

## **TOO MANY PRISONS STILL FAILING TO IMPLEMENT RECOMMENDED IMPROVEMENTS - PPO**

Sue McAllister, the Prisons and Probation Ombudsman (PPO), has published her annual report for 2019-20, a year which ended with the PPO reshaping its activities to ensure it could carry out its vital work during the COVID-19 period.

Sue McAllister expressed her frustration that PPO recommendations to improve the safety and care of vulnerable prisoners, and to address some avoidable causes of complaints, principally lost property, were not implemented in many prisons.

In the year, there were falls in the number of complaints the PPO received and the number of deaths it investigated. The PPO received 4,686 complaints in 2019/20, 6% fewer than the 4,968 in the previous year. It started investigations into 311 deaths, a 7% reduction from 2018/19, when the figure was 334. This figure was the fourth highest in the last ten years. There was a 7% decrease in the number of self-inflicted deaths, from 89 in 2018/19 to 83 this year.

Sue McAllister said: “We remain frustrated at the number of repeat recommendations we have to make, sometimes where changes have been promised (in an action plan

from the prison or from HMPPS HQ) but not delivered. In our efforts to better understand the barriers to the implementation of our recommendations, we have been working to develop options for trialling different ways of reporting what we find and how we make recommendations.”

It was also frustrating, she added, “that, for another year, the most common category of the complaints we received was property that had been lost or damaged in prison, or in transit from one prison to another, or was not allowed. Items of personal property are hugely important to prisoners and some, such as photographs or religious items, are irreplaceable.”

“We continue to receive assurances from HMPPS that they are making improvements to their arrangements for handling property, but it has taken far too long, and the much-needed improvements are long overdue.”

The PPO investigates all deaths in prisons and places of state detention in England and Wales. Sue McAllister said: “In some cases, the provision of healthcare was very poor and failed to meet the physical and mental health needs of patients. Whilst we found examples of good practice in some of the cases we investigated, in others we found that staff were not adequately trained, that there were not enough staff to carry out essential tasks or, in some cases, that healthcare professionals failed in their duty of care to patients. We also found that complex commissioning and delivery arrangements for prison healthcare sometimes caused delays to care, or a failure to deliver care, for example to patients with dementia.”

Investigators saw both good and poor examples of end of life care. Sue McAllister said: “Unfortunately, we continued to see far too many cases in which very elderly, frail and/or very unwell prisoners with limited mobility were escorted to hospital in handcuffs – and some remained restrained until shortly before they died. This is uncomfortable and undignified for prisoners and upsetting for their families. It is also distressing for prison staff to be chained to a dying prisoner. The PPO has been saying for years that it is simply unacceptable that such practices are allowed to continue.”

The report contains some disturbing case studies drawn from death investigations. These include the case of Mr C (page 40), a HIV sufferer who did not get the drugs

he needed for five months and was kept in restraints even in a medically-induced coma prior to his death in hospital. By the time his mother, who was treated with “gross insensitivity”, found out where he was, he was in a coma from which he did not recover.

Another case study (18-year-old Mr G on page 44, who took his own life) reflected a PPO concern over many years – that prison and medical staff rely too much on how a vulnerable prisoner describes or presents themselves and not enough on the individual's risk factors.

The report also raises concerns about drug-related deaths. Sue McAllister said: “We continued to be concerned about the apparent ease with which prisoners were able to obtain drugs, even in segregation units and high security prisons.”

In March 2020, the imposition of the national lockdown in response to the COVID-19 global pandemic brought significant changes to how PPO staff were able to work. Sue McAllister said: “At the start of lockdown, we were not able to access our offices and all our staff had to work from home. We had to be innovative about how we maintained our services.”

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#### **Notes to editors**

1. The report is available at [www.ppo.gov.uk](http://www.ppo.gov.uk)
2. The Prisons and Probation Ombudsman (PPO) is appointed by and reports directly to the Secretary of State for Justice. The Ombudsman's office is wholly independent of the services in remit, which include those provided by Her Majesty's Prison and Probation Service (HMPPS), the National Probation Service for England and Wales, the Community Rehabilitation Companies for England and Wales, Prisoner Escort and Custody Service, the Home Office (Immigration Enforcement), the Youth Custody Service, and those local authorities with secure children's homes. It is also operationally independent of, but sponsored by, the Ministry of Justice (MoJ).
3. The roles and responsibilities of the PPO are set out in the Terms of Reference (ToR), the latest version of which can be found in the appendices.
4. The PPO has three main investigative duties:
  - complaints made by prisoners, young people in detention, offenders under probation supervision and immigration detainees

- deaths of prisoners, young people in detention, approved premises' residents and immigration detainees due to any cause
  - using the PPO's discretionary powers, the investigation of deaths of recently released prisoners or detainees
5. Please contact John Steele on 07880 787452, or at [john.steele@justice.gov.uk](mailto:john.steele@justice.gov.uk) if you would like more information