All-Party Parliamentary Group on Penal Affairs
Chair: *Paul Maynard MP*
Vice Chairs: *Lord Carlile; Carolyn Harris MP; Baroness Prashar; Marie Rimmer MP; Andrew Selous MP*
Secretary: *Lord Hodgson of Astley Abbots*

Minutes of the Meeting of the All-Party Group on Penal Affairs, held on 24 October 2023

The role of the Prisons and Probation Ombudsman

Guest Speaker: Adrian Usher, Prisons and Probation Ombudsman

Present
Paul Maynard MP (in the chair)
Lord Attlee
Lord Bradley
Lord Hogg
Lord Ponsonby
Baroness Prashar

Apologies
Bishop Rachel Treweek
Lord Carlile

Attendees
Zoe Burton
Julia Braggins, Minutes
Mark Day, PRT, Clerk

Paul Maynard MP welcomed everyone to the meeting, and introduced the speaker **Adrian Usher.** He would speak for 15 -20 minutes, followed by questions.

Adrian Usher: It is very kind of you to offer me the opportunity to speak. I am six months in post today, and I came from a background of 35 years as a career detective with the Metropolitan Police. I spent my final seven years, five years in counter terrorism in detection, protecting people in this building and indeed this building itself and diplomatic premises across London, palaces across the country, and people across the world. Then I moved to Learning and Development. I was just explaining that one of the reasons I was very keen to take up this role was that the three main areas that the PPO looks at are: investigating deaths, which is something that I have done professionally; the investigation of complaints, which is something I did when I was with anti-corruption; and the accretion and dissemination of learning, which I did in my final years in the Met.

So it was with a great deal of enthusiasm, though I have to say not a great deal of speed, that I was appointed. It took about two years. So I think I get marks for perseverance. I want to be clear that anything I say is no criticism of anybody who has taken up my role before. Circumstances change, Covid, all sorts of things and challenges that previous Ombudsmen had. But I have taken some views about the direction the Ombudsman's office should go. I formed some of those views before I started. I read a hundred or so death investigations because they are available online and I could do that. And I made a

commitment to meet every single one of my 110 staff individually for at least half an hour, to understand their challenges, their frustrations, the joy they found in their work, and how we might make things better. I can't tell you that I didn't, on occasion, regret making that commitment. It led to some very long days and weeks. But I think it did give me a really good understanding from all angles: internally from my own staff, as well as meeting stakeholders to get their views, and of course, vitally, prisoners.

Out of that work came a refresh of our vision and values, which I launched about a month ago. I have some copies of those here, if anybody's interested in how we changed that plan on a page approach to what I think we should be doing. The bit I would want to focus on is the values. I have worked in organisations and departments where values were endlessly debated, and then they were placed on a poster, stuck on a wall, and largely ignored for the rest of the time they were there. For me the values – which is why we have phrased it the way we have: 'What We Value' – are things that my staff can turn to when they have got a difficult decision to make. When they don't know whether they should do something or not do something, or what path the investigation should take. The touchstone is our values. We value professional curiosity; we value ambitious thinking, diversity and inclusion, transparency, and teamwork. I have three main functions and it is possible that they can work in silos and that is not optimal. That I value, and that we value, teamwork is very important to me.

The biggest leap for my staff is ambitious thinking. I think that the Ombudsman's Office approach in the past has been effective in as much as they were getting the reports and investigations done in a relatively timely fashion, though that suffered during Covid. It has been a while since we raised our vision a little bit and thought about how we would establish tangible change, and try to assist HMPPS – and I do think that is my role – in making tangible differences to safety in prisons.

I will just touch on each of those three departments and the direction that we are taking. In terms of fatal incident investigations, last year the PPO office made 1600 recommendations to HMPPS. I just have the view that that is way too many. I have worked in an organisation that for lots of good reasons has been reviewed several times and it is possible to get recommendation fatigue. Then you are not trying to complete the recommendation to make a tangible difference for good, you are doing it to try to make the recommendation go away because you have hundreds of others that you are facing. I also think the recommendations were possibly at the wrong level. If you follow any public servant engaged in a complex, high risk, ever-changing process, you will be able pretty soon to say: you have done that wrong. You have made a mistake. You could do that to nurses, or to police officers; you could certainly do it to prison officers. I don't think that approach makes anything safer in the long run. I think it is more important to get to the why: why that mistake was made, and whether that was a training issue, whether that was something that should be tackled at a higher level than at prison officer or supervising officer grade. My instructions to my staff on recommendations have been: we need to get off the landing. You need to go to the governor's office, and possibly from there to Phil Copple's office or Amy Rees's office in order to effect tangible change. And what I definitely don't want is: if the response from the governor's office to a recommendation is 'I have sent out an email' then don't make that recommendation because we know nothing will change.

I will give you one example of the kind of change that I am trying to effect. An individual very sadly died of a drug overdose in a prison, and we investigated it. It would appear that three days before he died he had been taken into a scanning room because staff believed he may have had drugs internally in him. Three prison officers scanned him and the results were indeterminate. They did not know what to do. So they read the policy and they still did not know what to do. Until one of them said, just do it again. So they did it again, and it was very clear that the individual had drugs in him and they took him away and treated him appropriately for that. When the investigation is completed and comes to me there are two recommendations. The governor will ensure that everybody knows what to do as a result of an indeterminate scan, and – they hadn't filled a form in the second time, and I think they probably hadn't filled it in because they weren't sure whether they should have done it or not – the governor shall ensure that everybody fills in forms correctly. I believe that both of those recommendations were wrong. If three prison officers have read a policy and they still don't know what to do, it's the policy. We changed the recommendation. As for the form, could you say that that was a direct contributory factor to the death? No, I don't believe you could. We changed it to: The Director of Operations for HMPPS should revise the policy on indeterminate scanning to make it clear to all staff, which he did. That's a small example of the ballpark I think my office should be playing in. We need to make tangible differences.

There are two headings I have introduced into investigative templates: one is 'good practice', because we often find good practice and I think part of my responsibility is to ensure that the public have confidence in the criminal justice system. It is really the reason for my role. And if we have found good things, I think we should say that we have found good things. The second heading I have introduced is something called 'Governor to Note.' I won't hide things. If we do find forms not filled in, or officers not wearing a hat or some such, I am not going to be accused of brushing these things under the carpet. But I put them in an area called 'Governor to Note' because I believe that prison governors are professional people who have got where they are because they know what they are doing. I will make that assumption until I have evidence that they don't. Therefore if I point out to a fellow professional that there is something wrong in their institution, I assume they will do something about it.

I have taken this approach because I don't know how to run a prison, and however long I do this job I still won't know how to run a prison. But I can point out to a prison governor in 'Governor to Note' some things that he or she might want to do something about, against all the other risks that they have. I have several demonstrable examples of where the different type of recommendation we are now making has made a difference.

Secondly, complaints: we receive about 4,500 complaints a year. About half of those complaints are ineligible, which means that the prisoner – and it usually is a prisoner – hasn't complained to the prison, hasn't appealed and had that appeal turned down, and then comes to us. So both those pieces of information tell me that prisoners a) don't know who we are and b) if they do know who we are, they don't know the process. When I travel into prisons, and I think I've been to over 25 now, not many prisoners know who we are, and even fewer staff know what the Ombudsman's office is. I think part of the reason for that is my responsibility. I don't think we have been into prisons enough. I am always very impressed with the Independent Monitoring Boards (IMBs). They have lots of posters inside

prisons explaining to prisoners what they do, but that's because they are inside prisons all the time. I don't have that luxury. So we will be in prisons more.

But I think the other potential factor is the word 'Ombudsman'. If you put Ombudsman into one of those apps that tells you what is the level of education or qualification you have to have to understand the sentence 'I am the Prison Ombudsman', it comes back at near degree level. Not many of the people that I am dealing with in prison have that level of education. It is a barrier. So I have made the decision to change the name of that part of the Ombudsman's office. We have rebranded it, after consultation with prisoners and staff, and from the middle of November it will become Independent Prisoner Complaint Investigations (IPCI). We have done some rebranding work, which I also have here – hot off the press – and we will be visiting all 143 institutions that fall in our remit to give that message to prisoners; to gather hopefully some ambassadors among the prison population that really do understand what we do. Because I want more complaints and fewer ineligible complaints. Those two things will tell me whether this is succeeding or not. So IPCI, as it has inevitably become known, will be promoted heavily from next month and we have already done some trialling of that in some organisations and publications.

The second thing I have done with complaints is that I have published them on our website, which we never used to do. If you went onto our website you saw FII reports – fatal incident investigations – the lead part of the information on there was the institution in which the individual had died. I don't think that was right. If I was a bereaved family member, I would want to see my family member's name there at the centre of the investigation. They are why we are doing what we are doing. So on the FII side we now publish the names up front – we always publish them on the reports anyway. On the complaints side we now publish upheld complaints. One of the things that I also do – and I will be completely honest about this, I have spoken about this at the Prison Governors' Association – I will comment (in about 20% of cases at the moment, it will go down) that the Ombudsman has upheld the complaint, and is of the view that the prison should have resolved this without it coming to the Ombudsman.

We are also in the process of sending some complaints back to prisons in certain circumstances. If, at first blush, we think there is a very high likely likelihood that we will uphold that complaint, it is not a good use of public money for me to spend a long time writing a long report if it is something that I can pretty quickly decide. If a prisoner says they have lost some of their property and the prison does not have the right documentation to back up the fact that they have not lost the property, I am almost always going to find in favour of the prisoner. So why would I spend public money doing that? My experience of a very positive group of governors is that when I send something back they nearly always say: Yes, I am sorry, I am slightly embarrassed, we should have sorted this out. They are accommodating in that way.

So we are trying to speed that up, we are trying to gain more trust and confidence from prisoners, both by the name and the way we do business. We are going to change the reports to make them far easier to read. They are sometimes very long and contain an awful lot of prison rules. They read more like compliance than investigations. So that will change to make it easier for prisoners to understand. We know that some prisoners don't have the ability to read and write, and to get somebody to translate something for them

might put them in debt, and we know that debt can lead to violence. We don't want to be part of that chain. We will make this easier for prisoners.

The final thing I will talk about is our learning. It is hard to say this without sounding a little bit critical. When I looked at the learning that has been published by the PPO's office from about 2016 onwards, there were about five or six fairly short thematic pieces of work that have been supplied to the Prison Service. I don't think that is anything like enough. My whole job, as I have said I think, is to assist the Prison Service by gathering up all of the things we have learned from the thousands of investigations we are doing every year and to put that into a format that is helpful and useful to prison governors.

So as well as committing to four themed pieces of work every year, I have also committed to a publication called 'Governor to Note'. The first one went out last month. It will go out once a month and is a couple of pages of: here's some things that we are seeing at the moment. Here's some things that you might want to look at in your institution to see if it is going on there. When I was a borough commander, which is similar to a prison governor's job: high risk, lots of risk, lots of resource difficulties, and you were balancing those risks every day, I would have absolutely welcomed somebody writing to me once a month saying: here's a rock you might want to have a look under. It is in that spirit that that communication is made. I'm never going to ask prison governors: have you read it? I am never going to refer to it in any of my investigations and say look, I have told you about this seven times.

A lot of it is good practice, and we see good practice all the time. One of the things I would be slightly critical of HMPPS about is that their ability to disseminate that good practice between institutions is not optimal. If I can help with that then I will. A small example that we placed in there recently was one institution having a Do Not Resuscitate order clearly visible in a single cell, which made it really clear when that prisoner did have a heart attack that staff didn't go through inappropriate resuscitation. There are all sorts of examples that I could give you where prison governors innovate and do fantastic things, and sometimes make errors. It is to the benefit of the Prison Service that we disseminate them in a way that is positive. It took quite a long time, I will be absolutely honest, and went through quite a few versions, and my criticism of my own staff's writing of it was that it was too finger-waggy. The last thing that prison governors need is yet another thing coming through their door saying: here's something you should have done, Governor, and you're wrong for not doing it. The intention is that it is a cup of coffee with the governor and we are just having a chat.

The other thing that I think we have not been doing in quite the right way is that we have been investigating one complaint at a time, and saying we either uphold it or we don't uphold it. That doesn't help prisoners and it doesn't help HMPPS. We should have the ability to say: look here's an institution, you are an outlier in terms of losing property; or you're an outlier in terms of use of force. We make no comment on it other than to give you the data and the information. So to that end, a bit of a day one decision was to largely expand my analysis unit – I call it an intelligence unit, but apparently that's not right. In the civil service it's an analysis unit – and we have got many more bods in there so that we can start to get that strategic data that we can replay back into HMPPS and say: here are some

things you may want to look at, rather than just say we have upheld this, or we haven't upheld it.

I hope that is a very quick canter through the approach that I think it is right to take, and I am more than happy to take questions.

Paul Maynard MP thanked the speaker and said he was fascinated by that, partly because he had spent the past two days looking mainly at the effectiveness of Prevention of Future Deaths reports that coroners issue time and time again.

Lord Hogg said he did not think the PPO's office was sufficiently well known. He had been an MP for 30 years, and a prisons minister, and he didn't think he had encountered it. That was important because parliamentarians received complaints from prisoners, so he thought the PPO should communicate with MPs and Peers both about what he did, and how complaints should be referred where appropriate. Secondly, he had also been a member of a monitoring board. He thought the PPO's office should also focus on communicating with them, and when recommendations were made to governors, the monitoring boards should be made aware of them too, because they could chase them. Governors came and went but monitoring boards had historic memories.

Adrian Usher said he appreciated such experience, although monitoring boards might consider that chasing up recommendations might affect their independence. As regards communications with parliamentarians, he met regularly with the prisons minister. In his former role in the Met Police he had also set up the Parliamentary Liaison and Investigation Team (PLAIT) after the murder of Jo Cox MP, in order to communicate with parliamentarians as to how to access security. He could see the benefit of that and would give those comments full consideration.

Lord Ponsonby noted that the speaker had not mentioned probation, the other half of the job.

Adrian Usher commented that his office did not received many complaints from probation, probably because people in prison have more time and more focus, and probably the outcome is more important to them in terms of day to day living. But they certainly did investigate probation complaints, often about recall. They also investigated deaths within two weeks of release, to oversee the effectiveness of the handover between prison and probation. Maybe that work would expand, going forward.

Lord Atlee was interested in what the speaker had said about good news. He had recently investigated an accident on an MOD range, where a tank blew up. The MoD had not realised that the accident could occur. But the report covered a lot of things that were being done well.

Adrian Usher responded that he was always conscious that bereaved families would be reading the reports, so a long list of good practice might be difficult to take. But he would identify good practice where he found it, as this built credibility with prison governors and staff. He gave an example of somebody who had been on an ACCT (suicide prevention) process for over two years. Staff had worked really hard with this young man, although

sadly he did take his own life. His office had made ten recommendations against the prison. Then he read a second report where an awful lot had gone wrong, and his office had made nine recommendations. He wanted to bring that type of low-level recommendation fever to an end, and to recommend good practice that could be shared.

Pia Sinha said that the direction of travel towards more pithy recommendations would be welcomed by prison governors. She was reminded of a previous session concerning learnings from deaths in custody about recommendations for systemic changes. How would he reconcile the conflict between local operational changes and recommendations for more systemic change?

Adrian Usher said that it was well known that the Prison Service was struggling with staffing. Therefore prisons were not running regimes as they normally would, people were not engaged in meaningful activity, a known protective factor against self-harm and self-inflicted death. In such circumstances, he did not believe it was his role to write to the prisons minister telling them to increase pay and recruit fully otherwise people would die. If a prison responded to the criticism that the regime was not running properly by saying they did not have enough staff, first he wanted to check the evidence as to staff numbers, and also the resourcing decisions made on that day. If the conclusion supported the governor's response, then it was for him to reflect that in the report. Periodically the Justice Select Committee and other bodies would call for evidence and ask how often this had been a factor. His independence meant that he did not make political comments.

Danny Barrs asked whether there was the equivalent of the IMBs in probation. If not, there was no recourse for anyone on probation other than coming directly to the PPO.

Adrian Usher said he did not think there was an equivalent, although people could go to the Probation Service first. The Prison Service had a two stage process: you complained, then appealed, then came to the PPO. The Probation Service had a three stage process. One difference between people on probation and people in prison, however, was that the former had access to the internet, and all kinds of information, whereas prisoners did not. He had been surprised, when he walked down a prison landing, how many would see a tie and ask for information, such as how long their sentence was, or what activities they could take part in. When prisoners sought any kind of information they had to fill in a form, and that might not lead to a quick result.

Danny Barrs said that in his organisation they were dealing with a number of people on probation whose license conditions had changed, or who did not know what their conditions were.

Adrian Usher agreed, and reiterated that he felt quite shocked by the paucity of information available to those in prison.

Mark Blake thanked the speaker for his presentation and said he was impressed by the focus he had brought to the role. He mentioned the important role of voluntary organisations within prison, and said that, in that capacity, he had witnessed things he was not happy about. If the institution was not taking such concerns seriously, could a complaint from a third party come to the Ombudsman?

Adrian Usher said it could, and also that there were circumstances where a complaint could come from a prisoner without going through the first two stages. His office had some discretion.

Lord Hogg again mentioned the monitoring boards.

Adrian Usher said that technically a prisoner wanting to make a complaint should go to the prison, not the monitoring board. But if a prisoner had a complaint about not having a blanket in his cell, for instance, the monitoring board could probably get him one much more quickly. In regard to whistle-blowing in prison, there was legislation around it, as with everywhere else. Outside of that process, yes, and they often took complaints from family members too.

Lord Bradley was interested in the issue of information to Parliament. He confessed that he had not heard of PLAIT, despite being a Home Office Minister. He wondered if the PPO's office could broaden its communication channels for parliamentarians. Picking up the point about systems and strategies, he said he had that morning heard moving cases of deaths in prison and the common theme was the lack of information that the prisons had, on reception, about the vulnerabilities of the people who had ultimately committed suicide. Too often prison staff knew nothing about any previous screening or assessments. Did the PPO's office see itself as having a role in assisting the information flow within the criminal justice system as a whole?

Adrian Usher agreed with the analysis. His office frequently criticised institutions, and HMPPS's policies, and this was brought into stark relief in reception. He had been in Durham Prison watching 45 prisoners being discharged from a bus at 9pm to staff who were largely going home at 10pm. The chances of doing proper risk assessments were slim. Even if picked up the next morning, on the first night the prison did not know the risks they were holding. He agreed that it was his role to highlight where those chains were broken.

Sophie Ellis thanked the speaker for the bulletin published in September about the deaths of IPP prisoners. What response had there been from HMPPS and what needed to happen to prevent future deaths of that nature?

Adrian Usher said that he had got the response he wanted, in so far as there was a recognition that being on an IPP sentence was, in and of itself, seen as a risk. The ACCT documentation, which prompted prison officers to try to identify risk factors in respect of self-harm and suicide, was far from perfect but it was all there was. He did not think it was forward-facing enough, looking at what was coming up in the prisoner's life, rather than just their past. He also thought that prison officers paid more attention to what prisoners said, than to their risk factors. He thought his role was to highlight these things. As regards good practice, he investigated around 90 self-inflicted deaths a year. There were thousands of prisoners on ACCT. Prison staff saved thousands of lives a year, and he was always cognisant of that. His office saw those cases where it hadn't worked. As with the IPP issue, where there was a theme, it was important to point that out, both to the prison and more widely.

Shirley Riley appreciated the speaker's emphasis on the prisoner's perspective. She also appreciated the situation of prison staff put in front of a coroner's court. However prisons

were not just run by governors and staff. There was a multitude of other agencies involved. How could voluntary sector organisations share that learning, and be part of the solutions?

Adrian Usher said that this was quite a crowded space. There were many organisations that could legitimately ask to be part of the information-sharing, or to meet him regularly, but it was just not feasible. He recognised that there were many passionate and compassionate people working in prisons who wanted to make a difference, and had met some key stakeholders. He was happy to work with any of them. He also welcomed the point about the stressful nature of the coroner's court experience, and indeed facing his investigators, for prison staff. He was not going to criticise a young officer who had just discovered a dead prisoner in the cell and made a mistake with the code. He had made a short video to help prison staff who would be meeting his investigators, telling them what to expect, and the support they could access.

Andrea Coomber said she welcomed the name change, and the concern about the literacy levels of many prisoners. Had he considered ways of reaching those without the required level of literacy?

Adrian Usher said the roll-out, albeit slow, of digitisation into some areas of prisons was hugely welcome, whether in kiosks or in-cell technology, to make this as accessible as possible. His office would be part of that. For the time being, he thought the best way was for his staff to be in prisons more often, having more conversations with prisoners. He hoped to get prison service buy-in to the establishment of IPCI ambassadors, people like the Listeners and other prison services, who were clearly identifiable, and who people could go to. The challenge would always be in those remand prisons where the churn was so high. Trying to get information to stick in that environment was a challenge, but they would rise to it.

Angela Coomber asked whether remand prisoners, who currently made up 20% of the prison population, had equal access to the Ombudsman's office.

Adrian Usher responded that there were more complaints from longer-serving prisoners, which was a factor of being better known. He has been to all the London holding prisoners and very few prisoners knew who the Ombudsman was or what he did. They were all very welcoming of the name change. He was grateful to the Chief Inspector of Prisons who had very helpfully included a question that would help them monitor how well prisoners knew who they were and what they did.

Rosanna Ellul wondered whether, as well as looking at the type of recommendations being made, the speaker would also be looking at follow-up, or the implementation of those recommendations. She noted that there had been a lot of repeat recommendations.

Adrian Usher said he was hoping not to have so many repeat recommendations. There were ways of writing recommendations which could make it harder for the prison not to do something tangible to make a difference. He had appointed an implementation officer to follow up on the results of the action plans. As regards self-inflicted deaths, he had made a commitment to speak personally to every bereaved family.

Lord Hogg asked whether the speaker copied his recommendations to the Inspectorate, so that when they visited a prison they could identify whether a recommendation had been followed up.

Adrian Usher said that he sat about ten yards from the Chief Inspector and information flow between their organisations was very good. In all his reports, he copied in what both the Inspectorate and the IMB had said about that institution, particularly where it was relevant to what his office had found.

Phil Maguire said that his organisation ran national prison radio for people in prison. For several years they had worked in partnership with the PPO, and they would be happy to expand that work.

Adrian Usher said there was certainly work he wanted to do about the rebrand and anything that would help with that would be much appreciated.

Lord Atlee said that the commitment to meet families was very welcome, although that would mean at least one such meeting every week.

Adrian Usher agreed but said his experience of meeting the victims of crime had reminded him every day of what they were going through. It was the best way of keeping you honest, and reminding you of why you were doing what you did.

Ruth Armstrong said she had been delighted by what she had heard about the changes proposed. Her organisation did some work with the prisons ombudsman in Uruguay, who had an interesting approach. They trained the prisoners not only about what they did, but also about their rights. They also had ambassadors within the prison population, and a lot of their information came via a phone line, where prisoners or their families or other organisations could call in. She had a question about how the move within HMPPS to the OneHMPPS model, with regional directors who were heads of prison and probation, might affect the way the PPO's Office worked across their three areas of focus.

Adrian Usher said his office had adapted to the hierarchical structure of HMPPS in terms of information flow, so all regional directors would receive 'Governors to Note' just as prison governors did. As he had said, he would have failed if 'Governor to Note' became a performance measure to beat governors over the head with. If he had made a sensible recommendation to a prison, and he was going to have to make it again, then the prison group director would become involved. If again, then the regional director would become involved. He had recommended discipline be commenced more times in the first six months than had been the case for several years. Where standards fell far below what was expected it was right to highlight that, and that somebody answered some difficult questions. He said to prison officers: I will never stab you in the back but I may stab you in the chest. You will know it is coming because I will have told you.

Paul Maynard MP ended the meeting on that note (to laughter), and thanked Adrian Usher for a fascinating presentation. He had written lots of notes. He thanked everyone for coming, and looked forward to the next meeting, in their usual surroundings. He hoped they would be having the Secretary of State at some point, once a date had been agreed, as he had reassured him that members would not devour him limb from limb, and were all quite well behaved.