

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Russell Irvine, a prisoner at HMP Durham, on 7 November 2022

A report by the Prisons and Probation Ombudsman

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OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

If my office is to best assist HM Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Russell Irvine was found hanged in his prison cell at HMP Durham on 7 November 2022. He was 51 years old. I offer my condolences to Mr Irvine's family and friends.

Mr Irvine had been at Durham for three days when he died, after he was recalled for breaching the conditions of his licence. He had not been identified as at an increased risk of suicide and was not subject to any additional monitoring.

My investigation found issues with access to, use of and sharing of risk information amongst prison and healthcare staff completing Mr Irvine's initial risk assessments. Staff were reliant on Mr Irvine's presentation, rather than an objective assessment of his risk factors.

Durham is receiving additional support from HMPPS headquarters as a result of the number of self-inflicted deaths there in the last 12 months. The learning from this investigation can usefully inform considerations about staff training and suicide and self-harm risk management.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Adrian Usher
Prisons and Probation Ombudsman

September 2023

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Summary

Events

1. Mr Russell Irvine was convicted of murder in 1994 and sentenced to life imprisonment. He was managed under Prison Service suicide and self-harm prevention procedures, known as ACCT, on several occasions. Mr Irvine was released on licence in October 2022, but on 4 November 2022 he was recalled to HMP Durham for breaching his licence conditions.
2. In reception, Mr Irvine said that he was unhappy about his recall but had no thoughts of harming himself. He had been in prison before and understood how to access support. Mr Irvine told a nurse that he had not eaten for two days, which was noted on his medical record but not on his prison record. Prison staff were not made aware. A mental health nurse assessed Mr Irvine and found no evidence of mental illness. In the first night centre, Mr Irvine said he did not want to share a cell or use the telephone system.
3. Mr Irvine saw various members of staff as part of his reception and induction. No suicide or self-harm risks were identified based on Mr Irvine's presentation, and no additional monitoring was put in place. On 5 November, a healthcare assistant checked Mr Irvine's basic clinical observations, which were normal.
4. On 7 November, Mr Irvine told a healthcare support worker that once he knew whether his partner was going to stand by him, he would consider eating again. His clinical observations were slightly abnormal. That afternoon, Mr Irvine went to the wing office in an agitated state and said that he was unable to use the telephone system. Staff checked and told him that he had declined access on arrival but told him how he could apply.
5. During a routine check that evening, a prison officer found Mr Irvine hanging. She called for assistance and went into his cell, cut the ligature and worked with colleagues to try to resuscitate Mr Irvine. Ambulance staff arrived and took over. At 9.34pm they confirmed that Mr Irvine had died.

Findings

Assessment of risk

6. Some staff who saw Mr Irvine in reception were unaware of his history of management under ACCT processes or that he had been recalled to prison (which is a known risk factor for suicide). Healthcare staff did not have access to records and prison staff did not use them to inform initial risk assessments.

Mr Irvine's food refusal

7. When Mr Irvine told a reception nurse that he had not eaten for two days, she noted the disclosure in his medical records but did not follow the food refusal policy to manage the risks or monitor his food or fluid intake. There is no evidence that the information was passed to prison staff.

8. Mr Irvine did not collect any food during his time at Durham. Prison staff did not notice this and were unaware of policy requirements for prisoners refusing food.

Mr Irvine's healthcare

9. The healthcare Mr Irvine received at Durham was only partially equivalent to what he might have expected to receive in the community. The healthcare management of his not having eaten for several days was not sufficient. In addition, when Mr Irvine complained of feeling unwell and his observations were outside normal limits, no action was taken.

Recommendations

- The Governor and Head of Healthcare should review reception procedures to ensure that all staff have access to and consider relevant information, including digital PERs and prison records when assessing the prisoner's risk.
- The Governor and Head of Healthcare should ensure that staff do not rely on a prisoner's presentation alone when assessing suicide and self-harm risks.
- The Head of Healthcare should ensure that staff are aware of their responsibilities under the food refusal policy, including sharing information with prison staff and completing an incident report.
- The Governor should implement a process for monitoring food collection, to ensure follow up action can be taken where necessary.
- The Head of Healthcare should ensure that clinical checks on prisoners who are refusing food and/or fluids are carried out and recorded appropriately to ensure risks are managed.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Durham informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
11. The investigator visited Durham in February 2023. He obtained copies of relevant extracts from Mr Irvine's prison and medical records.
12. The investigator interviewed eight members of staff at Durham.
13. NHS England commissioned an independent clinical reviewer to review Mr Irvine's clinical care at the prison. She joined the investigator remotely for interviews of healthcare staff.
14. We informed HM Coroner for Durham of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
15. The Ombudsman's family liaison officer contacted Mr Irvine's father, his next of kin, to explain the investigation and to ask if he had any matters he wanted us to consider. Mr Irvine's father had no specific questions.

Background Information

HMP Durham

16. HMP Durham is a local prison, serving the courts of Tyneside, Durham and Cumbria. It has a maximum capacity of 985 men. Spectrum Community Health CIC provides primary healthcare services. Tees, Esk and Wear Valleys Foundation NHS Trust provides mental health services.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Durham was in November 2021. Inspectors reported that serious staff shortages had affected all aspects of healthcare provision and caused delays for prisoners trying to access support. Although the Head of Healthcare had a clear vision, oversight and strategic management had been affected by the lack of a deputy and the need for her to be involved in clinical delivery.
18. Inspectors also found that reception was a busy environment, with late admissions affecting the quality of provision. Similarly, the first night centre was busy, which affected the regime there.

Independent Monitoring Board

19. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to 31 October 2022, the IMB reported that Durham was a safe prison, with safety a priority for staff at all levels. However, Prisoners were not satisfied with the speed of healthcare processes. The Board noted that reception was a very busy area. Incidents of self-harm had reduced since the last annual report.

Previous deaths at HMP Durham

20. Mr Irvine was the seventh prisoner at HMP Durham to die since the beginning of 2021. The other deaths were all due to natural causes. There have been three further apparently self-inflicted deaths since Mr Irvine's, including one that occurred three days after Mr Irvine's. As a result, the prison is receiving additional support and monitoring from HMPPS headquarters.

Assessment, Care in Custody, and Teamwork (ACCT)

21. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner.
22. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be

regular multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.

23. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

24. In 1994, Mr Russell Irvine was convicted of murder and sentenced to life imprisonment. During his time in prison, he refused food on several occasions. Mr Irvine had also tied ligatures during his sentence and had been managed under suicide and self-harm monitoring procedures known as ACCT. Mr Irvine was released on licence in October 2022, but was recalled to Durham on 4 November after breaching his licence conditions. (This meant that he would restart the parole application process and once again have to work towards release.)
25. In reception, Mr Irvine was interviewed by two supervising officers (SOs), who completed an initial risk assessment. They did not check Mr Irvine's prison record so were unaware of his history of self-harm. Mr Irvine said that he was unhappy about the reasons for his recall but had no thoughts of harming himself. One of the SOs explained the support that was available in the prison, including chaplaincy, the Samaritans, and Listeners (prisoners trained by the Samaritans to provide peer support). Mr Irvine said that he had been in prison before and understood how to access support but did not need any at the time. Mr Irvine had previously resided on the vulnerable prisoners' unit (VPU), which prisoners can apply to for their own protection. He told the SOs that he did not wish to apply at the time.
26. In interview, one SO said that although she was not aware that Mr Irvine had previously been managed under ACCT procedures, she knew he was serving a life sentence and had been recalled to prison, which she noted was a potential trigger for suicide and self-harm. She assessed that there was no imminent risk of harm at the time.
27. A nurse completed Mr Irvine's initial health screening. She did not have access to any information about Mr Irvine's time in police custody or previous time in prison. Mr Irvine told her that he had not eaten or drunk any fluids while in police custody because he was unhappy about being recalled. She incorrectly recorded that there had been no change in custodial status (such as recall). She said in interview this was the answer Mr Irvine gave her. She referred him for a mental health assessment and noted on his record that his food and drink intake and basic medical observations (such as blood pressure, pulse, and temperature) should be monitored. In interview, she said that she told a member of prison staff that Mr Irvine had not been eating, but she could not remember who she told. She did not note this on Mr Irvine's records. It was her understanding that the officer would begin a food refusal sheet for Mr Irvine, in accordance with local policy. Mr Irvine told her that he had no thoughts of harming himself. She told Mr Irvine that if he had any concerns, he should see the nurse on the wing.
28. Mr Irvine also met with a nurse from the mental health team, who completed an initial mental health consultation. Mr Irvine said he had no thoughts of harming himself and had a friend outside prison who was supportive. He said he had not had anything to eat but could not remember for how long. In interview, she said that based on the consultation, she did not think Mr Irvine was refusing food as a form of control or self-harm, more that he was frustrated about his recall and had no appetite. She assessed that there were no signs of mental illness and no imminent risk to Mr Irvine's safety at the time. She concluded that he did not require the support of ACCT processes, but the decision should be reviewed if he continued to

refuse food. She recorded that Mr Irvine did not need the support of the mental health team.

29. Mr Irvine was taken to the first night centre, where an officer explained the support available and provided an induction pack. Although anxious, Mr Irvine said that he had no thoughts of harming himself. He declined access to the telephone system. The officer said in interview that she explained the consequences of this, but Mr Irvine did not raise any concerns. She noted on Mr Irvine's record that he was in a good mood and presented well. Mr Irvine refused to share a cell and was charged with a disciplinary offence as a result. He was allocated a double cell but as a single occupant.
30. The following morning, on 5 November, Mr Irvine met with a member of the chaplaincy as part of his induction. He said that he was okay and had no issues. He also met with an officer for an introduction to key work session (where prisoners are given a named officer as a first point of contact and with whom they meet regularly). She explained the purpose of key work and that Mr Irvine would be allocated a named key worker in due course. Mr Irvine said that he had been in prison before so understood the system. She was not aware of Mr Irvine's lack of food and would not usually have access to such information unless a prisoner told her, which he did not. Mr Irvine did not raise any issues with her.
31. A healthcare assistant saw Mr Irvine that afternoon and took his National Early Warning Score (NEWS, a tool developed by the Royal College of Physicians to detect clinical deterioration in adult patients) as part of the process for monitoring the impact of his food refusal. She recorded that Mr Irvine's score was zero, meaning his health had not deteriorated. She did not record anything about his food or fluid intake. Mr Irvine's records do not show any interaction with healthcare services on 6 November.

7 November

32. On the morning of 7 November, Mr Irvine saw a healthcare clerical support worker for a health assessment. His NEWS score was 1, meaning there was a low risk of deterioration in his health, but he said that he had "aches and pains" and an on/off cough. Mr Irvine said that he wanted to know if his partner was going to stand by him while he was in prison. He said he would ask his solicitor to contact her on his behalf, though he did not know if he had any credit to make a telephone call. Mr Irvine said that once he knew if his partner was going to stand by him, he would know whether to continue with his food refusal. Mr Irvine's body temperature was lower than average, and his blood pressure was higher than is normal. The support worker did not record any information on Mr Irvine's food or fluid intake, or take any further action as regards his temperature or blood pressure.
33. At 3.24pm that afternoon, Mr Irvine went to the wing office and spoke to a SO. He said that he was unable to contact anybody, and no one was helping him. An officer checked Mr Irvine's prison record and found he had declined access to the telephone system on arrival at Durham. The SO directed him to the induction office, which was open at the time and could provide access. Mr Irvine was upset and swore at her then left the office. In interview, the SO said she did not know if Mr Irvine ever attended the induction office.

34. At 7.30pm, an officer completed a routine check on the wing. Mr Irvine was lying on his bed at the time. At 8.53pm, she completed a further check and saw Mr Irvine hanging by a ligature made from the waist band of his trousers, attached to the top bunk bed. She tried to make an emergency call on her radio, but she was not certain that the message registered. In interview, she said that she shouted "staff" to request immediate assistance from colleagues within earshot. She shouted, "code blue" (meaning a prisoner is unconscious or having trouble breathing) and told a colleague to radio a code blue emergency, which he did. At 8.54pm, the control room called an ambulance. Hearing other staff approaching, she opened the cell door and went in. She cut the ligature with her anti-ligature knife and she and colleagues lowered Mr Irvine to the floor and began to perform cardiopulmonary resuscitation (CPR).
35. A nurse responded to the emergency call and joined the officers in the cell within two minutes. She could not detect a pulse so applied a defibrillator (a machine that in some cases can restart the heart). The defibrillator recommended continued CPR, which officers did. The ambulance arrived at the prison at 9.00pm and paramedics took over CPR. At 9.34pm, they confirmed that Mr Irvine had died.

Contact with Mr Irvine's family

36. The duty governor tried to appoint a prison family liaison officer (FLO) soon after Mr Irvine's death but was unable to identify an available trained FLO. To avoid a delay in informing Mr Irvine's family, she provided contact details for his father to the police, who went to his home and shared the news.
37. The following morning, the prison appointed a family liaison officer. The FLO confirmed with the police that they had contacted Mr Irvine's father and followed up with a call. He remained in contact with Mr Irvine's family, to provide ongoing support.
38. In line with HMPPS guidance, Durham offered a contribution to the costs of Mr Irvine's funeral. When our family liaison officer spoke to Mr Irvine's father, he was complimentary about the support that he received from the prison.

Support for prisoners and staff

39. After Mr Irvine's death, the duty governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
40. The prison posted notices informing other prisoners of Mr Irvine's death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Irvine's death.

Post-mortem report

41. Post-mortem tests showed that Mr Irvine died as a result of pressure on the neck due to hanging. No illicit substances were found in Mr Irvine's system.

Findings

Accessing and sharing risk information

42. Prison Service Instruction (PSI) 64/2011, Safer Custody, lists risk factors and potential triggers for suicide and self-harm, including a history of suicide or self-harm, violent offences against a person and recall to custody. It says all staff should be alert to the increased risk of self-harm or suicide posed by prisoners with these risk factors and should act appropriately to address any concerns. Any prisoner identified as at risk of suicide and self-harm must be managed under Assessment, Care in Custody and Teamwork (ACCT) procedures.
43. Person Escort Records (PERs) are electronic or hard copy documents used to share risk information when individuals move between police and prison custody. PERs are a key source of information for new receptions and should inform initial risk assessments completed by prison and healthcare staff.
44. Mr Irvine presented a range of potential risks. His index offence was murder, for which he had served 29 years. He had been recalled to prison for breaching his licence conditions very shortly after release and reported that he was frustrated by the decision. He must have known that he now faced a prolonged period in prison while he restarted the parole process. Mr Irvine had been monitored under ACCT procedures in prison in 2004 and 2016 and had a history of tying ligatures (a particularly risky behaviour). He said he had a low mood, did not yet know if his partner would stand by him, and had not eaten for a few days. Mr Irvine said that he did not want to harm himself.
45. It is clear that Durham have put efforts into ensuring reception processes are comprehensive. Prisoners have a health check and are interviewed by two senior prison officers and two nurses. They are assessed by a mental health nurse if required. Mr Irvine moved through each stage of the process. However, we found issues with information access and information sharing amongst healthcare and prison staff. This impacted on the quality of initial assessments.
46. The nurses who completed Mr Irvine's initial assessment did not have access to his digital prison records and PER, which contained information on his history and current circumstances. The Head of Healthcare told us that some healthcare staff could not access prison records or PERs as standard because they did not have NOMIS (the prison records system) accounts. A nurse erroneously noted on Mr Irvine's record that there was no change in his custodial status, despite him telling her he was frustrated about his recall to prison. Nursing staff noted in Mr Irvine's medical record that he was not eating and organised follow up checks by healthcare, which we discuss later in our findings. However, they did not share the information with prison staff to help manage the risks.
47. The supervising officers who interviewed Mr Irvine did not check prison records or the PER. An SO said that she was aware that Mr Irvine was a life sentenced prisoner who had been recalled to prison and that this was a potential trigger for risk suicide and self-harm. However, she did not see any signs that he presented a risk to himself. Both prison and healthcare staff concluded that Mr Irvine posed no

increased risk of harm to himself at the time of his reception and ACCT procedures were not used.

48. In assessing a prisoner's risk of suicide and self-harm, staff must balance what is known and recorded about the prisoner against what the prisoner says. They must then make a judgement on whether the prisoner's risk of suicide and self-harm is such that ACCT procedures are necessary. In Mr Irvine's case staff were overly reliant on his presentation and statements that he did not want to harm himself, without giving sufficient weight to his history and circumstances. Staff must have access to information, use the information available to them and share it between them when completing initial risk assessments to ensure they take into account historic information and current circumstances. This might have changed the outcome of their assessment of Mr Irvine.
49. Durham is currently receiving additional support from HMPPS headquarters because of the number of self-inflicted deaths there in the last 12 months. Risk identification in reception has been identified as a key issue and additional training has been provided to staff on risks, triggers and protective factors, with further training to follow. The prison's senior leadership team has implemented processes to improve first night interviews and initial health screens and to ensure that every prisoner is able to make a telephone call on their first night. These are welcome initiatives, but the issue of appropriate access to vital digital information remains a concern. We make the following recommendations:

The Governor and Head of Healthcare should review reception procedures to ensure that all staff have access to and consider relevant information, including PERs, and prison records when assessing the prisoner's risk.

The Governor and Head of Healthcare should ensure that staff do not rely on a prisoner's presentation alone when assessing suicide and self-harm risks.

Mr Irvine's food refusal

50. Guidance on prisoners who are refusing food is contained in PSI 64/2011 and the Department of Health publication *Guidelines for the clinical management for people refusing food in Immigration Removal Centres and Prisons*. The guidance says that a thorough assessment of a person's mental capacity and nutritional status should be undertaken immediately and there should be regular reassessments of the person's physical and mental state.
51. The healthcare department at Durham's food refusal policy says that details of food refusal should be reported to the duty prison manager responsible for the day to day running of the prison and the Primary Care nursing team. A prison incident report must be completed.
52. Mr Irvine told the nurse in reception that he had not eaten or drunk anything for some two days. She recorded this in Mr Irvine's medical records and said that she verbally passed the information on to prison staff, to ensure a food refusal sheet was started. This was not recorded in Mr Irvine's prison records. We were unable to verify if the information was shared between healthcare and prison staff, because the officers we spoke to did not recall the conversation. A nurse noted in Mr Irvine's records that if he continued to refuse food, ACCT procedures might be considered.

Prison staff were unaware of this consideration. The nurse did not complete an incident report in line with local healthcare policy. We make the following recommendation:

The Head of Healthcare should ensure that staff are aware of their responsibilities under the food refusal policy, including sharing information with prison staff and completing an incident report.

53. Prison officers remained unaware that Mr Irvine was not eating and therefore did not monitor his collection of meals from the servery. Durham's local review of Mr Irvine's death showed that his cell was unlocked at mealtimes, but he did not collect his food. There is no evidence of Mr Irvine eating any food during his time in Durham, and no indication that discipline staff noticed this, so the risk was not identified or acted on. The Department of Health's guidance notes that custodial settings should have a system in place that highlights when prisoners do not collect their meals. In interview, staff said they were not familiar with the policy to monitor whether prisoners collected meals. Some said that they relied on the prisoners working at the servery to let them know if food had not been collected. This did not impact on the outcome for Mr Irvine but must be addressed to ensure staff at Durham know how to monitor food refusal and respond appropriately to mitigate the risks. We make the following recommendation:

The Governor should implement a process for monitoring food collection, to ensure follow up action can be taken where necessary.

Mr Irvine's healthcare

54. The clinical reviewer concluded that the healthcare provided to Mr Irvine was not equivalent to that which he could have expected to receive in the community. As noted above, the fact that he had not eaten for two days prior to his arrival was not communicated from healthcare to prison officers.
55. The clinical reviewer also found that the follow up action taken to manage the risks of Mr Irvine's lack of eating was not sufficient. Neither of the checks on 5 or 7 November assessed Mr Irvine's food or fluid intake. No check was made on 6 November. On 7 November Mr Irvine complained of feeling unwell and his temperature and blood pressure were both outside normal ranges, but no action was taken by healthcare. We make the following recommendation:

The Head of Healthcare should ensure that clinical checks on prisoners who are refusing food and/or fluids are carried out and recorded appropriately to ensure risks are managed.

56. On arrival in Durham, Mr Irvine's regular prescribed medication was recorded by healthcare. He did not, however, collect his medication in his short time there. There is no evidence that Mr Irvine was reminded to collect his medication. While Mr Irvine's medications were not prescribed for the treatment of acute or critical conditions, continuity of medication is an important requirement for new receptions and this practice must be improved. We bring this learning to the attention of the Head of Healthcare.

Governor to note

Family liaison

57. PSI 64/2011 says that following a death in custody, the prison's family liaison officer should visit the next of kin in person to tell them and that this should be done quickly to ensure that the family does not find out from another source.
58. When Mr Irvine died, the duty governor was unable to locate an available family liaison officer. In light of this, and to avoid delays, the prison accepted the police's offer to contact Mr Irvine's family. We consider this was appropriate in the circumstances.
59. Durham has a list of trained family liaison officers. We were told that this list was out of date and included names of staff no longer in post. We found no cover arrangements to ensure FLO provision was in place at all times. We are satisfied that steps were taken to prevent a delay in communicating the news of Mr Irvine's death to his family, however we are concerned that the lack of cover arrangements may result in delays and risks families finding out from other sources in future. The Governor will want to reflect on our findings and assure himself that suitable family liaison provision is available at Durham.

Inquest

60. The inquest, held from 17 to 21 June 2024, concluded that Mr Irvine died by suicide. The jury determined:

"We believe on the balance of probabilities that Mr Irvine had the intentions and took his own life on the evening of 7 November 2022 by hanging in his prison cell, using a belt as a ligature, attached to his bunkbed. Mr Irvine also left a note in which he stated he was of sound mind. Based on the evidence provided, the facts state that a number of policies and processes were not actioned or put in place correctly. It is evident that Mr Irvine had previously documented risk factors for suicide and self-harm, however these factors were not identified by prison staff during the reception screening process. It is evident that not all of the actions taken by healthcare were in compliance with the relevant policies. It cannot be established on the evidence that these failings caused or contributed to Mr Irvine's death."

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