SPSO Scottish Public Services Ombudsman

The Scottish Public Services Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

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Scottish Parliament Region: Lothian

Case ref: 201403330, Scottish Prison Service
Sector: Scottish Government & Devolved Administration
Subject: Health: welfare and religion; policy/administration

Summary

Mr C complained about a prison officer inappropriately giving him a pen, which Mr C swallowed the next day, causing injury. Mr C also complained about the length of time it took for his complaint about this to be dealt with. I upheld both complaints and made several recommendations to the Scottish Prison Service (SPS) to address the failings in this case and prevent similar situations arising.

I decided to issue a public report on this case as my office has previously investigated and upheld a number of Mr C's complaints. The report lists the upheld cases from August 2013 to date. I accept that Mr C presents many challenges in terms of his care, however, I have grown increasingly concerned by the number of complaints from him which this office has upheld. This has raised concerns of systemic failure in the way that the SPS are managing Mr C and investigating his concerns. I also considered that Mr C had suffered a significant personal injustice in this case.

Mr C was in a separation and reintegration unit and being managed under a process which is used for handling prisoners who are at risk of suicide or self-harm. He had repeatedly harmed himself and as a result of this was allowed no items in his cell. At the time of the incident, Mr C was judged to be at high risk. SPS staff were to observe him at 15 minute intervals and he was only permitted to wear anti-ligature clothing (clothing specially designed to reduce the potential for self-harm). That day, Mr C was given a self-representation form in relation to a review of the application of a prison rule. Although the condition that he was to have no items in use in his cell was in place, Mr C was provided with a pen to complete the form. Mr C returned the form but kept the pen which he swallowed the next day. I understand that this caused an internal perforation and he needed surgery to retrieve the pen and repair the damage.

The SPS position is that the pen was provided to Mr C in good faith as he needed it to complete the form. I note their comments on there being scope to work slightly outwith the care plan conditions and that management considered that with their substantial knowledge of Mr C, this was an instance where staff

were able to do so. I did not agree that providing Mr C with a pen represented working slightly outwith the care plan. While I accept that the form needed to be completed, I did not find that sufficient account was taken of the condition that no items were permitted when providing him with the pen.

The SPS were also unable to provide copies of the relevant care documentation that was in place on the day of the incident. These records form an important part of Mr C's case history and I find it concerning that they appear to have gone missing and I am critical of this. I did, however, accept the SPS's position that the conditions were unchanged from care documents dated three weeks earlier.

I am also concerned that there appears to have been no attempt to retrieve the pen after Mr C had finished using it and that this was not explored by the SPS during their investigation. Similarly, there appears to have been no attempt to investigate Mr C's complaint that the prison officer made inappropriate comments when providing the pen. This serious allegation is against the principles of the care process that was in place and I would have expected this to be fully investigated by the SPS at the time.

Taking my concerns about this case in to account alongside the complaints already upheld for Mr C, I have made additional recommendations to address the wider issues in managing his care while he remains in prison. This related to the new role of Independent Prison Monitors, who help ensure prisoners' human rights are upheld and that life in prison contributes to their rehabilitation.

On the complaints handling aspects, the SPS provided their final response to Mr C well over a year after they received it and I do not consider the length of time Mr C had to wait for a response to be in any way reasonable. There is no documentary evidence to show that any investigation of Mr C's complaint took place after it was first received or that the prison officer concerned gave Mr C any explanation for the action taken. I note that the SPS have already noted this failing and that it has been identified as a learning point, however, I am highly critical of the complaint handling in this case. The lack of documentary evidence of any timely investigation coupled with missing care conditions and complaint paperwork is a matter of some concern.

Redress and recommendations

The Ombudsman recommends that the SPS:	*Completion date*
(i) issue a written apology to Mr C for the decision to provide him with a pen when the restrictive ACT 2 Care condition was in place;	23 September 2015
(ii) arrange a meeting between the Governor of Mr C's current prison and a senior member of the local NHS Board to discuss our ongoing concerns about his care and to ensure that there is appropriate senior oversight;	21 October 2015
(iii) highlight this issue to the new Independent Prison Monitors to ensure that they are aware of our concerns and inform Her Majesty's Inspectorate of Prisons for Scotland we have asked for specific steps to be taken in relation to Mr C;	21 October 2015
(iv) issue a written apology to Mr C for the delay in providing a response to his complaint;	23 September 2015
(v) issue a reminder to all staff involved in the handling of this case that all confidential complaints should be investigated and responded to in line with the Prison Rules and associated Staff Guidance on Prisoner Complaints and Disciplinary Appeals; and	23 September 2015
(vi) review how paperwork such as complaint forms and ACT 2 Care documents are managed to ensure that important information is not lost.	21 October 2015

Who we are

The Scottish Public Services Ombudsman (SPSO) investigates complaints about organisations providing public services in Scotland. We are the final stage for handling complaints about the National Health Service, councils, housing associations, prisons, the Scottish Government and its agencies and departments, the Scottish Parliamentary Corporate Body, water and sewerage providers, colleges and universities and most Scottish public authorities. We normally consider complaints only after they have been through the complaints procedure of the organisation concerned. Our service is independent, impartial and free. We aim not only to provide justice for the individual, but also to share the learning from our work in order to improve the delivery of public services in Scotland.

The role of the SPSO is set out in the Scottish Public Services Ombudsman Act 2002, and this report is published in terms of section 15(1) of the Act. The Act says that, generally, reports of investigations should not name or identify individuals, so in the report the complainant is referred to as Mr C. The terms used to describe other people in the report are explained as they arise and in Annex 1.

Introduction

1. Mr C complained to the Ombudsman about the actions of the Scottish Prison Service (the SPS). The complaints from Mr C I have investigated are that:

(a) the SPS inappropriately gave Mr C a pen on 24 January 2013 while he was being accommodated in specified conditions; (*upheld*); and

(b) there was an unreasonable delay in the SPS responding to Mr C's complaint; *(upheld)*.

Investigation

2. In order to investigate these complaints, my complaints reviewer considered all the information provided by Mr C and the SPS. Further enquiries were also made with the SPS which they responded to. In this case, we have decided to issue a public report on Mr C's case as we have previously investigated and upheld a number of his complaints. This has raised concerns of systemic failure in the way that the SPS are managing Mr C and investigating his concerns. It was also considered that Mr C had suffered a significant personal injustice as a result of the SPS's actions in this case.

3. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mr C and the SPS were given an opportunity to comment on a draft of this report.

Background

4. On 24 January 2013, Mr C was in prison in a separation and reintegration unit. Mr C was being managed under the SPS Assessment Context Teamwork to Care (ACT 2 Care) process which is used for handling prisoners who are at risk of suicide or self-harm. He had repeatedly harmed himself and was allowed no items in his cell as a result of this. The SPS have been unable to provide copies of the relevant ACT 2 Care documents for this date, however, they have supplied a copy of earlier ACT 2 Care paperwork dated 3 January 2013 and confirmed that Mr C's conditions were unchanged from this time.

5. On 24 January 2013 Mr C was judged to be at high risk due to erratic behaviour, threats of self-harm and his previous history in this area. The SPS staff were to observe him at 15 minute intervals, he was only permitted to wear anti-ligature clothing (clothing specially designed to reduce the potential for self-harm) and was not allowed any items for use in his cell.

6. That day, Mr C was given a self-representation form in relation to a review of the application of a prison rule. Although the ACT 2 Care condition that he was to have no items in use in his cell remained in place, Mr C was provided with a pen to complete the form. Mr C returned the form but kept the pen which he swallowed the next day. I understand that this caused an internal perforation and he required surgery to retrieve the pen and repair the damage.

(a) The SPS inappropriately gave Mr C a pen on 24 January 2013 while he was being accommodated in specified conditions

Concerns raised by Mr C

7. Mr C submitted a Prisoner Complaint Form 2 (PCF2) in relation to this incident on 18 February 2013. In this complaint he explained that on 24 January 2013, he was allowed no items in his cell due to the risk he posed to himself. Mr C said that he was not allowed cutlery and had to use polystyrene cups and paper plates. He went on to say that he was given the self-representation form at lunchtime and asked a prison officer (the Prison Officer) for a pen and a newspaper. Mr C advised that the Prison Officer came to his cell alone and posted a newspaper under the door stating: 'there's a pen as well, do yourself some damage'. Mr C said that he passed the completed form back to the Prison Officer who photocopied it and gave him a copy back but left the pen which he swallowed the next day. Mr C complained about the Prison Officer's alleged comment and that he had been given a pen. He questioned why the SPS had case conferences to decide how prisoners were to be managed if staff ignored the recommendations made.

The SPS response

8. On 19 February 2013, the Governor of the prison where Mr C was being held acknowledged Mr C's complaint and advised that a copy had been passed to the Unit Manager for investigation.

9. The SPS provided their final response to this complaint over a year later on 21 August 2014. In this, they stated that Mr C complained that the Prison Officer had given him a pen contrary to the ACT 2 Care documentation that he was being managed under. The SPS advised that the Unit Manager had discussed the incident with Mr C (on 26 July 2014) and that it had been agreed that the pen was provided in trust and good faith to allow the form to be completed.

10. The SPS provided my complaints reviewer with a copy of the Unit Manager's notes of the meeting with Mr C on 26 July 2014. These noted that while Mr C stated he had never received any response to the matter, the Unit Manager recalled that a response was given by way of the Prison Officer explaining their actions. The Unit Manager stated he attempted to resolve Mr C's complaint by explaining that the decision to provide Mr C with a pen was one which the Prison Officer felt was right to make at the time, invoking some trust while meeting his need and right to make self-representations. The Unit Manager considered that the decision was legitimate and that the Prison Officer obviously felt it was a safe thing to do at the time, feeling that there was sufficient trust and that Mr C would not do anything with the pen. He noted that with hindsight, this trust had been misjudged but considered that it was correct in the spirit in which it was done.

11. My complaints reviewer also made a number of further enquiries with the SPS during the investigation of Mr C's complaints. In their response, the SPS advised again that they were unable to provide the relevant ACT 2 Care paperwork from 24 January 2013 but confirmed that Mr C's conditions had not changed from earlier ACT 2 Care documents dated 3 January 2013.

12. In light of the Unit Manager's recollection that this complaint had been resolved by an explanation from the Prison Officer, the SPS were asked for further information about this. The SPS advised that the Prison Officer in fact had no recollection of being asked about the incident or investigated over the allegation. No written submissions were made by the Prison Officer in relation to this subject. The SPS advised that they were unable to account for the Prison Officer's position and informed my complaints reviewer that there was no supporting evidence in relation to this.

13. Mr C complained to the SPS that the Prison Officer had said: 'there's a pen as well, do yourself some damage' when the pen was provided. The SPS were asked whether this had been addressed during their investigation. They said that the Prison Officer denied making the comment and that any such allegations would have been investigated, however, the SPS were unable to provide any evidence that this matter had been considered during their investigation of Mr C's complaint.

14. The SPS were asked to comment on why the pen that Mr C was given was not retrieved along with the form he had been asked to complete. They

stated that Mr C had been given the pen at a time when staff viewed it as appropriate in terms of his presentation and need. The SPS advised that this action/practise is not extraordinary, as even under the circumstances of ACT 2 Care, staff will continually interact and make decisions around an individual where they seek to enhance their relationship and work to progress the situation. They stated that these decisions do not extend in a wholesale manner away from the most recent ACT 2 Care case conference plan, however, they considered there to be scope to work slightly outwith this. The SPS maintained that with their significant knowledge of Mr C's behaviours, particularly fluctuations in mood and levels of compliance/interaction, prison management understood the scenario by which staff felt it was safe to work outwith this and considered that the decision to provide him with a pen on 24 January 2013 was such an instance. The SPS were unable to provide any information about the retrieval of the pen.

Relevant policies, procedures, legislation, etc

15. Guidance on the ACT 2 Care is provided in the SPS Suicide Risk Management Strategy. In section 2.1 on Key Issues In Care, this guidance states:

> 'Prisoners who are “at risk” should be allowed to retain their personal belongings, although there may be circumstances where it is unsafe to do so. This again is a team decision. The items not allowed in use must be specified.'

16. In section 5.1 on Key Issues in Teamworking, it states:

> 'The Care Plan is a team document open to all that are responsible for the care of the prisoner. The care plan will stay with the prisoner wherever he is located e.g. in the residential area, work party, etc. This will be used to inform staff of the required actions to ensure his/her care whilst under ACT 2 Care. When the case is eventually closed, the completed documentation will be filed in the health care record.'

(a) Decision

17. I am critical that the SPS have been unable to provide copies of the relevant ACT 2 Care documentation that was in place on 24 January 2013. These records form an important part of Mr C's case history and I find it concerning that they appear to have gone missing. I do, however, accept the SPS's position that the ACT 2 Care conditions were unchanged from

3 January 2013. As such, at the time of this incident Mr C was considered to be at high risk and was allowed no items for use in his cell.

18. The guidance on ACT 2 Care states that prisoners should be allowed to retain their personal belongings, although there may be circumstances where it is unsafe to do so. It also states that items not in use must be specified. I consider that it was clear from the ACT 2 Care conditions that Mr C was not allowed any items for use in his cell. From the guidance, it is clear that a restriction like this is not the norm and that a decision to control the items available to prisoners being managed on ACT 2 Care is taken after consideration by the multi-disciplinary team at a case conference.

19. The SPS position is that the pen was provided to Mr C in good faith as he needed it to complete the self-representations form. I note their comments on there being scope to work slightly outwith the ACT 2 Care plan and that management considered that with their substantial knowledge of Mr C, this was an instance where staff were able to do so. I do not agree that providing Mr C with a pen represented working slightly outwith the care plan. While I accept that the self-representations form needed to be completed, I do not find that sufficient account was taken of the ACT 2 Care condition that no items were permitted when providing him with the pen.

20. A complete restriction on items is not a standard approach and had been decided on because of the high risk Mr C posed. The guidance on ACT 2 Care states that the care plan is used to inform staff of the required actions to ensure care whilst prisoners are being managed under ACT 2 Care and I do not consider that this was the case for Mr C. I am also concerned that there appears to have been no attempt to retrieve the pen after Mr C had finished using it and that this was not explored by the SPS during their own investigation of this complaint. Similarly, there appears to have been no attempt to investigate Mr C's complaint that the Prison Officer made inappropriate comments when providing the pen. This serious allegation is against the principles of ACT 2 Care and I would have expected this to be fully investigated by the SPS at the time.

21. Taking all of the above into account, whilst I appreciate that the staff may have had substantial knowledge of Mr C's case and behaviour, I do not consider it was appropriate to deviate from the ACT 2 Care plan on 24 January 2013. I find the decision to provide Mr C with a pen when the

condition restricting items was in place amounted to maladministration. Consequently, I uphold this complaint.

22. My office has received a high volume of complaints from Mr C across a number of prisons where he has been held. I accept that Mr C presents many challenges in terms of his care, however, I have grown increasingly concerned by the number of complaints which have been upheld following consideration by my office. The following is a list of all the case references where we have upheld a complaint from August 2013 to date:

Reference	*Summary of subject*
201300584	Refusal to provide kosher diet
201300592 / 201300593	Issues around permission, observations and breaks when using restraints
201300603 / 201300685	Missing paperwork and complaints handling
201300691	Lack of action to inform family of hospitalisation
201303972	Removal from ACT 2 Care process and complaints handling
201304620	Use of restraints and complaints handling
201304654	Lack of medical assistance and complaints handling
201305131	Complaints handling
201305305	Complaints handling
201400854	Complaints handling
201405121	Record-keeping
201405223	Application of a prison rule
201407446	Use of restraints and risk assessment (complaints relate to the custody and escorting service acting on behalf of the SPS)
201407060	Use of restraints and complaints handling (complaints relate to the custody and escorting service acting on behalf of the SPS)
201407699	Complaints handling

23. Taking my concerns about this case in to account alongside the complaints already upheld for Mr C, I have made additional recommendations to address the wider issues in managing his care while he remains in prison. This year, the first voluntary Independent Prison Monitors were recruited following the introduction of the role by Her Majesty's Inspectorate of Prisons for

Scotland (HMIPS). The role holds statutory authority under the Public Services Reform (Inspection and Monitoring of Prisons) (Scotland) Order 2014. Independent Prison Monitors are essential within the Scottish justice system as they help ensure prisoners' human rights are upheld and that life in prison contributes to their rehabilitation. One of my recommendations relates to this new role.

(a) Recommendations

24.	I recommend that the SPS:	*Completion date*
(i)	issue a written apology to Mr C for the decision to provide him with a pen when the restrictive ACT 2 Care condition was in place;	23 September 2015
(ii)	arrange a meeting between the Governor of Mr C's current prison and a senior member of the local NHS Board to discuss our ongoing concerns about his care and to ensure that there is appropriate senior oversight; and	21 October 2015
(iii)	highlight this issue to the new Independent Prison Monitors to ensure that they are aware of our concerns and inform HMIPS we have asked for specific steps to be taken in relation to Mr C.	21 October 2015

(b) There was an unreasonable delay in the SPS responding to his complaint

Concerns raised by Mr C

25. Mr C explained that on 18 February 2013, he submitted a PCF2 to complain about this incident and received confirmation from the Governor that it would be investigated by the Unit Manager. Mr C submitted a further PCF2 on 13 January 2014 as no response had been received. He complained that the original PCF2 had been received by the Governor on 19 February 2013 and that a response was due by 26 February 2013 but this had not been provided. By this point Mr C had been transferred to another prison and had been advised that staff there were unable to find any details of a response on the system. Mr C also submitted a Prisoner Complaint Form 1 (PCF1) in relation to this matter as he had not received a response to his second PCF2 within the seven day timescale.

26. Mr C received a response dated 21 January 2014 to his second PCF2 advising that the Governor anticipated that the Unit Manager's investigation had

been completed and that Mr C should have been provided with the outcome. Mr C was advised that the Unit Manager would be spoken to and arrangements made for a copy of the response to be provided.

27. Mr C submitted a third PCF2 in relation to this matter on 17 February 2014. Mr C has advised that he did not receive any response to his third complaint. Mr C also advised that a further PCF2 was completed on 8 July 2014 and informed us that again, no response was received.

28. Mr C met with the Unit Manager on 26 July 2014 and received a final written response to his complaint dated 21 August 2014.

The SPS response

29. As previously referred to, it was noted at the meeting of 26 July 2014 that while Mr C stated he had never received a final response to the matter, the Unit Manager recalled that a response was provided by the Prison Officer explaining the reasons for the decision. However, during my investigation, this was refuted by the Prison Officer who had no recollection of being asked about the incident or investigated over the allegation.

30. In response to an enquiry from my complaints reviewer, the SPS advised that Mr C's original PCF2 was received on 19 February 2013 and allocated the appropriate reference numbers with an interim response being issued that day. They referred to Mr C's meeting with the Unit Manager on 26 July 2014 which they advised was arranged as the complaint had been ongoing for some time. The SPS went on to say that paper copy complaint files had been checked but that the relevant paperwork had been removed and no other copy was available. They advised that without this, they were unable to evidence that the complaint had been responded to within a reasonable time. They considered that the form had been misfiled.

31. The SPS acknowledged in their response to my complaints reviewer's enquiries that some information that they had submitted for this investigation was not supported by written evidence and apologised for this. They advised that this had been recognised as a learning point by those involved.

Relevant polices, procedure, legislation etc

32. The Prisons and Young Offenders Institutions (Scotland) Rules 2011 provides a timeframe for responding to complaints of this nature in Rule 124:

'Complaints to the Governor in relation to confidential matters

124.—(1) This rule applies to complaints made by a prisoner to the Governor concerning any confidential matter.

…

(4) Subject to paragraph (5), the Governor must consider any complaint to which this rule applies and inform the prisoner in writing and in a sealed envelope of his or her decision within 7 days of the complaint being made and of the reasons for that decision.

(5) If, in exceptional circumstances, the Governor is unable to give a decision within the period specified in paragraph (4), he or she must:

(a) inform the prisoner of the reasons for the delay;

(b) advise the prisoner of the timescale within which the decision will be given; and

(c) inform the prisoner in writing and in a sealed envelope of the decision and of the reasons for the decision as soon as practicable.

(6) The Governor, upon issuing a decision to the prisoner under paragraphs (4) or (5), must inform the prisoner of the process by which the complaint may be referred to the Scottish Public Services Ombudsman.

…'

(b) Decision

33. Rule 124(4) provides that the Governor must inform prisoners in writing of their decision within seven days of the complaint being made and of the reasons for their decision. While Mr C received an interim response advising that the Unit Manager was to investigate, the SPS's final response was not issued until 21 August 2014. I do not consider the length of time Mr C had to wait for a response to be in any way reasonable.

34. Although the Unit Manager advised Mr C at the meeting on 26 July 2014 that the complaint was dealt with by way of an explanation from the Prison Officer, that staff member has subsequently advised that they have no recollection of being asked about the incident or there being any investigation. Even if this action had been taken, it would not be in line with the process for responding to PCF2 complaints as set out in Rule 124 where a response is required in writing.

35. There is no documentary evidence to show that any investigation of Mr C complaint took place after it was received by the SPS on 19 February 2014 or that the Prison Officer gave Mr C any explanation for the action taken. I note that the SPS have already noted this failing and that it has been identified as a learning point, however, I am highly critical of the complaints handling in this case. The lack of documentary evidence of any timely investigation coupled with missing ACT 2 Care and complaint paperwork is a matter of some concern.

36. Taking all of the foregoing into account, I uphold this complaint.

(b) Recommendations

37. I recommend that the SPS:	*Completion date*
(i) issue a written apology to Mr C for the delay in providing a response to his complaint;	23 September 2015
(ii) issue a reminder to all staff involved in the handling of this case that all confidential complaints should be investigated and responded to in line with the Prison Rules and associated Staff Guidance on Prisoner Complaints and Disciplinary Appeals; and	23 September 2015
(iii) review how paperwork such as complaint forms and ACT 2 Care documents are managed to ensure that important information is not lost.	21 October 2015

38. The SPS have accepted the recommendations and will act on them accordingly. We will follow-up on these recommendations. The SPS are asked to inform us of the steps that have been taken to implement these recommendations by the dates specified. We will expect evidence (including supporting documentation) that appropriate action has been taken before we can confirm that the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Mr C	the complainant
the SPS	the Scottish Prison Service
ACT 2 Care	Assessment Context Teamwork Care
PCF2	Prisoner Complaint Form 2
the Prison Officer	a member of prison staff
the Governor	the governor of the prison Mr C was held
the Unit Manager	the member of staff investigating Mr C's complaint
HMIPS	Her Majesty's Inspectorate of Prisons Scotland
PCF1	Prisoner Complaint Form 1

Annex 2

Glossary of terms

ACT 2 Care	the SPS's process for managing prisoners who are at risk of suicide or self-harm
anti-ligature clothing	clothing specially designed to reduce the potential for self-harm
PCF1	form for complaints to the Residential First Line Manager
PCF2	form for confidential complaints

Annex 3

List of legislation and policies considered

SPS Suicide Risk Management Strategy

The Prisons and Young Offenders Institutions (Scotland) Rules 2011