Prisons & Probation Ombudsman
Independent Investigations

Introducing the Prison and Probation Ombudsman for England and Wales

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Alternatives to imprisonment: identification and exchange of good practice

Milan, 12 March 2016

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Agenda

- History
- Role and vision
- Independence
- Staff and resources
- Complaint investigations
- Fatal incident investigations
- The future

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History of PPO

- Following prison riots in 1990, a judicial inquiry said part of cause was lack of prisoner confidence in complaint processes and lack of any independent adjudication
- To restore legitimacy, an independent prison Ombudsman was established in 1994
  - In 2006, role expanded to complaints from offenders on probation and immigration detainees
- In 2004, in response to Article 2 ECHR, responsibility for investigating all deaths in prison added
  - In 2006, deaths in immigration detention and probation hostels added

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Role and vision

- Independent investigation of:
  - Complaints by prisoners, young people in detention, immigration detainees and offenders on probation
  - Deaths of prisoners, young offenders, immigration detainees and offenders living in probation hostels
- Vision:
  - To carry out independent investigations to make custody and community supervision safer and fairer

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Independence

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

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Staff and resources

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

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Jurisdiction

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

Complaints

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Why is an independent element in complaints important?

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

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Numbers

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

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Complaints: issues

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

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Complaints: outcomes

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

Fatal incidents

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Why independent investigations of fatal incidents?

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

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Fatal incidents: issues

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

  - 241 in prison
  - 7 in probation hostels
  - 2 in immigration detention

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Fatal incidents: outcomes

- Bereaved families central to investigation
  - consulted and involved
  - supported by Family Liaison Officers
- Local and national recommendations
  - 99% accepted - if rejected, Head of service writes personally to the Ombudsman
  - Action plans required
  - Recommendations followed up by inspectors

Learning Lessons

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

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The future

More complaints

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

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The future

More deaths

- More deaths from natural causes
  - Prisoners ageing: 12,000 over 50; 4000 over 60
  - Fastest growing segment of prison population over 60
  - Longer sentences and late in life prosecutions for historic sex offences
- Sharp 30% increase in suicide and doubling of homicides 2015-16
  - Mental ill-health
  - New psychoactive substances ("legal highs")
  - Stresses in system

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The future

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