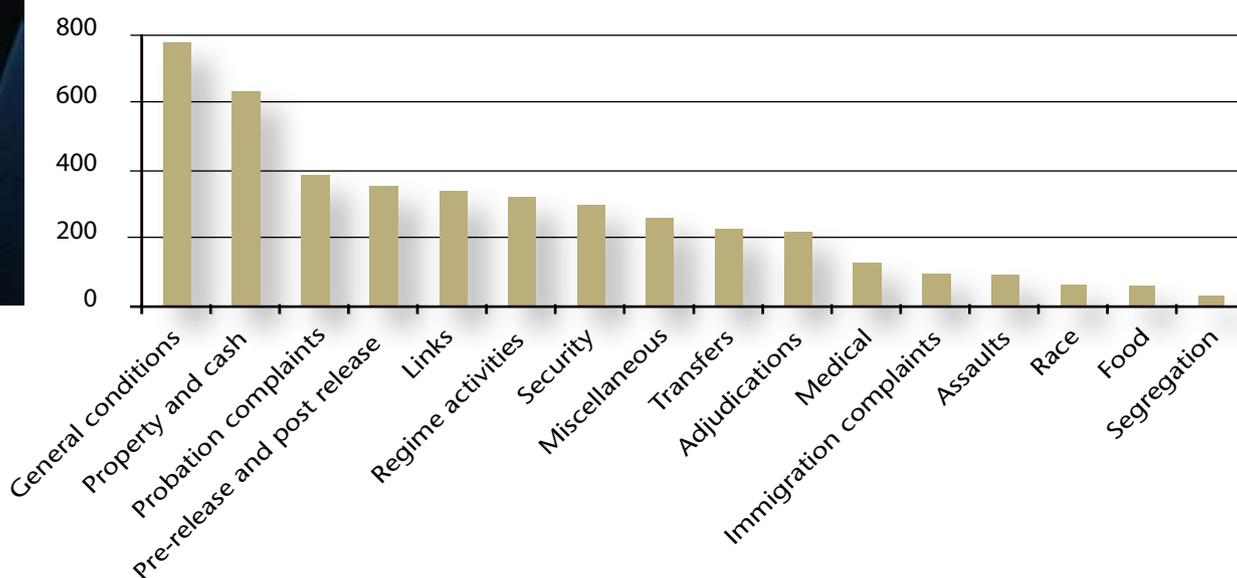
In common with what has been the case ever since the office opened, the majority of complaints received are not eligible for investigation. Most of these (78 per cent) had not followed the necessary procedures, usually meaning that the complainant had not completed all the stages of the internal complaints system prior to contacting my office. Some 10 per cent of the ineligible complaints

received were not within my remit, and 8 per cent were outside time limits. Despite this, the proportion of ineligible complaints has reduced and is at its lowest level since 2003–04. I find this trend encouraging, indicating as it does that potential complainants are becoming more familiar with the rules under which we operate. However, this has a significant impact upon the workload of my office. With an eligibility rate of 42 per cent in 2008–09, the total number of complaints to investigate grew by 10 per cent notwithstanding the apparent fall in complaints received.

Of the 1,515 complaint investigations completed by my office, I found in favour of the complainant in 436 cases (29 per cent) and my investigators achieved mediated settlements in 117 of these.

The following chart illustrates the types of complaint received from all services in remit.

Total complaints received by category 2008–09



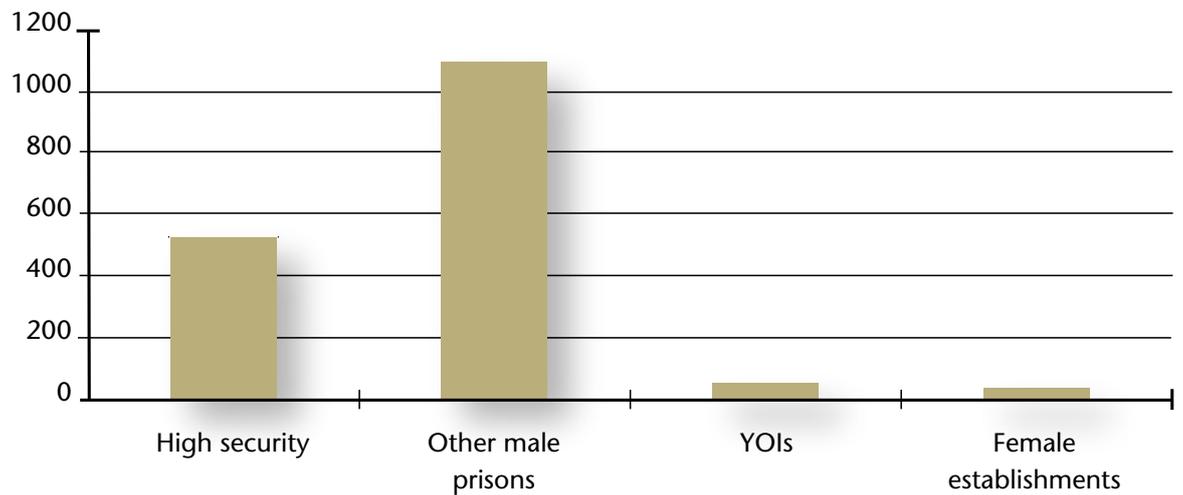
THE YEAR IN FIGURES

Given the predominantly male make-up of the prison population, it is not surprising that most complaints came from men. However, whereas women make up 5 per cent of the prison population, it is disappointing that they accounted for only 2 per cent of the complaints I received. I am also very conscious that few young people in custody use my office. Whereas

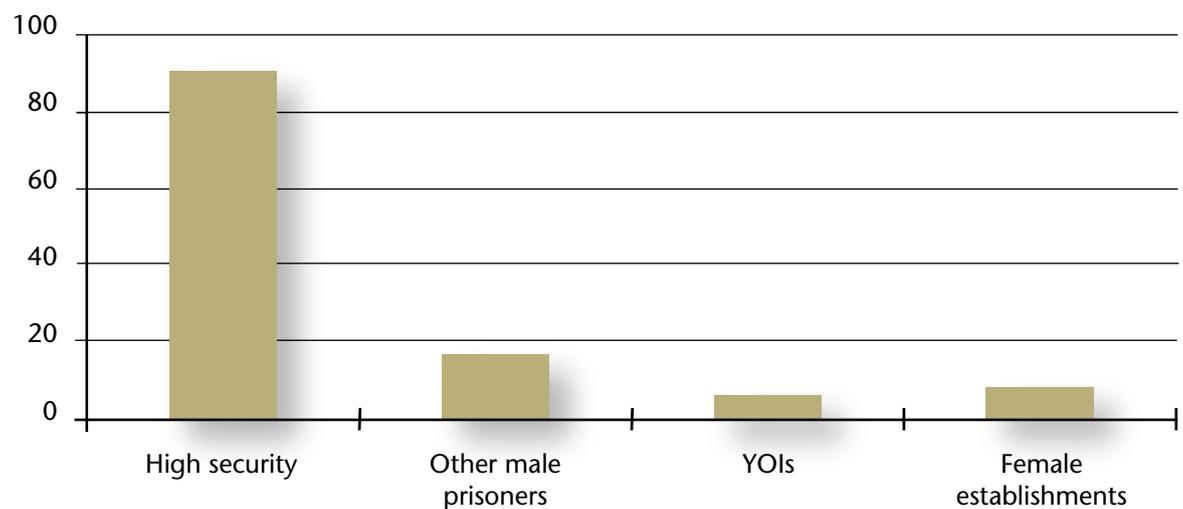
people under the age of 21 account for 14 per cent of the prison population, just 2 per cent of the complaints I received came from that age group.

The following charts indicate that prisoners in the high security estate are considerably more likely to complain to my office than other groups.

Total eligible complaints received from prisons 2008–09



Eligible complaints received 2008–09 per 1,000 prison population



The average time taken for a complaint to be completed in 2008–09 was 16 weeks and 53 per cent of all complaints were completed within my target time of 12 weeks from the moment the complaint is assessed as eligible for investigation. This represents a considerable improvement on the last reporting year.

I am also pleased to report that strengthening the management and working practices of the PPO's assessment team has resulted in more than a twofold increase in the number of complaints assessed for eligibility within the target of 10 working days. The percentage of cases assessed within the target time is also at 53 per cent, although there is clearly room for further improvement.

As the time that detainees will remain in IRCs is uncertain, the assessment of their complaints is given priority.

Fatal incidents

As I have said earlier, fewer deaths were referred to my office in 2008–09 than in

the previous year. The total number of deaths investigated was 181. This included five discretionary cases. Two of these involved men who had been recently released from prison, and one who was on compassionate release. One was an immigration case. I also investigated one death in Guernsey Prison at the request of the authorities there.

The table below shows the distribution of the 181 deaths on which investigations were opened.

In addition to the new investigations opened, fatal incident investigators continued to work on cases outstanding from the previous year. A total of 188 draft reports and 168 final reports were issued in 2008–09.

The number of anonymised reports published on our website (www.ppo.gov.uk) has more than doubled. There are over 450 reports now publicly available, and this constitutes a unique archive for administrators and researchers, both in this country and abroad.

Cause of death	Male prison	Female prison	YOI	Approved Premises	Court	IRC	Discretionary	Secure Training Centre	Total
Self-inflicted	56	2	5	2	0	0	0	0	65
Natural causes	93	3	0	7	0	1	3	0	107
Homicide or attack	2	0	0	0	0	0	0	0	2
Illicit drug overdose	1	0	0	0	0	0	0	0	1
Unclassified	2	0	0	1	1	0	1	0	5
Accidental	0	0	0	1	0	0	0	0	1
Total	154	5	5	11	1	1	4	0	181

Stakeholder feedback

This year I undertook the first full survey of stakeholders to find out what they think of the work of the PPO office and how it might be improved. The survey looked in detail at all aspects of our work, including both front-line services: complaints and fatal incident investigations. I received 586 completed responses. More than 50 per cent of those were from operational staff including 91 from Governors, Directors and IRC managers. Over 70 Independent Monitoring Board chairs responded, as did some 35 Coroners.

A particularly pleasing result concerned the professionalism of PPO staff. Around 90 per cent of Governors and Approved Premises managers said they found my staff to be polite, courteous and professional. 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 helpful and respectful.

However, only half as many rated PPO as 'very efficient', and it is clear that delays in completing investigations and issuing reports are affecting how we are seen by many stakeholders. Although more than 66 per cent of all respondents thought complaint investigations were completed in a reasonable time, 42 per cent thought that fatal incident investigations should be timelier and 59 per cent thought that reports could be produced more quickly.

It is also apparent that we need to do more to keep stakeholders up to date with

progress on our investigations. Although more than half of respondents felt that they received sufficient information, I am also looking to improve our performance in this area during 2009–10.

That aside, PPO reports are well thought of: over 80 per cent of respondents said that reports and letters are properly concise and easy to understand. The same proportion of respondents thought that conclusions and recommendations were reasonable and fair. However, while 60 per cent of respondents thought that recommendations in fatal incident reports led to changes in practice, the remaining 40 per cent thought that they made little difference. I was also disappointed to learn that only 53 per cent of Governors (the one group who were asked this question) thought that complaints recommendations resulted in systemic changes.

Overall three-quarters of our stakeholders said the services we provide are good or very good.

A full report of the findings of the survey is on our website, and we plan to repeat the survey next year. Managers are also using the results to identify areas for improvement.

Development activities

My office's business plan for 2008–09 included a programme of actions designed to create a more professional organisation. Details of what we have achieved are set out in the table opposite.

AIM	A more strategic approach and building our leadership capability
ACTION	All senior managers took part in leadership training.
	All managers' performance plans included leadership objectives.
	Changes made to senior management team structures and processes.
AIM	Reinforcing independence
ACTION	In conjunction with the Ministry of Justice we developed:
	– drafts of a new framework document setting out our respective roles and responsibilities;
	– a series of draft protocols setting out standards for corporate services provided to the Ombudsman's office; and
	– drafts of revised Terms of Reference. ⁴
AIM	Getting the most from staff
ACTION	I developed and implemented an improved induction process.
	A new Training and Development Plan was adopted for all staff.
	I commissioned a training consultant to develop bespoke training modules on investigation techniques, work organisation, assertiveness, communications and drafting. These were rolled out to staff during the year, and they will be ongoing.
AIM	Being organised to deliver services
ACTION	I carried out an operational review of the complaints function and work began on implementing the recommendations.
	I began negotiations with the Ministry of Justice to provide sufficient office accommodation.
AIM	Managing performance
ACTION	I conducted a stakeholder survey. The results will inform the business planning process for the coming year.
	Results of a staff survey were analysed and carried forward to the 2009–10 business plan.
AIM	Effective communications and stakeholder management
ACTION	To inform my review of PPO's publicity materials, I conducted a survey of complainants' awareness of my office, the accessibility of my current materials and their ease of use.
	I reviewed and made improvements to my quarterly newsletter, <i>On the Case</i> .
	I commissioned two DVDs that will come on stream during 2009–10.

⁴ I anticipate that final versions of all these documents should be agreed and made available on my website during 2009–10. See also footnote 6 on page 58.



The costs of the office

In the reporting year, the office cost £7.8 million. Of the total, around £5.6 million represented the office's budget and £2.2 million was the notional share of the Ministry of Justice central costs. The table below provides the full details.

	£
Staffing costs (salaries)	4,416,693
Non-pay running costs	1,194,701
Share of departmental overhead ⁵	2,162,273
Capital	Nil
Total	7,773,667

⁵ Based on the 2007–08 figures inflated by 2 per cent as the official Ministry of Justice figure was unavailable at the time of publication.

MISSION STATEMENT



Within one united office, to deliver two services that contribute to just and humane penal and immigration detention systems:

- To provide prisoners, those under community supervision and those in immigration detention with an accessible, independent and effective means to resolve their complaints.
- To provide bereaved relatives, the Prison Service, National Probation Service, UK Border Agency and the public at large with timely, high-quality investigation of deaths in prison custody and other deaths in remit.

TERMS OF REFERENCE



Terms of Reference⁶

Complaints

1. The Prisons and Probation Ombudsman, who is appointed by the Secretary of State for Justice, is independent of the Prison Service and the National Probation Service for England and Wales (the NPS) and reports to the Secretary of State for Justice.

2. The Ombudsman will investigate complaints submitted by the following categories of person.⁷

- individual prisoners who have failed to obtain satisfaction from the Prison Service complaints system and who are eligible in other respects; and
- individuals who are, or have been, under the supervision of the NPS or housed in NPS accommodation or who have had pre-sentence reports prepared on them by the NPS and who have failed to obtain satisfaction from the NPS complaint system and who are eligible in other respects.

3. The Ombudsman will normally act on the basis only of eligible complaints from those individuals described in paragraph 2 and not on those from other individuals or organisations.

4. The Ombudsman will be able to consider the merits of matters complained of as well as the procedures involved.

5. The Ombudsman will be able to investigate:

- decisions relating to individual prisoners taken by Prison Service staff, people acting as agents of the Prison Service, other people

working in prisons and members of the Independent Monitoring Board, with the exception of decisions involving the clinical judgement of doctors and those excluded by paragraph 6. The Ombudsman's Terms of Reference thus include contracted-out prisons, contracted-out services and the actions of people working in prisons but not employed by the Prison Service; and

- decisions relating to individuals described in paragraph 2 taken by NPS staff or by people acting as agents of area boards in the performance of their statutory functions, including contractors, and not excluded by paragraph 6.

6. The Terms of Reference do not cover:

- policy decisions taken by a Minister and the official advice to Ministers upon which such decisions are based;
- the merits of decisions taken by Ministers, save in cases which have been approved by Ministers for consideration;⁸
- the personal exercise by Ministers of their function in the setting and review of tariff and the release of mandatory life sentenced prisoners;⁹
- actions and decisions outside the responsibility of the Prison Service and the NPS such as issues about conviction, sentence or immigration status; cases currently the subject of civil litigation or criminal proceedings; and the decisions and recommendations of outside bodies including the judiciary, the police,

⁶ These are the terms of reference in force during 2008–09. New terms of reference came into effect on 11 June 2009 although these may be reviewed further during 2009–10.

⁷ Complaints from those in immigration detention came within remit from 1 October 2006. This was formalised in a letter I received from the Minister of State for Immigration and Asylum on 28 November 2006.

⁸ A personal Ministerial decision is one where the Minister makes a decision either in writing or orally following the receipt of official advice or signs off a letter drafted for their signature.

⁹ These functions no longer exist.

the Crown Prosecution Service, the Parole Board and its Secretariat.

Submitting complaints and time limits

7. Before putting a grievance to the Ombudsman, a complainant must first seek redress through appropriate use of the Prison Service and NPS complaints procedures. Complainants will have confidential access to the Ombudsman and no attempt should be made to prevent a complainant from referring a complaint to the Ombudsman.

8. The Ombudsman will consider complaints for possible investigation if the complainant is dissatisfied with the reply from the Prison Service or the NPS area board or receives no final reply within six weeks (in the case of the Prison Service) or 45 working days (in the case of the NPS).

9. Complainants submitting their case to the Ombudsman must do so within one calendar month of receiving a substantive reply from the Prison Service or, in the case of the NPS, the area board. However, the Ombudsman will not normally accept complaints where there has been a delay of more than 12 months between the complainant becoming aware of the relevant facts and submitting their case to the Ombudsman, unless the delay has been the fault of either of the Services.

10. Complaints submitted after these deadlines will not normally be eligible. However, the Ombudsman has discretion to consider those where there is good reason for the delay, or where the issues raised are so serious as to override the time factor.

Determining eligibility of a complaint

11. The Ombudsman will examine complaints to consider whether they are

eligible. To assist in this process, where there is some doubt or dispute as to the eligibility of a complaint, the Ombudsman will inform the Prison Service or the NPS area board of the nature of the complaint and, where necessary, the Prison Service or area board will then provide the Ombudsman with such documents or other information as the Ombudsman considers are relevant to considering eligibility.

12. The Ombudsman may decide not to accept a complaint or to continue any investigation where it is considered that no worthwhile outcome can be achieved or the complaint raises no substantial issue. The Ombudsman is also free not to accept for investigation more than one complaint from a complainant at any one time unless the matters raised are serious or urgent.

Access to documents for the investigation

13. The Director General of the Prison Service and the National Director of the NPS will ensure that the Ombudsman has unfettered access to the relevant service's documents. This will include classified material and information entrusted to that service by other organisations, provided this is solely for the purpose of investigations within the Ombudsman's terms of reference and subject to the safeguards referred to in paragraph 16 below for the withholding of information from the complainant and public in some circumstances.

Local settlement

14. It will be open to the Ombudsman in the course of investigation of a complaint to seek to resolve the matter by local settlement.

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Visits and interviews

15. In conducting an investigation the Ombudsman and staff will be entitled to visit Prison Service or NPS establishments, after making arrangements in advance, for the purpose of interviewing the complainant, employees and other individuals, and for pursuing other relevant inquiries in connection with investigations within the Ombudsman's Terms of Reference and subject to the safeguards in paragraph 16 below.

Disclosure of sensitive information

16. In accordance with the practice applying throughout government departments, the Ombudsman will follow the Government's policy that official information should be made available unless it is clearly not in the public interest to do so. Such circumstances will arise when disclosure is:

- against the interests of national security;
- likely to prejudice security measures designed to prevent the escape of particular prisoners or classes of prisoners;
- likely to put at risk a third party source of information;
- likely to be detrimental on medical or psychiatric grounds to the mental or physical health of a prisoner or anyone described in paragraph 2 of these Terms of Reference;
- likely to prejudice the administration of justice including legal proceedings; or
- of papers capable of attracting legal professional privilege.

17. Prison Service and NPS staff providing information should identify any information which they consider needs to be withheld on any of the above named grounds with a further check undertaken by the relevant service on receipt of the draft report from the Ombudsman.

Draft investigation reports

18. Before issuing a final report on an investigation, the Ombudsman will send a draft to the Director General of the Prison Service or to the National Director of the NPS depending on which service the complaint has been made against, to allow that service to draw attention to points of factual inaccuracy, to confidential or sensitive material which it considers ought not to be disclosed, and to allow any identifiable staff subject to criticism an opportunity to make representations.

Recommendations by the Ombudsman

19. Following an investigation all recommendations will be made to the Secretary of State for Justice, or to the Director General of the Prison Service or to the National Director of the NPS or to the chair of the area board as appropriate to their roles, duties and powers.

Final reports and responses to complaints

20. The Ombudsman will reply to all those whose complaints have been investigated, sending copies to the relevant service, and making any recommendations at the same time. The Ombudsman will also inform complainants of the response to any recommendations made.

21. The Ombudsman has a target date to give a substantive reply to the complainant within 12 weeks from accepting the

complaint as eligible. Progress reports will be given if this is not possible.

Prison Service and NPS response to recommendations

22. The Prison Service and NPS have a target of four weeks to reply to recommendations from the Ombudsman. The Ombudsman should be informed of the reasons for delay when it occurs.

Annual Report

23. The Ombudsman will submit an annual report to the Secretary of State for Justice, which the Secretary of State for Justice will lay before Parliament. The report will include:

- a summary of the number of complaints received and answered, the principal subjects and the office's success in meeting time targets;
- examples of replies given in anonymous form and examples of recommendations made and of responses;
- any issues of more general significance arising from individual complaints on which the Ombudsman has approached the Prison Service or the NPS; and
- a summary of the costs of the office.

Fatal incidents

1. The Ombudsman will investigate the circumstances of the deaths of the following categories of person:

- prisoners (including persons held in young offender institutions). This includes persons temporarily absent from the establishment but still in

custody (for example, under escort, at court or in hospital). It excludes persons released from custody, whether temporarily or permanently. However, the Ombudsman will have discretion to investigate, to the extent appropriate, cases that raise issues about the care provided by the prison;¹⁰

- residents of NPS Approved Premises (including voluntary residents); and
- residents of immigration detention accommodation and persons under Immigration Service-managed escort.

2. The Ombudsman will act on notification of a death from the relevant service. The Ombudsman will decide on the extent of investigation required depending on the circumstances of the death. For the purposes of the investigation, the Ombudsman's remit will include all relevant matters for which the Prison Service, the NPS (including area boards) and the Immigration Service are responsible, or would be responsible if not contracted for elsewhere by the Secretary of State for justice or area boards. It will therefore include services commissioned by the Secretary of State for Justice from outside the public sector.

3. The aims of the Ombudsman's investigation will be to:

- establish the circumstances and events surrounding the death, especially as regards management of the individual by the relevant service or services, but including relevant outside factors;
- examine whether any change in operational methods, policy,

¹⁰ Further to a second letter from the Minister for Immigration and Asylum, also dated 28 November 2006, this discretionary power also applies following a person's release from immigration detention.

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practice or management arrangements would help prevent a recurrence;

- in conjunction with the NHS where appropriate, examine relevant health issues and assess clinical care;
- provide explanations and insight for the bereaved relatives; and
- assist the Coroner's inquest in achieving fulfilment of the investigative obligation arising under Article 2 of the European Convention on Human Rights, by ensuring as far as possible that the full facts are brought to light and any relevant failing is exposed, any commendable action or practice is identified, and any lessons from the death are learned.

4. Within that framework, the Ombudsman will set Terms of Reference for each investigation, which may vary according to the circumstances of the case, and may include other deaths of the categories of person specified in paragraph 1 where a common factor is suggested.

Clinical issues

5. The Ombudsman will be responsible for investigating clinical issues relevant to the death where the healthcare services were commissioned by the Prison Service (until March 2006), by a contractually managed prison or by IND.¹¹ The Ombudsman will obtain clinical advice as necessary, and will make efforts to involve the local Primary Care Trust (in Wales, the local health board) in the investigation. Where the healthcare services were commissioned by the NHS, the NHS will have the lead responsibility for investigating clinical issues under existing

procedures. The Ombudsman will ensure as far as possible that the Ombudsman's investigation dovetails with that of the NHS.

Other investigations

6. Investigation by the police will take precedence over the Ombudsman's investigation. If at any time subsequently the Ombudsman forms the view that a criminal investigation should be undertaken, the Ombudsman will alert the police. If at any time the Ombudsman forms the view that a disciplinary investigation should be undertaken by the relevant service, the Ombudsman will alert the relevant service. If at any time findings emerge from the Ombudsman's investigation that the Ombudsman considers require immediate action by the relevant service, the Ombudsman will alert the relevant service to those findings.

7. The Ombudsman and the Inspectorates of Prisons and Probation will work together to ensure that relevant knowledge and expertise is shared, especially in relation to conditions for prisoners and detainees generally and judgements about professional probation issues.

Disclosure of information

8. Information obtained will be disclosed to the extent necessary to fulfil the aims of the investigation and report, including any follow-up of recommendations, unless the Ombudsman considers that it would be unlawful, or that on balance it would be against the public interest to disclose particular information (for example, in exceptional circumstances of the kind listed in the relevant paragraph of the Terms of Reference for complaints). For that purpose, the Ombudsman will be able to share

¹¹ As the reference to March 2006 suggests, the first part of this sentence is now otiose. IND should be read to mean the UK Border Agency.

information with specialist advisers and with other investigating bodies, such as the NHS and social services. Before the inquest, the Ombudsman will liaise with the police regarding any ongoing criminal investigation.

Reports of investigations

9. The Ombudsman will produce a written report of each investigation which, following consultation with the Coroner where appropriate, the Ombudsman will send to the relevant service, the Coroner, the family of the deceased and any other persons identified by the Coroner as properly interested persons. The report may include recommendations to the relevant Service and the responses to those recommendations.

10. The Ombudsman will send a draft of the report in advance to the relevant service, to allow the service to respond to recommendations and draw attention to any factual inaccuracies or omissions or material that they consider should not be disclosed, and to allow any identifiable staff subject to criticism an opportunity to make representations. The Ombudsman will have discretion to send a draft of the report, in whole or part, in advance to any of the other parties referred to in paragraph 9.

Review of reports

11. The Ombudsman will be able to review the report of an investigation, make further enquiries, and issue a further report and recommendations if the Ombudsman considers it necessary to do so in the light of subsequent information or representations, in particular following the inquest. The Ombudsman will send a proposed published report to the parties referred to in paragraph 9, the relevant Inspectorate and the Secretary of State

for Justice (or appropriate representative). If the proposed published report is to be issued before the inquest, the Ombudsman will seek the consent of the Coroner to do so. The Ombudsman will liaise with the police regarding any ongoing criminal investigation.

Publication of reports

12. Taking into account any views of the recipients of the proposed published report regarding publication, and the legal position on data protection and privacy laws, the Ombudsman will publish the report on the Ombudsman's website.

Follow-up of recommendations

13. The relevant service will provide the Ombudsman with a response indicating the steps to be taken by the service within set timeframes to deal with the Ombudsman's recommendations. Where that response has not been included in the Ombudsman's report, the Ombudsman may, after consulting the service as to its suitability, append it to the report at any stage.

Annual, other and special reports

14. The Ombudsman may present selected summaries from the year's reports in the Ombudsman's Annual Report to the Secretary of State for Justice, which the Secretary of State for Justice will lay before Parliament. The Ombudsman may also publish material from published reports in other reports.

15. If the Ombudsman considers that the public interest so requires, the Ombudsman may make a special report to the Secretary of State for Justice, which the Secretary of State will lay before Parliament.

STAFF OF THE PPO OFFICE 2008–09



Staff of the PPO office 2008–09

Ombudsman

Stephen Shaw CBE

Senior Personal Secretary

Jennifer Buck

Deputy Ombudsmen

Rhian Evans (*retired March 2009*)

Tony Hall

Jane Webb

Acting Deputy Ombudsmen

David Barnes (*died in service
November 2008*)

Ali McMurray

Personal Secretary

Janet Jenkins

Assistant Ombudsmen

Louise Baker

John Cullinane

Sarah Hughes

Marian Morris (*to October 2008*)

Gordon Morrison

Olivia Morrison-Lyons

Colleen Munro

Thea Walton

Nick Woodhead

Head of HR and Business Development

Caroline Smith

Head of Central Services

Eileen Mannion

Senior Research Officer

Sue Gauge

Senior Investigators and Investigators

Christina Arsalides

Terry Ashley

Don Barrell (*to June 2008*)

David Cameron

Karen Chin

Steve Clarke

Althea Clarke-Ramsay

Paul Cotton

James Crean

Anthony Davies

Lorenzo Delgaudio

Rob Del-Greco

Susannah Eagle

Angie Folkes

Andrew Fraser

Ann Gilbert

Kevin Gilzean

Alan Green

Natasha Griffiths

Helena Hanson

Diane Henderson

Denise Hotham (*to September 2008*)

Ruth Houston

Joanna Hurst

Karen Jewiss

Mark Judd

Razna Khatun

Madeleine Kuevi

Lisa Lambert

Anne Lund

Steve Lusted

Lisa Maddison

Kirsty Masterton

Lisa Mcilpatrick

Steven McKenzie

Beverly McKenzie-Gayle

Tracy Mulholland

Anita Mulinder
Vidia Narayan-Beddoes
Peter Nottage
Amanda O’Dwyer
Ben Rigby
Anna Siraut
Amanda Steyn
Kevin Stroud
Rick Sturgeon
Anne Tanner
Jonathan Tickner
Stephen Toyne (*to January 2009*)
Ian Truffet
John Unwin
Louisa Watkins
Nicola Weir
Karl Williamson
Jane Willmott
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Demelza Penberth

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Laura Stevenson

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John Maggi

Assistant Information Manager

Jay Mehta

Office Manager

Geoff Hubbard

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Mark Chawner

Requisitions Officer

Samantha Rodney

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Anthony Davies
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