Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Samuel Stewart, a prisoner at HMP Wormwood Scrubs, on 15 July 2023

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

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 His Majesty's 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 Samuel Stewart was found dead in his cell at HMP Wormwood Scrubs on 15 July 2023. The post-mortem examination found that he died from psychoactive substances (PS) and cocaine use. I offer my condolences to Mr Stewart's family and friends.

Mr Stewart had been convicted of manslaughter and was awaiting sentencing when he died. Two days before Mr Stewart's death, he was sacked from his job in the waste management team after a parcel containing drugs, which had been thrown into the prison grounds, was found in his trolley. He denied involvement and expressed concerns to his family that this incident could affect his prison sentence.

It is unclear why Mr Stewart was sacked and not suspended pending investigation. I have recommended that the Governor investigate to establish why standard procedures were not followed in this case.

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

Following the inquest conclusion that Mr Stewart died suddenly in his sleep due to drug use, this report has also been amended to remove references to Mr Stewart having taken his own life.

Adrian Usher
Prisons and Probation Ombudsman **July 2024**

Contents

Summary

Events

1. Mr Samuel Stewart was remanded to HMP Wormwood Scrubs on 20 June 2022, charged with murder. Mr Stewart had told police that he would kill himself in prison, so reception staff at Wormwood Scrubs started suicide and self-harm prevention procedures (known as ACCT).

2. On 22 June, Mr Stewart attended court and was remanded to HMP Belmarsh. Staff there continued to monitor him under ACCT procedures until 1 July.

3. On 14 September, Mr Stewart attended court again and was remanded back to Wormwood Scrubs.

4. On 24 April 2023, Mr Stewart's murder trial began, and he attended court each day for four weeks. Reception staff should have screened him for suicide and self-harm risk on his return from court each day, but the Head of Safety told us that staff did not have time to do this. On 25 May, Mr Stewart was acquitted of murder but found guilty of manslaughter. As Mr Stewart's status had changed from remand to convicted prisoner, a factor that could increase his risk of suicide and self-harm, reception staff should have referred him for a healthcare assessment but did not do so.

5. On 13 July, Mr Stewart was working in the waste management team when a parcel was thrown over the wall into the prison grounds. The parcel, which contained drugs and other illicit items, was subsequently found in Mr Stewart's trolley, though CCTV showed that another prisoner had put the parcel there. Several prisoners, including Mr Stewart, were immediately sacked. The next day, during phone calls to family and friends, Mr Stewart said that he had been arrested for handling the illicit parcel but that he was not involved and had just been doing his job. He expressed concern that he was being treated unfairly and that his arrest might affect his sentence.

6. At around 10.45am on 15 July, an officer went to Mr Stewart's cell to unlock him so he could collect his medication. When Mr Stewart did not respond, the officer went into the cell to check on him. He found that Mr Stewart was cold and stiff. He called a medical emergency code and he and a colleague started cardiopulmonary resuscitation (CPR). Healthcare staff arrived shortly afterwards and asked the officers to stop CPR as it was clear that Mr Stewart had been dead for some time. Paramedics arrived at around 11.00am and confirmed that Mr Stewart was dead.

7. Police later found several handwritten notes in Mr Stewart's cell where he expressed his guilt towards the victim of his offence and gave instructions about what he wanted to happen to his belongings. The results of the post-mortem and toxicology tests found that Mr Stewart died from psychoactive substances (PS) and cocaine use.

Findings

8. Mr Stewart was sacked immediately from his job. The Head of Security told us that he would have expected prisoners in this situation to be suspended pending investigation and could not explain why this did not happen in Mr Stewart's case.

9. Mr Stewart was not screened for suicide and self-harm risk on his return from court and was not referred for a healthcare assessment when he was convicted. We acknowledge that it was another seven weeks before Mr Stewart died but bring this issue to the Governor's attention.

10. We found that Mr Stewart's mental health nurse saw him regularly and had a good, supportive relationship with him. We consider this was an example of good practice.

Recommendations

- The Governor should investigate the circumstances that led to Mr Stewart being sacked from his job to establish whether standard protocol was followed.

The Investigation Process

11. HMPPS notified us of Mr Stewart's death on 15 July 2023.

12. The investigator issued notices to staff and prisoners at HMP Wormwood Scrubs informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

13. The investigator obtained copies of relevant extracts from Mr Stewart's prison and medical records.

14. NHS England commissioned an independent clinical reviewer to review Mr Stewart's clinical care at the prison.

15. The investigator and clinical reviewer interviewed seven members of staff at the prison in November 2023.

16. We informed HM Coroner for West London of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

17. The Ombudsman's family liaison officer contacted the legal representatives of Mr Stewart's family to explain the investigation and to ask if the family had any matters they wanted us to consider. The legal representatives asked about Mr Stewart's location, the health care he received, whether he was monitored under ACCT, the circumstances in which he was found and whether he was under investigation for handling illicit substances. We have addressed these issues in the report.

18. We shared our initial report with the legal representatives of Mr Stewart's family. They raised a number of factual inaccuracies which we have amended in this report.

19. We shared our initial report with the Prison Service. The Prison Service did not raise any factual inaccuracies with our report.

Background Information

HMP Wormwood Scrubs

20. HMP Wormwood Scrubs is a category B local male prison, with an operational capacity of 1,273. The prison accepts sentenced and remand prisoners over the age of 21 as well as young adults (18-21 years old) on remand only. The prison has five main wings, with two wings providing single-cell accommodation.

21. Practice Plus Group (PPG) provides primary healthcare services and Barnet, Enfield and Haringey NHS Mental Health Trust provides mental health services.

HM Inspectorate of Prisons

22. The last inspection of Wormwood Scrubs took place in June 2021. Inspectors found that there had been improvement since their previous inspections in 2017 and 2019, with a calm, well-ordered and safer atmosphere. However, inspectors were concerned that prisoners continued to spend 23 hours a day locked in their cells, and they considered that, compared to other prisons, leaders had not done enough to address this. Although the level of violence was one of the lowest inspectors had seen in a local prison, they considered that this was due to the amount of time prisoners spent locked in their cells. Inspectors were concerned that prisoners continued to be denied access to work, education and association. They also noted that leaders were working to improve access to key work, but they considered more needed to be done to address this.

23. In HMIP's survey, 29% of respondents said that it was easy to get illicit drugs. Inspectors reported that there was a published substance misuse strategy, and the associated action plan was comprehensive. There was a monthly drug strategy meeting and there was some evidence that this addressed identified actions.

Independent Monitoring Board

24. 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 May 2022, the Board were concerned about the length of time many prisoners spent locked in their cells and found it unsatisfactory that there was no statistical data available to monitor this. They noted that, while some prisoners could combine part-time working with 75 minutes of activity each day to gain more time out of their cells, many unemployed prisoners were often locked in their cells for 23 hours each day. The Board considered that this was negatively impacting on the mental health of prisoners and had increased the number of referrals to the mental health team who, due to staff shortages, were failing to meet the target to see prisoners within five working days (at the time of the report, there was a four-week waiting time). The Board also found that the key work scheme, designed to improve safety by engaging with prisoners, was not functioning due to staff shortages.

Previous deaths at HMP Wormwood Scrubs

25. Mr Stewart was the 13th prisoner to die at Wormwood Scrubs since July 2020. Of the previous deaths, six were self-inflicted, five were from natural causes and one was drug-related. There were no similarities between the findings in our investigation into Mr Stewart's death and the findings from our investigations into the previous deaths.

Psychoactive substances (PS)

26. Psychoactive substances (formerly known as 'new psychoactive substances' or 'legal highs') are a serious problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

Key Events

27. On 20 June 2022, Mr Samuel Stewart was remanded in prison, charged with murder, and sent to HMP Wormwood Scrubs.

28. Mr Stewart's Person Escort Record (PER – a document that accompanies prisoners between police custody, courts and prisons which sets out the risks they pose) noted that Mr Stewart had mental health issues and that he had told police he would kill himself in prison.

29. Reception staff noted that Mr Stewart had a diagnosis of schizophrenia, a personality disorder, anxiety and depression. He told staff he had previously been an inpatient in a psychiatric hospital due to auditory and visual hallucinations. Mr Stewart also had a history of substance misuse. Reception staff started suicide and self-harm prevention procedures (known as ACCT).

30. On 22 June, Mr Stewart attended court and was remanded to HMP Belmarsh. Staff there continued to monitor him under ACCT procedures until 1 July. During this time, Mr Stewart consistently told staff that he was not suicidal. He engaged well with the mental health and substance misuse teams and staff noted no concerns about suicide or self-harm.

31. On 14 September, Mr Stewart attended court for a plea hearing and was again remanded to Wormwood Scrubs awaiting trial in April 2023. Reception staff noted previous risk factors and referred him to the mental health team. Mr Stewart also requested support from the substance misuse team.

32. On 7 October, a nurse carried out a mental health assessment with Mr Stewart. He told her that he had been struggling to cope with the loss of his mother several years before as well as having difficulties with contact with his 13-year-old daughter. He said he had visual and auditory hallucinations and spoke about his previous misuse of alcohol and crack cocaine. She later discussed his case with colleagues at a multidisciplinary meeting and took Mr Stewart onto her caseload with a plan to see him every two weeks.

33. On 19 October, a nurse saw Mr Stewart. He told her he had settled onto D Wing and was coping well. He had engaged with Listeners (peer supporters trained by the Samaritans) as he felt stressed about his offence and court case. He told her that he had obtained a job in waste management. This was a trusted position which allowed him more time out of his cell. He said he wanted to keep busy, so she referred him for music therapy and yoga which he subsequently took part in each week.

34. On 29 November, Mr Stewart had a psychiatric review. The psychiatrist noted that, on his current medication, Mr Stewart was not showing any signs of psychosis.

35. On 26 January, a member of the substance misuse team assessed Mr Stewart. By this time, he was located on the Incentivised Substance Free Living (ISFL) unit on D Wing, where he was supported in abstaining from misusing illicit substances and underwent regular drug testing. Staff provided him with in-cell relapse prevention packs. Mr Stewart continued to engage with support from the substance misuse team and the ISFL unit and provided 11 negative drug test samples between

January and July 2023. Records show one positive test for opioids on 6 March 2023, but we found no evidence that this was discussed with him or what action was taken against him.

36. On 21 February, an occupational therapist saw Mr Stewart. He said he felt low in mood, and that his medication was affecting his sleep and routine. He said he enjoyed music and creativity to help his mood. The occupational therapist referred Mr Stewart to the mental health team to review his medication.

37. On 27 February, Mr Stewart had a further review with the psychiatrist. He told the psychiatrist that he was having suicidal thoughts due to issues with his daughter and his ex-partner. He reported having flashbacks about his offence and difficulty sleeping. The psychiatrist noted that he discussed ACCT monitoring with Mr Stewart who said he would not harm himself and did not want to be monitored as he felt this was intrusive. The psychiatrist increased Mr Stewart's dosage of amitriptyline (an antidepressant) to help with his increased anxiety and disturbed sleep. The psychiatrist said at interview that he assessed Mr Stewart was stable with no signs of psychosis and that he was always happy to share information with him. He considered that Mr Stewart was well supported by a nurse and that any concerns would be shared with him if necessary.

38. On 22 March, a nurse saw Mr Stewart. He told her that he was experiencing low mood and he was hearing voices. When interviewed, she said she considered ACCT monitoring but did not consider it necessary as Mr Stewart said he was not suicidal and often spoke about his family as protective factors.

39. On 24 April, Mr Stewart's murder trial began. It was expected to last four weeks. Mr Stewart was seen by healthcare staff each day to assess his fitness for court and reception staff spoke to him on his return each day. The Head of Safety said that for prisoners attending court daily for trial, it was not possible for staff to conduct a welfare check on them each time they returned from court. However, she agreed that any change in circumstances, such as being convicted or sentenced, should result in a welfare check which should be documented.

40. During the trial, Mr Stewart missed some appointments with a nurse. He saw her on 8 and 21 May and reported that the trial was going as expected. He said he was preparing for the worst but was coping well. She advised him how to seek support if he needed it after his return from court if there was no one available from the mental health team.

41. On 25 May, Mr Stewart was acquitted of murder but found guilty of manslaughter. His status had therefore changed from remand prisoner to convicted prisoner. We found no evidence that anyone in reception conducted a welfare check on him when he returned to the prison that day and he was not assessed by healthcare staff as he should have been.

42. On 2 June, Mr Stewart told a nurse that his trial had concluded, and he was awaiting sentencing in September. He expected to receive a sentence of 15 years in prison. Mr Stewart said that he was relieved that he was cleared of murder, and he felt supported by his family.

43. On 8 June, a member of the substance misuse team held a review with Mr Stewart. He expressed an interest in completing a formal programme to address his substance misuse and was put on the list to attend the next course.

44. On 29 June, a nurse saw Mr Stewart. He told her that he hated being in prison and said he was not sure how he would cope with a long sentence. She noted that he was keen to keep busy and to help others and she agreed to find out if there were any voluntary positions he could be put forward for. She later recommended him to be a mentor and she said he was pleased with this. Mr Stewart had also put in an application to be a Listener.

45. On 5 July, Mr Stewart attended a bereavement counselling session in relation to the loss of his mother. He spoke openly about his experience of past trauma. His next session was due to take place on 10 July, but he failed to attend.

46. On 12 July, Mr Stewart's records show that Mr Stewart's application to be a mentor was discontinued. Records indicate that he had allegedly been telling staff and prisoners that he was already a mentor. A nurse said that she thought Mr Stewart had said this because he was simply excited at the prospect of being a mentor. However, this was viewed negatively by the person considering his application and she therefore refused to progress it. She said she was disappointed for Mr Stewart as she knew how keen he was to be a mentor. On the same day, Mr Stewart's prison record shows that his application to be a Listener had been refused. The reason for this was not noted. The records do not show if or how these rejections were communicated to Mr Stewart.

Events of 13 and 14 July

47. On 13 July, the waste management team were working in the prison grounds when a parcel containing drugs and other illicit items was thrown over the wall into the prison grounds (known as a 'throwover'). An officer was supervising the waste management team, but she did not see the throwover. She said she was alerted by the control room to stop all movement of the prisoners and when security staff arrived, they searched them. They found the parcel in Mr Stewart's trolley. CCTV showed another prisoner had put the parcel onto the trolley. She said that security staff took over management of the incident and she later learnt that some prisoners, including Mr Stewart, had been sacked.

48. We found no evidence of an investigation into what happened during this incident. The Head of Security said he would have expected the prisoners involved to be suspended pending an investigation, but this did not happen. He could not explain why the correct protocol had not been followed or why Mr Stewart had been immediately sacked.

49. On 14 July, Mr Stewart made phone calls to his sister and two friends during which he told them that he had been 'arrested' for his involvement in the throwover, which he denied. He said that he was only doing his job and he did not touch the parcel. He expressed concerns about being unfairly treated and was worried that this incident could affect his sentence. (Staff had placed Mr Stewart on a disciplinary charge, which is sometimes referred to as 'a nicking'. He was awaiting an adjudication hearing.)

50. Records show that Mr Stewart last used his in-cell telephone at around 7.41pm to make a call to his criminal defence solicitor. This call was not recorded as communications between prisoners and their lawyers is confidential. However, the solicitor agreed to speak to the investigator about the nature of the call. The solicitor described the conversation as normal and they discussed his upcoming sentencing. He spoke to her about daily life, and he played her some music he had been learning on the guitar. He was upset about losing his job, but his solicitor said she had no concerns that Mr Stewart was at risk of suicide or self-harm during their conversation and was shocked when she heard he had died.

51. The night officer spoke to Mr Stewart at his cell door at around 8.53pm and noted no concerns. Mr Stewart was not subject to any welfare checks during the night.

Events of 15 July

52. At around 5.33am on 15 July, during the routine morning roll check, the night officer looked into Mr Stewart's cell and had no concerns.

53. At around 9.16am, an officer unlocked Mr Stewart's cell to allow him to collect his medication. He said he saw him on his bed in his usual sleeping position. He decided to leave him to sleep a bit longer as he was often difficult to wake.

54. The officer said he looked into Mr Stewart's cell again at around 10.45am and saw him lying on the bed in the same position. When he called out to Mr Stewart and he did not respond, he realised that something was wrong. He immediately went into the cell to check on him and found him to be cold and stiff.

55. The officer immediately called an emergency code blue (to alert the control room that a prisoner is unresponsive or not breathing and an ambulance is required) and tried to start cardiopulmonary resuscitation (CPR). He said that he found this difficult as Mr Stewart was stiff, so he radioed his colleague, a Supervising Officer (SO) to ask him to come and assist him. The SO arrived promptly, and he and the officer continued CPR while waiting for healthcare staff to arrive.

56. Healthcare staff arrived shortly afterwards and asked staff to stop CPR as it was clear that Mr Stewart had been dead for some time. Paramedics arrived at around 11.00am and confirmed that Mr Stewart was dead.

Information received after Mr Stewart's death

57. Police later found some handwritten notes in Mr Stewart's cell in which he expressed his guilt towards the victim of his offence and gave instructions about what he wanted to happen to his belongings.

Contact with Mr Stewart's family

58. At around 1.15pm on 15 July, the prison's family liaison officer and a prison manager went to Mr Stewart's sister's home to break the news of her brother's death. The Prison Service contributed to the funeral expenses in line with national instructions.

Support for prisoners and staff

59. A prison manager 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.

60. The prison posted notices informing other prisoners of Mr Stewart's death and offered support. Staff reviewed all prisoners assessed as at risk of suicide or self-harm in case they had been adversely affected by Mr Stewart's death.

Post-mortem report

61. The post-mortem and toxicology reports showed that Mr Stewart died from psychoactive substances (PS) and cocaine use.

Findings

Assessment and management of Mr Stewart's risk of suicide

62. Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody), sets out the processes (known as ACCT) that staff should follow when they identify that a prisoner is at risk of suicide and self-harm. The PSI provides a list of risk factors and triggers that may increase the risk of suicide and self-harm. These include violent offences against another person and a mental illness diagnosis, both of which applied to Mr Stewart.

63. Staff correctly started ACCT procedures for Mr Stewart when he first arrived at Wormwood Scrubs on 22 June 2022, which continued until 1 July. This was the only time Mr Stewart was supported using ACCT. Although Mr Stewart subsequently had periods of feeling low in mood, and indeed reported thoughts of suicide to both his mental health nurse and the psychiatrist, he received good support from the mental health team. The psychiatrist and his mental health nurse assessed that Mr Stewart was being supported by the mental health team, described his family as protective factors against suicide and concluded that he did not need ACCT support. We consider this was reasonable in the circumstances. However, opportunities were missed to reassess Mr Stewart's risk after his court appearances and particularly after his conviction for manslaughter, which we address below.

64. Mr Stewart had a history of substance misuse and was receiving support from the prison's substance misuse team. While he had 11 negative drug tests between January and July 2023, Mr Stewart did have one positive result for opioids in March 2023. However, there was no further indication that he was taking or storing drugs in the lead up to his death. Nevertheless, it is a concern that Mr Stewart was able to access PS and cocaine in prison, and possibly on the ISFL unit, which is supposed to promote drug free living. We bring this to the Governor's attention.

Screening for suicide and self-harm risk following court attendance

65. Prison Service Order (PSO) 3050, Continuity of Healthcare for Prisoners, notes that events that require a prisoner to leave the prison and pass back through prison reception, such as court appearances, can have a significant impact on the health and wellbeing of a prisoner and says, "For those prisoners passing through reception, prisons must have protocols in place for screening them for any potential healthcare, or suicide/self-harm issues."

66. Prison Service Instruction (PSI) 07/2015, Early Days in Custody, says that reception staff should be alert to factors that may increase suicide and self-harm risk. It lists a change in status (e.g., from remand to convicted/sentenced) as a factor that may increase risk and says that prisoners whose status has recently changed should be referred for an assessment by healthcare staff.

67. The Head of Safety told us that prisoners coming back through reception each day during a trial would be briefly checked by reception staff but, due to the number of prisoners going in and out of the prison each day, there was not sufficient resource to carry out a full welfare check. Mr Stewart was not checked for suicide and self-harm risk on his return from court each day as he should have been. In particular,

no one checked on him properly after he was convicted. This constituted a change in status and as such, he should have been referred to healthcare staff for assessment.

68. We acknowledge that it was another seven weeks before Mr Stewart died and that he was seen regularly by a mental health nurse in that time. Nevertheless, the correct procedures were not followed by reception staff, and we bring this issue to the Governor's attention.

Mr Stewart's dismissal from his job

69. Mr Stewart was sacked immediately from his job when the illicit parcel was found in his trolley. He denied involvement and expressed concern to his family and friends that the incident might affect his prison sentence. CCTV footage showed that another prisoner placed the parcel in his trolley and there was no evidence that Mr Stewart was involved in bringing illicit items into the prison. The Head of Security told the investigator that the usual protocol would have been for Mr Stewart to be suspended, pending an investigation, and he was unsure why he had been sacked immediately. We recommend:

The Governor should investigate the circumstances that led to Mr Stewart being sacked from his job to establish whether standard protocol was followed.

70. We could not establish whether the decisions to refuse Mr Stewart's applications to become a mentor and a Listener were communicated to him and what reasons were given. We bring this to the Governor's attention.

Clinical care

71. The clinical reviewer noted that Mr Stewart was under the care of the mental health team throughout his time at Wormwood Scrubs. She found that he had an appropriate care plan which recognised the positive role activity played in his mental health. He saw his mental health nurse regularly and engaged well with her. His risk to himself was regularly assessed and found to be low, which the clinical reviewer considered appropriate. Mr Stewart was provided with appropriate psychosocial treatment and safety advice in relation to his substance misuse.

72. The clinical reviewer found that the health care provided to Mr Stewart was appropriate to his needs and was delivered to a particularly good standard. She concluded that the health care Mr Stewart received at Wormwood Scrubs was equivalent to that which he could have expected to receive in the community.

Good practice

73. We found that Mr Stewart's mental health nurse provided him with a good level of support and encouragement, and they had a solid working relationship. She met regularly with Mr Stewart and documented full details of meaningful, supportive contact with him from October 2022 until the time of his death. The clinical reviewer noted that she was particularly diligent in her attempts to support Mr Stewart during and after his trial. We highlight this as an example of good practice.

Governor to Note

74. The officer did not get a response from Mr Stewart when he initially unlocked him at 9.16am on 15 July. From his experience of Mr Stewart, the officer believed he was asleep and therefore decided not to disturb him. However, when he tried to wake him over an hour later, he found that he had been dead for some time. While we consider that this failure to get a response from Mr Stewart earlier did not impact on the eventual outcome for him, we bring this to the Governor's attention to ensure that staff are reminded to follow the correct unlock procedure at all times.

Inquest

75. The inquest, held on 10 March 2025, concluded that Mr Stewart's death was drug related and that he died a sudden death in his sleep.

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