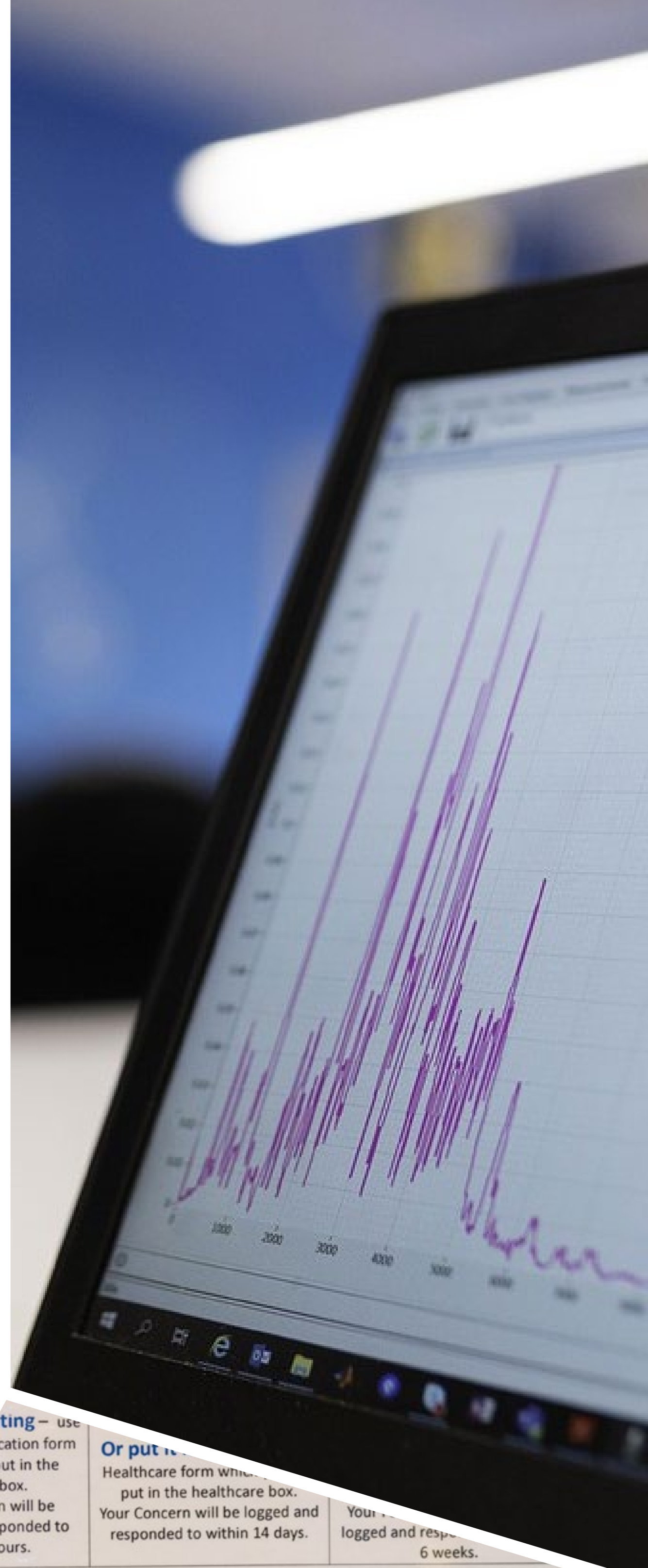
Prisons & Probation Ombudsman
Independent Investigations

Annual Report
2025 to 2026

CP 1606



Prisons and Probation Ombudsman

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Annual Report 2025 to 2026

Presented to Parliament
by the Lord Chancellor and Secretary of State for Justice
by Command of His Majesty

July 2026

CP 1606

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ISBN 978-1-5286-6244-4

E03549573 07/26

Printed on paper containing 40% recycled fibre content minimum

Printed in the UK by HH Associates Ltd. on behalf of the Controller of His Majesty's Stationery Office

Designed by Design102.co.uk

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The role and function of the PPO

The Prisons and Probation Ombudsman (PPO) is appointed by and reports directly to the Secretary of State for Justice. The Ombudsman's office is wholly independent of the services in remit, which include those provided by HM Prison and Probation Service (HMPPS), the Prisoner Escort and Custody Service (PECS), the Home Office (Immigration Enforcement), HMPPS Youth Custody Service, and those local authorities with secure children's homes.[1] It is also operationally independent of, but sponsored by, the Ministry of Justice (MOJ).

The roles and responsibilities of the PPO are set out in the terms of reference, the latest version of which can be found in the appendices.

The PPO has three main investigative duties:

Complaints from prisoners and young people in custody are investigated by Independent Prisoner Complaint Investigations (IPCI). IPCI is part of the PPO.[2]

1 The Youth Custody Service, a discrete part of HMPPS, has been the commissioner or provider of the Children and Young People's Secure Estate since September 2017. The Youth Justice Board ceased to be the provider in February 2017, when it temporarily moved to the MOJ.

2 IPCI investigates complaints from young people detained in secure training centres and young offender institutions. Its remit does not include complaints from children in secure children's homes.

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

Resolve complaints

Investigate deaths

Special investigations

Identify and disseminate learning

Ensure trust and confidence in the criminal justice system

What we value

Ambitious thinking

Professional curiosity

Diversity and inclusion

Transparency

Teamwork

Foreword

Adrian Usher
Prisons and Probation Ombudsman

In February this year, I was officially re-appointed by the Lord Chancellor which will see me remain as the Ombudsman until April 2029. This has allowed me the time to reflect upon my previous three years as Ombudsman, and the achievements of my staff, alongside thinking about where we can bring the most value going forward. With that in mind, I have taken a slightly different approach to my foreword this year and devoted a little more space to the future than I would ordinarily.

The 12 months covered in this report represent a huge amount of effort in delivering a substantially improved output and performance while accommodating rising demand and no greater resource. All three areas of focus for the PPO, complaint investigations, fatal incident investigations and the Learning Analysis and Business Services (LABS) function, which has oversight of special investigations, have risen to these challenges impressively. As in previous years, I will leave, with a great deal of pride, the relevant deputies of those departments to report in detail on their achievements. However, there are some themes that I believe are worth highlighting for the consideration of the government, HMPPS, the Home Office and interested parties.

For the work of our fatal incident investigations department, the number of deaths in prisons remains high, continuing to place sustained pressure on our investigative services. The prison population is ageing, producing greater strain upon health and welfare provision. Suitable accommodation for prisoners with the full spectrum of age-related illnesses and disabilities is increasingly hard to procure, leading to sub-optimal care that we repeatedly comment upon in our reports. However, in recent history, the delivery of appropriate and compassionate palliative care was often performed in the majority to a high standard by a smaller number of prison staff. As the numbers remain high, that experiential expertise is more thinly spread across a larger number of establishments that will take time to learn and embed best practice.

Self-inflicted deaths have reduced in terms of hard numbers, as compared to last year. The risk however is not evenly spread, with the Long-Term High Security Estate and reception prisons continually having the highest level of self-inflicted deaths. While the Long-Term High Security Estate often receives greater resource and focus from HMPPS, I believe reception prisons, overall, carry the greatest risks of self-inflicted deaths without proportionate assistance in terms of training, staff numbers or the fabric of the estate. This leads me to often ask the question regarding reception prisons: why is so much risk purposefully concentrated in so few establishments with the unremitting, detrimental effect on prisoners and prison staff? Could that risk not be more evenly spread across the service?

“

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Against the backdrop of rising demand and static resource, I am enormously impressed by the work of the fatal incidents investigators to have substantially improved their timeliness in terms of issuing the initial report of a death. This relieves pressure on coroners and inquest processes but most importantly gives family members answers to their questions far more efficiently than previously and allows for learning from our investigations to be swiftly embedded.

IPCI, our department that investigates complaints from prisoners and young offenders, has also faced an increase in demand and has equally impressively improved, yet again, the timeliness and efficiency of their outcomes. By appropriately returning complaints to the prisons where insufficient attention has been given by them to an early complaints resolution, to improved triage practices and the growing success of the IPCI Ambassador scheme, complaints are dealt with quicker and by the most appropriate body more frequently than ever before.

It remains the case that I believe that prisons are still not incentivised to focus upon early complaint resolutions sufficiently. When considering property complaints, which constitute the most voluminous category for us, it is noteworthy that they also attract the highest uphold rate at just over 50%. It is not sustainable for the PPO to be scrutinising, with substantial expenditure of public money, exactly the same facts as a prison has already done, and in half of the cases arriving at a different conclusion. I am currently working with HMPPS on a pilot with 10 prisons to explore if there is a more efficient way of addressing property complaints.

Our LABS function undertook the most significant special investigation in the history of the PPO with the investigation into the sustained, historic, physical and sexual abuse that took place at Medomsley Detention Centre between 1961 and 1987. Our 18-month-long endeavour delivered a comprehensive, entirely evidence-based report that revealed the full scale and horror of what happened to thousands of victims at the centre. It represented an incredible victory for the victims who had maintained lifelong campaigns to have their voices heard. It resulted in the victims receiving public apologies from the government, Durham Police and the Independent Monitoring Board (the successor to the Board of Visitors that was in place at the time) and also the establishment of the Youth Custody Safeguarding Panel.

The fact that the report was well received by victims, the government and other significant stakeholders, demonstrates the skill of those who carried out the investigation. That it was delivered on time and within a tight budget has only strengthened my belief that rather than the current disconnected approach to individual

investigations that arise periodically within the HMPPS or Immigration Removal Centre (IRC) environment and are carried out by a variety of individuals and organisations, the PPO is best placed to deliver that investigation. A more efficient default position should be that if anything occurs within the scope of the services within our remit and requires investigation, then as our knowledge, experience and expertise has previously demonstrated, we are the right organisation to conduct it.

Sharing learning with the services in our remit continued to be at the forefront of the LABS team's output this year. From starting another special investigation into the use of restraints on pregnant women in prison, to sharing thematics on epilepsy, self-inflicted deaths and segregation, the insight shared will undoubtedly aid policy, frontline and operational staff in their working practice.

I look to the coming year and beyond with a clear understanding of the weight of responsibility shared by all of us who are seeking to help address the serious and long-standing challenges within the criminal justice system. But I also look ahead with optimism. The implementation of the Sentencing Bill will no doubt provide some challenges alongside opportunities. At the PPO, our role in the process, as with everything connected with the services in remit, is to assist decision-makers with hard evidence upon which to base their thinking.

Thinking about our priorities over the coming year and beyond, I reflect upon my first three years as Ombudsman. When I first took up my post, I met individually with every member of my staff to understand their challenges and perspectives. I have just repeated that exercise as well as meeting with other stakeholders, including prisoners and prison staff, to consider where we should focus our efforts.

It remains an absolute priority of my office to seek out the best evidence to inform policies and practices aimed at reducing self-harm and suicides within the services in remit. I am shocked and saddened that the rate of self-inflicted deaths means that a prisoner in England and Wales will kill themselves approximately every five days. Even more sobering is the realisation that of those who take their own lives, our recent research found that 11% of them do so within the first 48 hours of entering the prison system in reception prisons alone.

I intend to increase our focus on the reception processes in prisons further and it is my hope that our learning lessons bulletin published on this topic this year aids that intention. Seeking out best practice within training and risk assessment processes, powered by optimal digital technology and resourcing models that ensure staff have the time, knowledge and tools to understand the risks held in prison, and making the best decisions to mitigate those risks will all play a part. As will those prisons where reception staff are really valued by their leaders as people who save lives every day by being skilled at their work, which is undoubtedly the case.

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I am shocked and saddened that the rate of self-inflicted deaths means that a prisoner in England and Wales will kill themselves approximately every five days.

I remain seriously concerned that I continue to find cases where prisoners who took their own lives had no credit on their phone account. It is no secret that I think there should be an overhaul of the prison phone system. Prisoners should pay a set fee each month and receive a number of minutes that are determined by the governor. Instead, they currently pay for calls by the minute, meaning there's less of an opportunity to speak to loved ones during difficult and challenging times. I believe this is not only an opportunity to incentivise good behaviour, but also one that can lead to better decisions in a time of need.

Deaths from unintentional overdoses by those misusing drugs continue to be a concern both within and beyond prison. Drug-related deaths continue to make up almost a quarter of all deaths we investigate. In prison, drug-related deaths made up 13% of all deaths we investigated this year. Concerningly, other non-natural deaths make up 54% of post-release deaths we investigated. I have adjusted our focus in those investigations to not solely look at the drug strategy in the prison that combats the supply side of the equation. In a world of increasingly sophisticated drone technology, an extremely lucrative criminal economy that fuels staff corruption, and the impossibility of running a completely risk-free visitor system, all mean that the reality is that some drugs will inevitably make it into prisons. I believe it is at least as important for drug strategies to include tangible tactics to deliver against the demand side of the equation too. Education programmes that effectively communicate the actual risks of consuming synthetic psychoactive substances, regimes that do not result in prisoners being behind their cell doors for excessive periods leading to inevitable temptation to escape the boredom and frustration, and prison and healthcare staff reacting compassionately and promptly to those in need of help to overcome addiction, are all as important as trying to reduce supply.

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When prisoners and prison staff do not harbour a prolonged sense of injustice, it leads to a calmer atmosphere in prisons and better outcomes for all. The more promptly complaints from prisoners are resolved, the less likely a sense of injustice

is to fester and a substantially more positive outcome is delivered for the public purse. We will continue to look at ways that we can encourage prison staff to seek the earliest opportunity to resolve a complaint that is fair to all concerned, including the taxpayer.

Finally, as I look to the future, it would be remiss not to air my most serious concern that impacts across service delivery in prisons and probation. It is a surprising anachronism that HMPPS is the largest public service body that I can bring to mind that has no independent oversight of staff conduct. In many public services there exists an imbalance of power between the provider and the public receiving the service. This is why police officers, doctors, lawyers and nurses are among the many professions that build public confidence by being subject to scrutiny by an independent body. It is hard to think of another occupation that exercises more power over every aspect of an individual's life than that of a prison officer. Yet, in all but a very small percentage of cases, investigations into staff conduct, including use of force, and any subsequent disciplinary hearings take place not only within HMPPS but within the very institution where the member of staff works, conducted by colleagues that they work alongside every day. There is a very stark and obvious difference between the consequences for police officers compared to prison officers who are facing investigations, often for actions taken in very similar circumstances. It is nearly a quarter of a century since the recognition that in order to maintain public confidence, an independent investigative body was necessary to scrutinise police conduct. I believe it is the right time for a similar model to be applied to HMPPS staff.

My last word will, as always, go to my staff. The successes described in this report belong to them. They impress me every day with their knowledge, dedication and compassion. Driven by a shared desire to assist services in remit to be as safe, just and rehabilitative as possible, I believe it is an honour to lead them.

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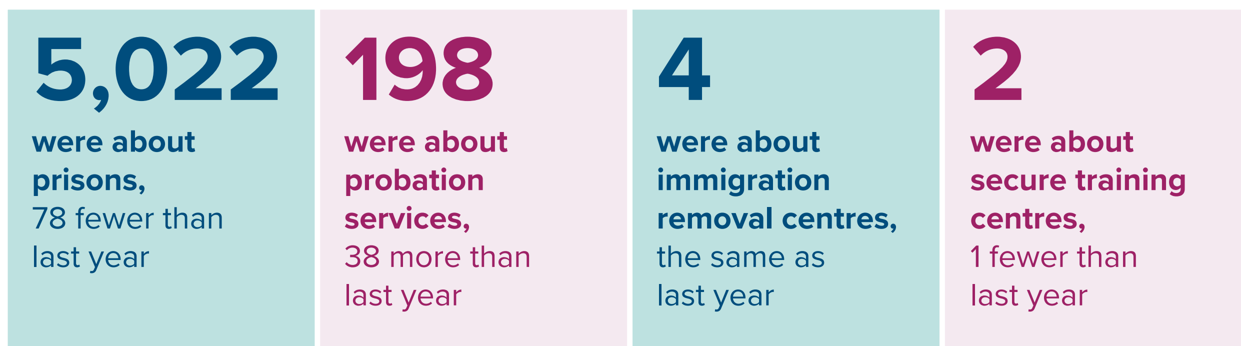
The year in figures

Complaints

We received **5,226 complaints**, a decrease of 1% compared to last year. Of these:



*This measure has replaced 'eligibility letters sent' as part of the approach to tracking the timeliness of our assessment work.
†See the 'about the data' section for an explanation of definitions.

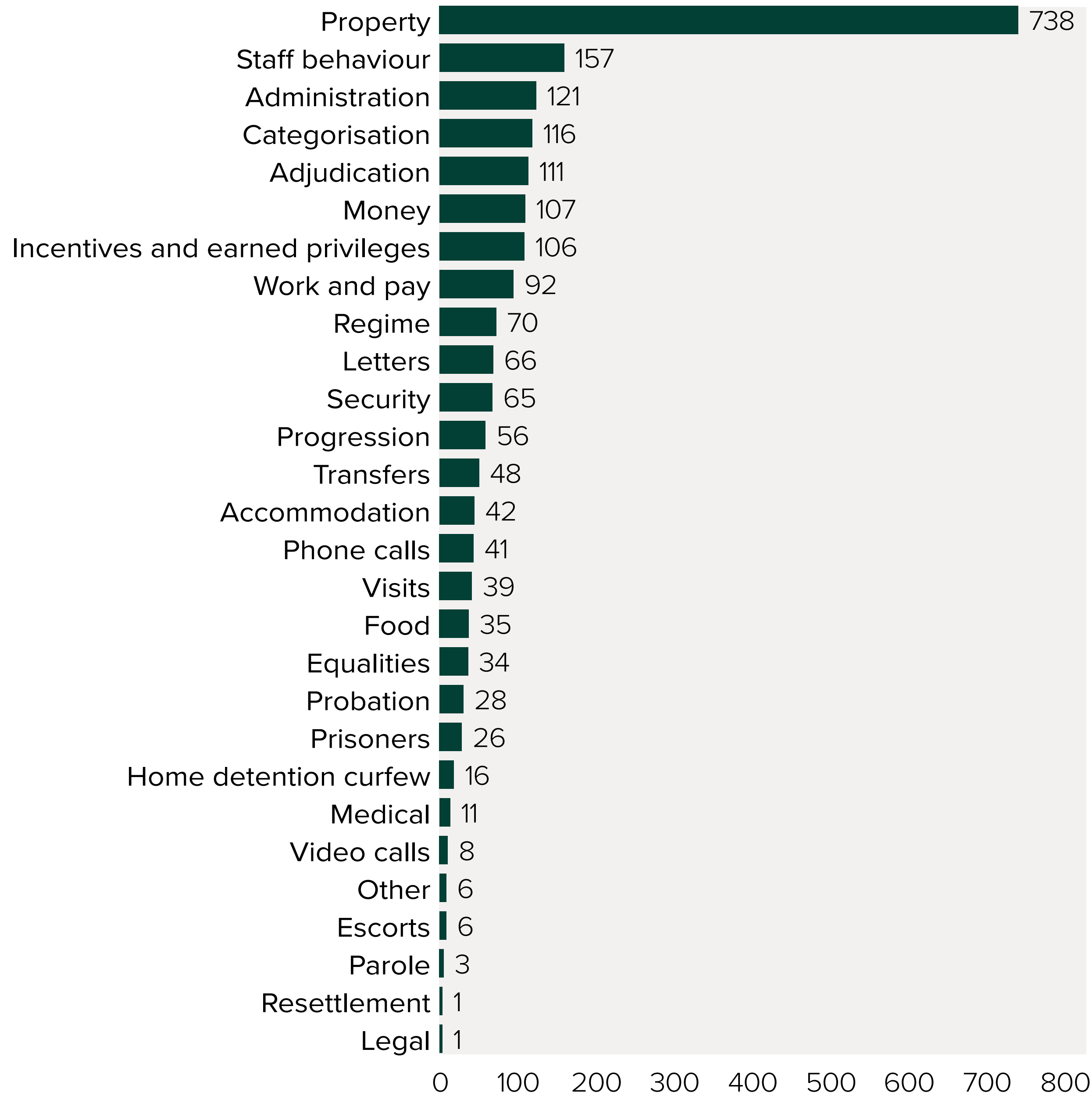
We completed **2,150 investigations** compared to 2,471 in the previous year, a decrease of 13%. Of these:

‡This timeliness metric does not include 95 pushback cases completed.

We do not investigate eligible cases if, for example, the complaint does not raise a substantive issue or if there is no worthwhile outcome. This helps us to appropriately allocate resources.

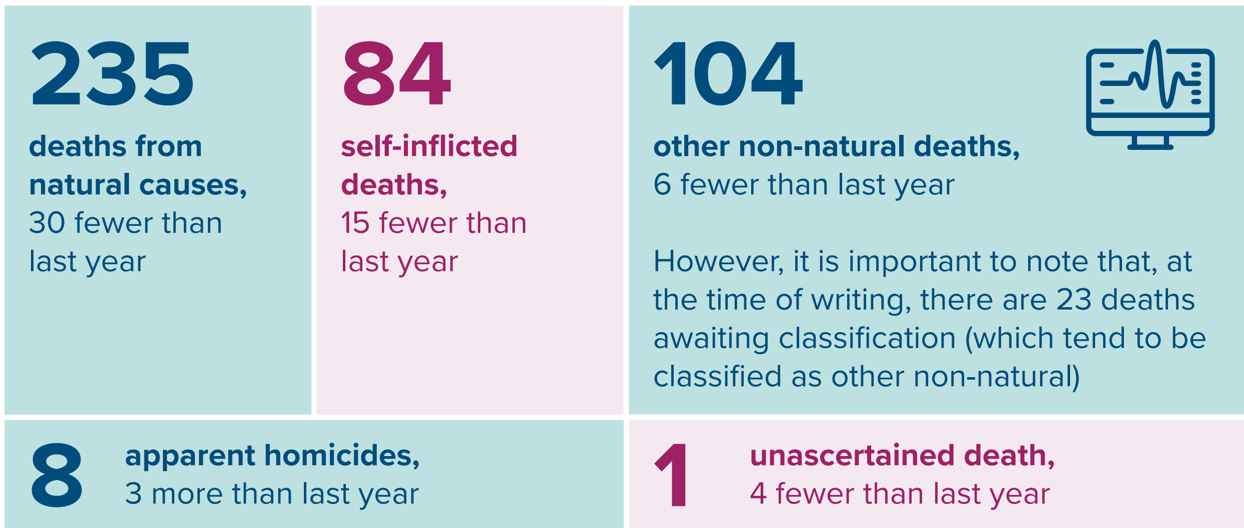
Of the cases we received:

Complaints completed in 2025 to 2026 by category

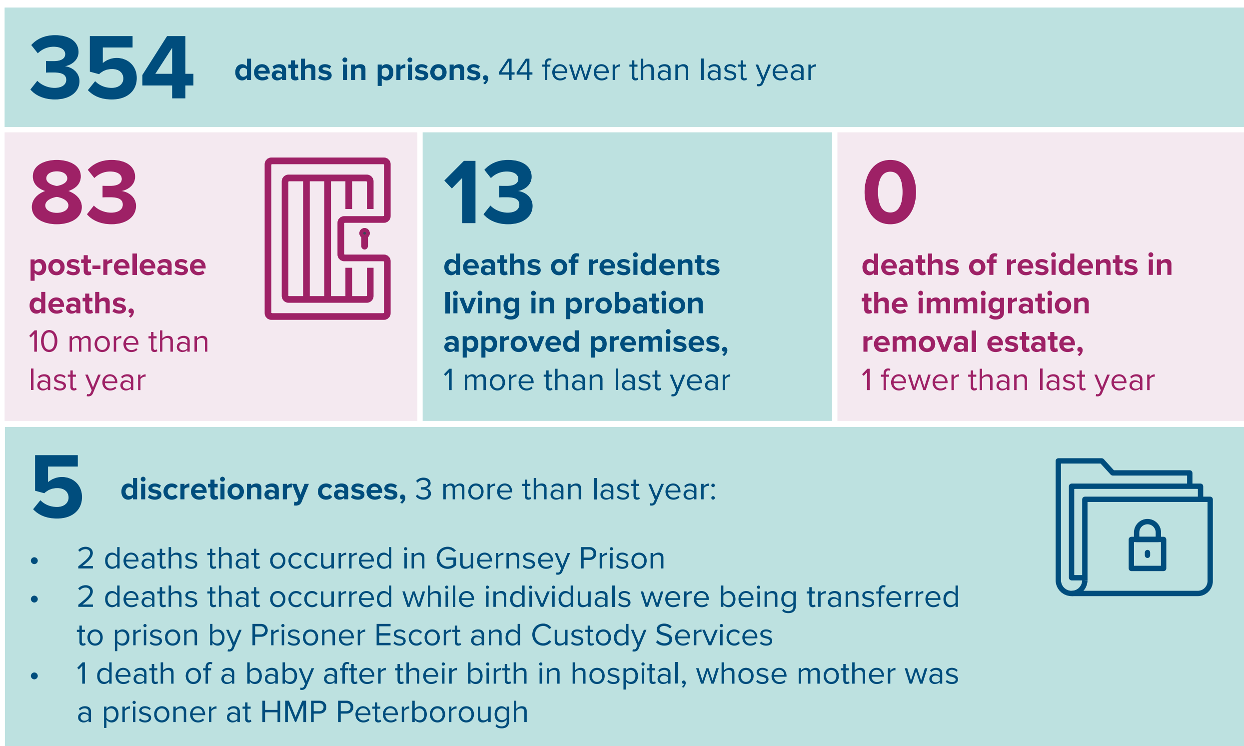


Fatal incidents

We started investigations into **455 deaths**, a 6% decrease compared to the previous year. We began investigations into:

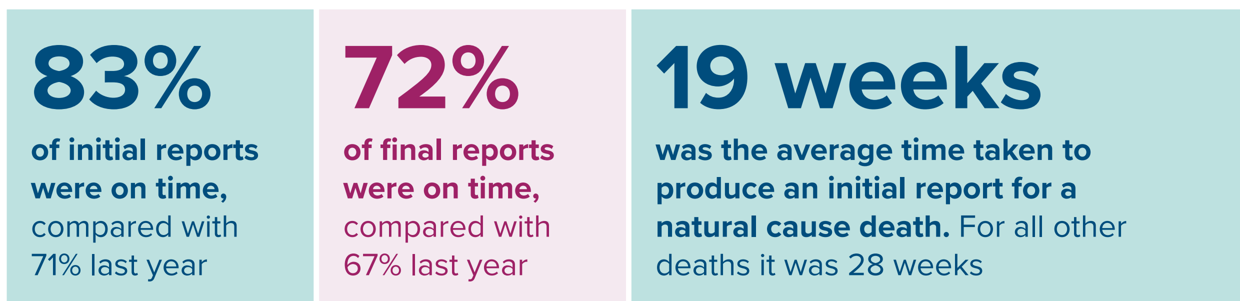


Of the **455 deaths**, the location of investigations started consisted of:



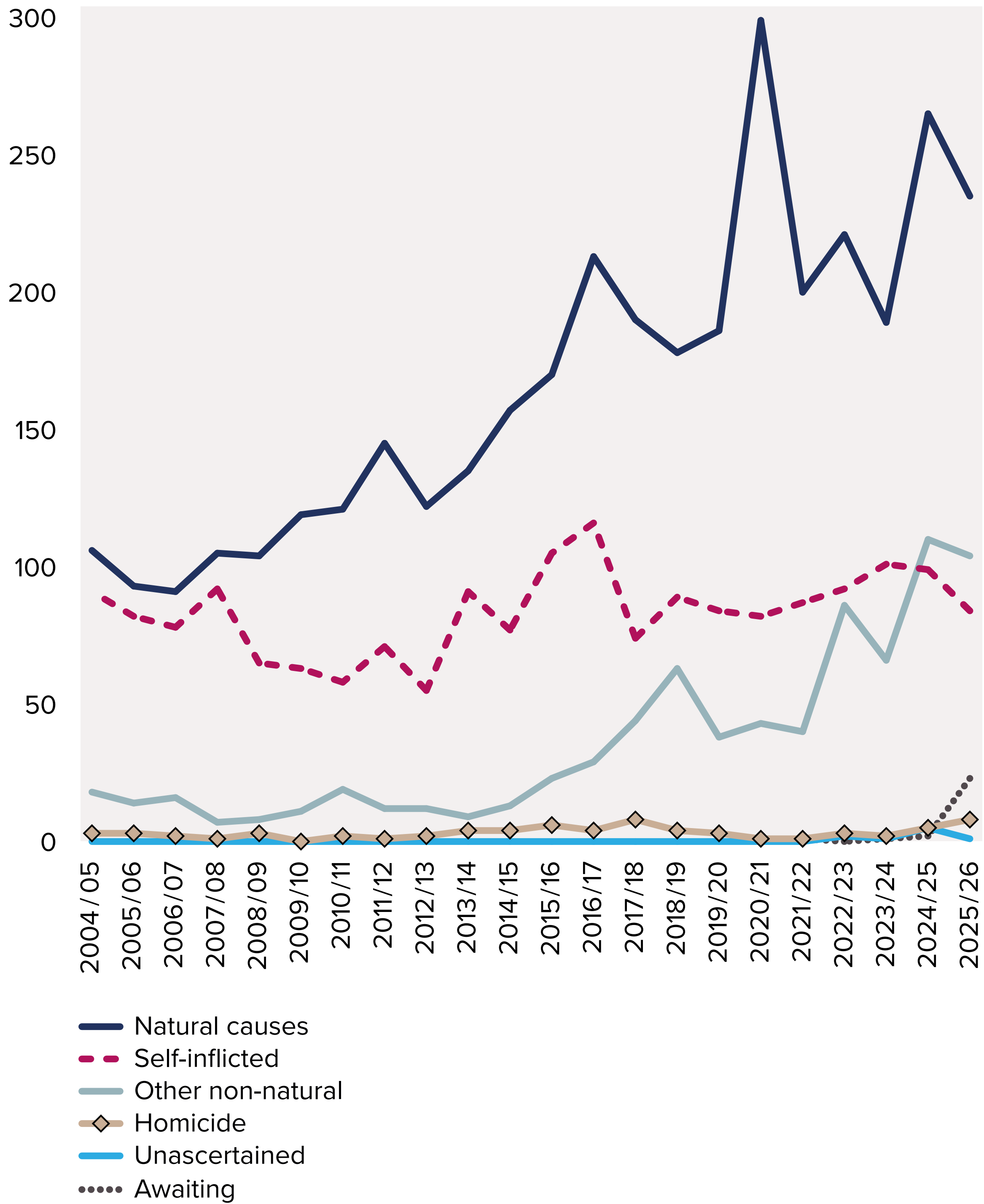
Fortunately, this year we began **no investigations of fatal incidents in secure children's homes,** equal to last year.

This year we issued **508 initial reports and 495 final reports,** compared to 412 initial reports and 416 final reports last year.



Between 1 April 2025 and 31 March 2026, **448 reports were published on the website,** which is a 23% increase from the year before.

Fatal incidents investigated



Investigating complaints

Lee Quinn
Acting Deputy Ombudsman for Complaints and Acting Director of Independent Prisoner Complaint Investigations

I took over from Miriam Minty as the Acting Deputy Ombudsman for Complaints in 2025. I have worked at the PPO for many years as an Assistant Ombudsman in the complaints team and I am proud of what we have achieved in this financial year.

This year saw the strengthening of our work in IPCI and emphasising the importance of complaints to both staff and prisoners.

The enthusiasm for IPCI Ambassadors across the prison estate, which we launched in 2024, saw both staff and prisoners embracing the initiative and coming up with ideas to improve the complaints process.

We also refined the IPCI form that prisoners use to complain to us based on their feedback, to continue to drive down the number of ineligible complaints we receive by making it even easier for them to use.

Tackling ineligibility and reducing the barriers to prisoners being able to complain remained at the top of our agenda this year. We focused on the 17 prisons with the highest number of ineligible complaints, visiting 13 of them in the financial year, and discussing improvements to their complaint handling processes. We adopted a more granular approach to cases from these prisons so we could understand why they are ineligible, distinguishing between those cases outside our remit, and those cases that have come to us ‘early’, before the internal complaints process has been completed by the prisoner. In addition to this, we produced an IPCI awareness video for prisoners on how to complain both to the prison and to us which is accessible to prisoners on our website, Content Hub and Launchpad, WayOut TV, National Prison Radio and in select prisons. We also produced a video to help staff understand prisoners’ complaints which is available on our website, MyLearning and on our YouTube channel.

As highlighted in Adrian’s foreword, property complaints continued to dominate the cases we investigated this year. We looked for innovative ways to address the high number of complaints we receive, including convening a roundtable with HMPPS policy and operational staff, which led to refinements in the property framework.

We continued to see that the origin and resolution to many complaints lies in the system of operational policy that underpins regime delivery. In 2025 to 2026, we worked with policy officials outside individual complaints to try to establish a

common understanding of difficult policy areas. We hope that by engaging early with HMPPS and establishments, we can make complaints less of an adversarial process and part of the landscape of prison improvement.

Improvements in our performance

We focused on improving the timeliness of our investigations this year, which increased from 66% to 87%. We completed 2,150 cases compared to 2,471 last year and upheld 31% of them. The lower completion rate does not mean we have done less work, instead we have refocused resources on improving the complaints process across the services in remit, and working to support and improve establishments where prisoners struggle to submit complaints or secure a meaningful resolution.

Providing a timely response to complaints submitted and flagging those which are not yet eligible for investigation was a priority for us this year as it increases confidence among complainants – we are here and we are responding to them quickly. I am proud to say that 92% of cases we received were assessed within time.

In last year's annual report, Miriam spoke about the importance of ensuring prisons investigate complaints properly first.[3] This year, we continued to focus on pushing back those cases to prisons where we assessed their response as not adequate. We returned 30 of the 95 total pushback cases to them for further consideration before we carried out investigations.

Cases that come to us too early

Crucially, we introduced a metric in 2025 to 2026 to differentiate between those truly ineligible cases which do not fall under our remit, and those early cases where someone has complained to us without going through the internal complaints process. We now define these as 'early cases'.

In 2025 to 2026, we identified 2,021 cases as having been received 'too early' and wrote back to those prisoners asking them to complete the internal prison complaints process first. This is a significant number making up 39% of the complaints we received. We have been working with those prisons where we see a lot of early cases and also flagged to complainants the existence of IPCI Ambassadors who can help them understand and navigate the complaints process properly.

Early resolution cases

In 2025 to 2026, we allocated more resource to trying to resolve complaints earlier. Complaints can often be complicated by the passage of time. Prisoners and staff move, records are lost and sometimes policy changes. Identifying and focusing on cases which can be resolved quickly at a lower level, before circumstances change, has led to an increase in timely outcomes (92%) and quicker resolutions for complainants. We will try to do more of this in the next financial year, freeing up resource to focus on those more complicated complaints that take longer to resolve.

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3 Prisons and Probation Ombudsman (2025). Annual Report 2024 to 2025. Available online at: **https://ppo.gov.uk/corporate_document/annual-report-2024-to-2025/**

IPCI Ambassadors

Our IPCI Ambassador scheme continues to be a main strand for raising awareness of the complaints process, with 62 prisons signed up at the time of writing. These prisons are committed to implementing and maintaining a scheme where prisoners champion the complaints process. This is not just automatic work – with the volume of prisoner and staff changes, we need to ensure that the ambassadors remain an intrinsic part of ensuring prisoners' voices are heard within the complaints system.

We produced three newsletters for Ambassadors and prisons this year, providing advice and guidance on how to submit a good complaint. We also drew attention to good practice in the complaints space for staff, to encourage them to implement this learning. Our January 2026 newsletter highlighted the launch of certificates of achievement for those prisoners who become ambassadors. The certificate celebrates their skills and experience gained and provides a valuable record of their support of the initiative. We wanted their involvement in the scheme to be viewed as a positive contribution by individual prisoners who are improving the way their prison works.

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Working with complainants outside of the adult male prison estate

Although we receive the most complaints from male prisoners, it is important that we continually look at ways we can support our most vulnerable complainants and those who we receive fewer complaints from.

People on probation

We worked with probation colleagues to look at the complaints framework for those under community supervision. In 2024 to 2025, we received 160 complaints from people on probation, and although this rose to 198 in 2025 to 2026, we want to understand this relatively low number considering the number subject to community supervision or post-custodial licence. We await the publication of a new, more streamlined probation complaints framework, which we hope will provide a less resource-intensive but more accessible complaints process. The current three-stage complaints process is lengthy, needing an unnecessary final sign-off that adds little by way of quality. The path to a quicker resolution will benefit both staff and those on probation alike.

Young people in custody

Our report into the historical abuse at Medomsley Detention Centre published in November 2025 identified that not much had changed in the landscape of complaints over the last 40 years. Young people in custody are still reliant on staff to deliver an effective complaints process which has not changed since Medomsley's time. Isabelle Trowler, the Chief Social Worker for England and Wales, was tasked to review complaints and safeguarding within the youth custody estate, and we consulted with the team to give our views and learning on the complaints and safeguarding processes.

In the last year we received 42 complaints from the youth estate, and of the complaints we investigated, we upheld 42% of them. We continued to seek a close working relationship with the independent advocates within the youth estate, a role currently fulfilled by Barnardo's.

In the forthcoming year, we propose to look more closely at the reasons we uphold a significantly higher number of complaints from young people in custody.

Those in immigration detention

Detained persons are historically underrepresented in the number of complaints submitted to this office. We are aware that the Home Office has a robust multi-layered complaints process that covers a range of complaints issues, however, the treatment of immigration detainees is often a matter of public debate, and we must consider whether there is more we can do here to determine whether there are obstacles to those complaining.

This year, we conducted a deep dive into the low numbers of complaints received from those detained in IRCs which revealed several possible reasons for not complaining. The short-term nature of detention periods was a factor. Detained persons were often released before the complaint process could be completed, or complainants were removed from the country. Although such complaints would still be eligible for investigation by us, these were rarely pursued. It was also evident that the main factor of concern for complainants was related to their immigration status or associated claims for asylum or representations against the decision to remove them. These issues are outside the remit of the PPO. Some of these factors may be more difficult to address, such as

shorter stays at IRCs which can mean that complainants are not willing or failing to complete the complaints process in time to allow a PPO investigation, as this is out of our control.

However, we have identified several ways we can increase awareness of the PPO and the complaints process to detained individuals, such as targeted communications, increased visits to IRCs and ensuring promotional material is available to all in a variety of languages. We also plan to work more closely with the Home Office and their contractors to understand trends and areas of concern in complaints received by them, particularly in relation to serious issues such as the use of force within immigration detention or during removal processes.

Women in prison

This year, we investigated 65 complaints from women in prison compared to 44 last year. We continued our commitment to increasing awareness and understanding of IPCI within women's prisons, recognising the importance of trust, confidence and procedural justice in the complaints process. This included a series of visits to women's establishments, during which we held focus groups and structured discussions with women in custody about how and when to complain, what IPCI does, and how complaints progress.

Alongside this work, we have continued strategic collaboration with the Women's Prison Group Director and senior colleagues to consider complaint trends, emerging themes and the wider factors shaping how complaints are raised, understood and progressed across the women's estate.

Achieving better complaint outcomes

As mentioned, we firmly embedded the practice of resolving complaints at the lowest level this year and there was a reduction in the number of reports we issued with formal recommendations. We made 427 recommendations compared to 457 last year. This reflects a more proportionate response to the complaints we investigate as we are trying to engage establishments in the process of implementing and agreeing change, and providing redress, rather than producing formal reports that can be overly prescriptive.

Aligned with this, we have been working closely with policy teams in HMPPS and the Home Office to highlight thematic issues, errors or ambiguities we see in the application of policy. In 2025 to 2026, we met extensively with HMPPS' policy teams to share our findings on several areas including use of force, X-ray body scanners, adjudications and the complex area of safeguarding in the youth custodial estate. Having these discussions allowed us to raise issues outside the difficulties of individual complaint resolution and provide evidence and argument for the improvement of policy and regime delivery. While it is unlikely there will ever be a point where we do not receive any complaints, it remains a goal to do all we can to improve the services in remit and reduce complaints at source.

Complaints recommendations

Our vision behind conducting independent investigations is to make custody and offender supervision safer and fairer. Our investigations provide an opportunity to correct injustices and help produce recommendations to improve learning within organisations, including at a national level. Our recommendations must be specific, measurable, realistic and time-bound, with tangible outcomes to structure learning and deliver the required changes needed to reduce the likelihood of repeat failings.

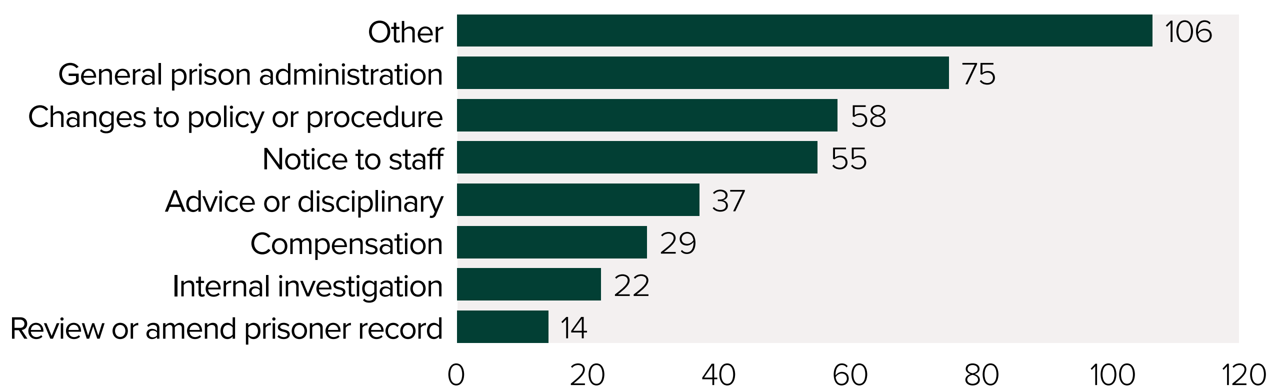
When a recommendation is made after a complaint investigation, the organisation in remit must confirm whether they accept our recommendation and provide evidence of implementation. In cases where the service in remit does not accept a recommendation, the Director General Operations at HMPPS must inform the PPO for public sector prisons. For other services in remit, and for privately managed prisons, a designated senior manager must respond.

We count recommendations about complaints in cases where we have issued the final report within the financial year. Please see the 'About the data' section for more details.

Disappointingly, we continue to identify repeat concerns and failings in our complaint investigations. We make the same recommendations, sometimes in the same establishments, and sometimes after the recommendations have been accepted and action plans agreed to implement them.

In 2025 to 2026, we made 427 recommendations across 174 cases, with an average of 2.5 recommendations per case. At the time of writing, we are awaiting a response to 40 of these recommendations. 379 have been accepted. We have received evidence that 93% of these recommendations have been implemented.

Complaint recommendations, by action (2025 to 2026)



WORKS SERVICES
FARMS & GARDENS
LAUNDRY
WORKSHOPS

Investigating fatal incidents

By Susannah Eagle
Deputy Ombudsman for Fatal Incidents

This reporting year saw a decrease in the number of reported deaths we accepted for investigation. There was a decrease in the number of all death types other than homicides within prisons. Concerningly, there was an increase in deaths within 14 days of release from prison.

The impact of drugs in prison

We share the concerns of HM Chief Inspectorate of Prisons, Independent Monitoring Boards and indeed the government and HMPPS about the prevalence of illicit drug use in prisons. Our fatal incident investigations are stark reminders of the dangers of psychoactive substances – unknown chemical compounds with unpredictable effects. This year, Adrian spoke publicly about the need for better prisoner education on the dangers of psychoactive substances, and we began work to consider how our investigations into drug-related deaths can have greater impact.

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Our fatal incident investigations are stark reminders of the dangers of psychoactive substances – unknown chemical compounds with unpredictable effects.

Deaths from natural causes and the use of restraints on older prisoners

Our investigations into deaths from natural causes this year continued to raise important issues about the healthcare and treatment offered to prisoners. In many cases, our investigations, including the clinical review commissioned by NHS England, showed that the clinical care provided is at least equivalent to what the individual could have expected to receive in the community. However, we worked closely with colleagues in NHS England and HMPPS on epilepsy-related deaths of prisoners this year, as our investigations revealed that their care needs to be improved (greater detail of this work is explained from page 36). This new approach to collaborative working has proved to be effective and we plan to build on it to address other health-related themes.

A proportion of the deaths from natural causes that we investigate involve elderly men serving long sentences. Often in the weeks and months before their deaths, they are frail, with mobility issues, and sometimes receiving palliative care for terminal conditions. Despite these factors, we frequently find that they have been

restrained (by handcuffs and/or escort chains) for hospital visits and admissions.

In 2025 to 2026, we continued to work closely with colleagues in HMPPS to challenge the inappropriate use of restraints and to ensure that decision-makers are confident about a proportionate approach to risk management. This collaborative approach includes an escalation route, culminating in a tripartite meeting between the PPO, the prison and the HMPPS Operational Director for security. We held the first such meeting in May 2026 with a prison where we had made a third recent recommendation about the inappropriate use of restraints. While we hope that such meetings will be relatively rare, they will form part of the armoury of options available to us to robustly address the disproportionate use of restraints.

Troubleshooting areas of concern

Our casework this reporting year identified other themes of concern. In most cases, our findings relate to local systemic issues, but sometimes we identify issues of national significance. In these cases, our recommendations are focused on changing the national policy or the overarching guidance to staff.

We identified an inconsistency between the different forms of guidance for staff on conducting welfare checks when unlocking prisoners. Conducting welfare checks is good practice both because unlocking cells provides a natural point in the day to check prisoners are alive and well, and because it protects staff to check it is safe to unlock a cell before doing so. We recommended that national guidance should be reviewed and made consistent so that staff were clear about their responsibilities.

We continued to find too many examples of staff falsifying records this year, as highlighted in last year's annual report.[4] In our work, this tends to relate to falsified ACCT documentation (suicide and self-harm procedures) or roll checks (the routine security checks required at points during the day or night to account for all prisoners). Disappointingly, we identified staff who recorded checks they did not do or that did not meet the expected standards. Last year, our work led to guidance for governors and directors to use CCTV footage as part of quality assurance processes to evidence that ACCT checks were taking place as recorded. This year, we recommended that the guidance be extended to using CCTV to confirm that staff had conducted good quality roll checks that met expectations. In some cases, we are disappointed that more robust action has not been taken to address the falsification of records. As he set out in the foreword, Adrian is increasingly concerned by the lack of independent oversight of staff conduct issues.

During this reporting year, Adrian has been vocal about the particular risk carried by reception staff, particularly in reception prisons where a disproportionate number of self-inflicted deaths occur. Our work has revealed the skill and confidence staff require to understand the static and dynamic risk factors related to suicide and self-harm in prison, to quickly review all relevant information about a newly-arrived prisoner and use all of their knowledge to assess the risk of suicide and make robust decisions on the use of ACCT procedures. Adrian's talk to prison staff during National Safety Week

4 Prisons and Probation Ombudsman (2025). Annual Report 2024 to 2025. Available online at: **https://ppo.gov.uk/corporate_document/annual-report-2024-to-2025/**

in 2025 focused on this area, drawing on findings from our fatal incident investigations.

We have used other channels to influence change this year and are pleased that HMPPS has taken steps to review and strengthen training for reception staff and to ensure healthcare staff have access to all relevant information when a prisoner arrives to help them make robust assessments of risk. This work culminated in the publication of a Learning Lessons Bulletin on self-inflicted deaths in reception prisons setting out our key strategic lessons for HMPPS (see page 37 for further information).

Homicides

This reporting year, we began investigations into eight homicides, a 60% increase on last year. We monitor our ongoing investigations for themes or significant issues of concern that we can share with HMPPS while waiting for the completion of criminal proceedings. This year, we continued work with the National Police Chiefs Council to update our Memorandum of Understanding to ensure effective communication and information sharing between the PPO and police investigations.

Commitments to a stronger performance

In line with our Race Action Plan, the fatal incidents team continued work to embed an approach to investigating potential race discrimination in fatal incident investigations. This will strengthen the PPO's commitment to identifying and tackling race discrimination in the cases we investigate.

Despite workloads remaining high, the fatal incidents team's performance continued to improve against our published objectives this year. In 2025 to 2026, we issued 508 initial reports to bereaved families, the service in remit, the coroner and other stakeholders: 83% of these were in time. For natural death initial reports, 89% were issued on time, 78% of other non-natural death reports were on time and 74% of self-inflicted death reports were on time. We know that our learning is most effective when we can share it promptly and it can inform timely inquests.

Fatal incident recommendations

When we make recommendations in a fatal incident investigation, the service in remit must confirm when a recommendation is accepted and produce an action plan outlining what action will be taken and when, and who will be responsible for it.

We count recommendations about fatal incident investigations in cases where the final report was issued in the financial year. Please see the 'About the data' section for more details.

We issued 495 final investigation reports following deaths in custody and made recommendations in 42% of these cases. We made a total of 437 recommendations with an average of 2.1 per case.

At the time of writing, 99% of our recommendations were accepted in this financial year with no rejections. The outcome of the remaining 1% was categorised as 'other'. This refers to cases that were neither accepted nor rejected, for example, one recommendation was retracted due to a local policy change.

Health provision

Our recommendations about health provision highlighted the following issues:

- the need to review or develop local policies or governance processes in line with national guidelines
- absent or inadequate healthcare referrals, assessments or escalation
- poor record keeping, with the rationale behind key decision-making often undocumented
- staffing issues (e.g. insufficient clinical capability or general competencies and role understanding)
- care plans not being developed, reviewed, person-centred, or actioned
- failure to recognise or respond to deterioration of health in prison, in particular staff use of and compliance with NEWS2
- inadequate information sharing and communication inside and between establishments, including inter-agency
- poor medication management in practice

General administration

Recommendations about general administration highlight failures to meet guidelines and policy requirements in relation to prison systems. Our recommendations outlined the following issues:

- the need to review or develop local policies or governance processes in line with national guidelines
- staff misunderstanding their respective roles and responsibilities
- inadequate identification, assessment, or management of prisoners' risk
- lack of healthcare involvement in operational processes
- poor information sharing and access including inter-agency communications

Suicide and self-harm prevention

Recommendations about suicide and self-harm prevention relate to following ACCT procedures and national guidelines. The issues highlighted include:

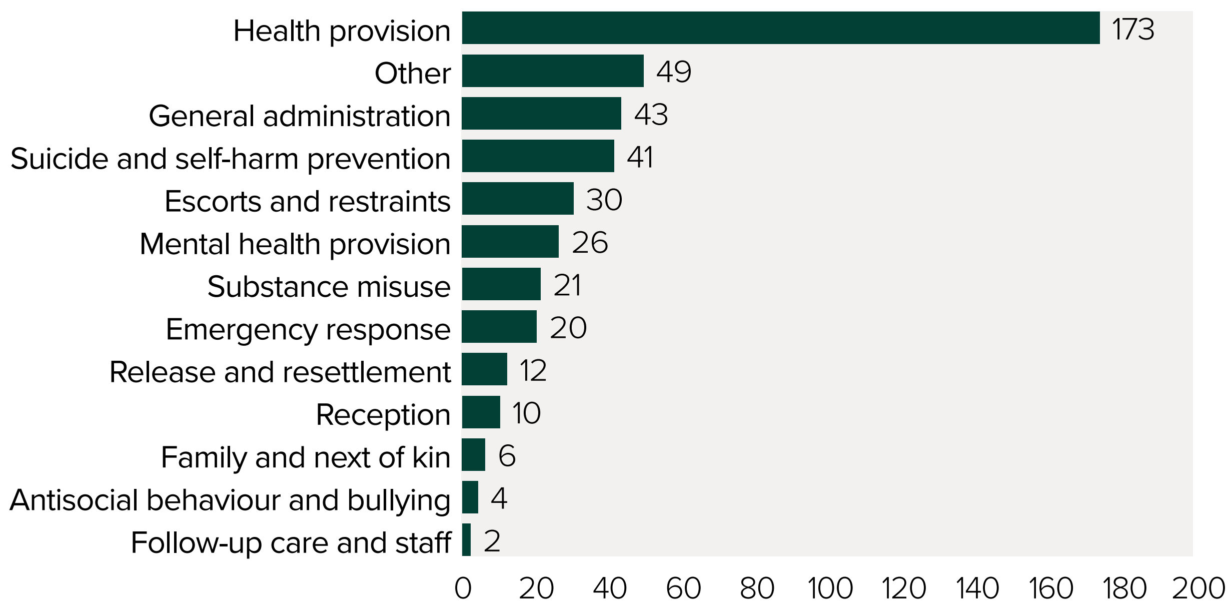
- inadequate identification, management, or response to risk assessments, with staff often relying on presentation rather than known risk factors or not using all available information
- absent or inadequate ACCT quality assurance processes
- poor record keeping, with the rationale behind key decision-making often undocumented
- the need to review or develop local policies or governance processes in line with the national guidelines
- poor management of ACCT processes including care plans not being tailored or the level of observations being insufficient
- staffing issues (e.g. insufficient risk identification capability or role and responsibility understanding)
- absence of healthcare input into ACCT processes including multidisciplinary ACCT reviews

Escorts and restraints

We have seen a rise in recommendations regarding the use of force and the use of restraints during hospital escorts and bed watch since 2024 to 2025. The following issues were highlighted in our recommendations:

- lack of consideration for the prisoner's health, mobility or present risk when assessing the appropriateness of using restraints, with several cases highlighting use on high-risk populations (such as pregnant women and terminally ill prisoners)
- absent or inadequate quality assurance, reviewing or auditing processes
- the need to review or develop local policies or governance guidelines in line with the Graham Judgement
- poor record keeping, documentation or information sharing
- insufficient training or guidance

Recommendations (following death) by category



Operational learning and impact

Kimberley Bingham
Deputy Ombudsman for Learning, Analysis and Business Services

The Learning, Analysis and Business Services (LABS) team leads on the strategic aspects of the PPO's business. This includes research, policy, business planning and business services. We draw on the PPO's investigations to determine the thematic issues that need to be raised with services in remit and other stakeholders.

The team also leads and delivers the special investigations the PPO is asked by ministers to undertake. During 2025 to 2026, this included the investigation into Medomsley Detention Centre and the review of the restraint of pregnant prisoners attending medical appointments at hospital.

Investigation into the failing of Medomsley Detention Centre

In November 2025, Adrian published the report of his investigation into the abuse of young men at Medomsley Detention Centre.[5] Over 2,000 trainees detained at Medomsley were physically and sexually abused between 1961 and 1987. In 2023, the then Lord Chancellor and Secretary of State for Justice, Alex Chalk, asked the Ombudsman to look at what authorities knew about the abuse, and whether and how they intervened.

> “
> The investigation team interviewed 74 witnesses and reviewed nearly 8,000 evidence documents … This work has given the victims a voice.

The investigation team interviewed 74 witnesses and reviewed nearly 8,000 evidence documents. The team disbanded in 2025 and the report was handed to the PPO's LABS team, who along with our communications team, managed its production and publication. This work has given the victims a voice.

In the report, the Ombudsman asked ministers to consider three issues.

1. That there was currently no independent party in establishments that asked children in detention about their custody experience through a safeguarding lens.
2. That the complaints process for children in custody now is broadly the same as it was when Medomsley operated. It is not easy to make a complaint for reasons

5 Prisons and Probation Ombudsman (2025). Investigation into the failing of Medomsley Detention Centre between 1961 and 1987. Available online at: **https://cdn.websitebuilder.service.justice.gov.uk/uploads/sites/14/2025/11/31.122_PPO_Special-investigation-report_WEB.pdf**

from low literacy skills to fearing reprisal for raising issues.

3. That the victims had never received a public apology from any government.

In response, the government gave a public apology and established the Youth Custody Safeguarding Panel to review how children in custody are currently being kept safe and how they can speak up if something is wrong.

The restraint of pregnant women in prison during pregnancy-related hospital escorts

On 30 March 2026, Lord Timpson, the Minister of State for Prisons, Probation and Reducing Reoffending, commissioned the PPO to undertake an independent review of the restraint of pregnant prisoners who attended medical appointments.

This work follows on from publicly voiced concerns at the start of 2025 by the PPO and others about the use of restraints in prisons more generally, as Susannah's fatal incidents section of this report notes. The PPO is looking at the period 1 January 2021 to 31 December 2025 to see how the hospital escorts of pregnant prisoners were handled. We started to review essential documentation from these escorts and will speak to women and staff about their individual experiences of, and views about, the use of restraints. The review aims to uncover any bad practice around the use of restraints, give the women involved a chance to talk about their experiences and offer recommendations to HMPPS. We are due to publish our report in 2026.

Epilepsy

As already highlighted throughout this report, the PPO noticed there appeared to be a high number of fatal incidents in prison caused by epilepsy or where the prisoner had been diagnosed with epilepsy.

The LABS research team was tasked with investigating this further. They looked at our cases over a 10-year period and found some stark findings. For example, 0.64% of deaths in prison in the last 10 years were sudden or unexpected deaths in epilepsy (SUDEP), but SUDEPs make up around 0.15% of deaths per year in the UK. Epilepsy can be a non-life-threatening condition when managed appropriately. In many cases we reviewed, we found there were no clear care plans or care plans were not followed properly, highlighting the need for better practice to support those with epilepsy in prison.

The PPO's researchers, policy lead and the fatal incidents team worked with prison GPs, consultants and NHS England to produce a Learning Lessons Bulletin of our findings which was published in November 2025.[6]

The Chief Medical Officer, Professor Chris Whitty, also included some of our findings in his report on the health of people in prison, on probation and in the secure NHS estate in England.[7]

We have continued to work with NHS England on this issue who are, at the time

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6 Prisons and Probation Ombudsman (2025). Fatal Incident Investigations Learning Lessons Bulletin Issue 20: Epilepsy. Available online at: **https://ppo.gov.uk/learning_research/fatal-incident-investigations-learning-lessons-bulletin-issue-20-epilepsy/**

7 Chief Medical Officer (2025). The health of people in prison, on probation and in the secure NHS estate in England. Available online at: **https://assets.publishing.service.gov.uk/media/690b6f65c22e4ed8b0518515/full-report-chief-medical-officer-health-of-prisoners-accessible.pdf**

of writing, developing a framework for prison settings for health, based on National Institute for Health and Care Excellence guidelines, to highlight what good epilepsy care would look like.

We are also working with HMPPS to ensure that their policies recognise the increased risk of suicide in those who have epilepsy and the risk of prisoners with epilepsy being placed in single cells. We are also working with them to develop resources to raise awareness among prison staff and to ensure they know what steps to take in response to certain situations.

Self-inflicted deaths in reception prisons

In response to our intelligence showing the frequency in which self-inflicted deaths in reception prisons occur, in March 2026 we published a Learning Lessons Bulletin looking at these deaths over the past five years.[8] This follows the risk-factors to the suicide and self-harm bulletin we published in 2014.[9]

We found that reception prisons have one of the highest self-inflicted death rates of all prison functions. These prisons pose an increased risk due to the high levels of churn, reducing the amount of time staff have to accurately assess and combat risk for self-inflicted death.

With 41% of prisoners from the sample dying in the first month of entering a reception prison, there is clearly an increased need for sufficient assessment and support within the early days at reception prisons. Additionally, the population itself is acutely vulnerable, with the majority being unsentenced or remand prisoners and so face uncertainty about their future. Reception staff need to have the right training and work collaboratively to identify high-risk prisoners in the early days.

Segregation

We also published a Learning Lessons Bulletin[10] in March 2026 about the deaths of prisoners who were being segregated. Just under 11 years ago, we published a bulletin on self-inflicted deaths of segregated prisoners and we continued to see several of the same issues in our most recent research.[11]

Our research revealed that prisoners are still being placed in segregation despite being managed under suicide and self-harm procedures (ACCT). This should only be done under exceptional circumstances.

We also saw cases of prisoners dying of natural causes while in segregation, which showed the importance of checking a prisoner's physical health before segregating them. In many of the cases we

8 Prisons and Probation Ombudsman (2026). Fatal Incident Investigations Learning Lessons Bulletin Issue 22: Self-inflicted deaths in reception prisons. Available online at: **https://ppo.gov.uk/learning_research/fatal-incident-investigations-learning-lessons-bulletin-issue-22-self-inflicted-deaths-in-reception-prisons/**

9 Prisons and Probation Ombudsman (2014). Learning Lessons Bulletin: Self-inflicted deaths of prisoners on ACCT. Available online at: **https://ppo.gov.uk/learning_research/learning-lessons-bulletin-self-inflicted-deaths-of-prisoners-on-acct/**

10 Prisons and Probation Ombudsman (2026). Learning Lessons Bulletin Issue 21: Segregation. Available online at: **https://ppo.gov.uk/learning_research/fatal-incident-investigations-learning-lessons-bulletin-issue-21-segregation/**

11 Prisons and Probation Ombudsman (2015). Learning Lessons Bulletin Issue 8: Segregation. Available online at: **https://ppo.gov.uk/learning_research/learning-lessons-bulletin-issue-segregation/**

investigated, the procedures in segregation were not followed properly and we urged governors to make sure their staff were meeting the policy requirements.

Trend spotting and use of data

Our research team has continued the drive to learn from and use our wealth of investigation data. In 2025 to 2026, they developed a new trend-spotting process to identify emerging issues more systematically within our fatal incident investigations. These insights will help us to flag areas of concern in real-time. They will also point to topics that require further analysis.

We also established a 'topic board' to draw together this information, along with ideas from PPO staff, so that we can focus our efforts on the issues that will make the most difference to our service users.

We reviewed our surveys this year which are issued to bereaved families, those involved in fatal incident investigations, complainants and stakeholders. We held sessions with investigators to play back the survey findings and identify key operational changes to make. This helped us to understand where we are making a difference and where we could be even better. Survey respondents can be confident that we are listening to them and acting because of their feedback. For more information on our surveys, visit the stakeholder feedback – emerging findings section from page 41.

The Ombudsman's appearances in front of Parliament

In May 2025, Adrian appeared before the Justice Committee to provide oral evidence on their inquiry into Rehabilitation and Resettlement. He was part of a panel which gave evidence on the regime within prisons, time-out-of-cell, staffing, population constraints and issues with prison buildings. He also spoke about the issue of prisoner phone contracts and the difficulties the cost of calls is causing for prisoners.

In December 2025, Adrian appeared before the Welsh Affairs Committee to provide oral evidence on their inquiry into Prisons, Probation and Rehabilitation in Wales. In this session, he gave evidence on the deaths and complaints in Welsh prisons and HMP Parc's response to the cluster of deaths in 2024.

Consultation responses

This year, our policy team reviewed 20 policies and frameworks from both HMPPS and the Home Office.

When advising on policies, we highlight parts that may need strengthening or further explanation. Using the learning shared in our segregation Learning Lessons Bulletin, our team provided further advice on the Segregation Policy Framework and, at the time of writing, HMPPS' policy team continues to consult on it.

We provided advice on the Home Office Detention Service Order (DSO) on Assessment Care in Detention Teamwork, using the expertise our fatal incident investigators have developed from dealing with the ACCT process used in prisons. We also provided advice on their DSO on use of force using learning from a complaint we investigated about force used in an immigration removal centre.

Race Action Plan

The LABS team leads the production of the PPO's published Race Action Plan. The plan includes three objectives:

- to support our staff from ethnic minority backgrounds
- to improve investigator knowledge and address race in our casework
- to strengthen and analyse our race data

A highlight in 2025 to 2026 was the day-long workshop with the Independent Office for Police Conduct to embed an internal approach to support our investigators who see potential issues of race inequality in their fatal incident investigations.

We also worked with our IPCI complaints team to record issues of race that appeared in prisoner complaints and this is being monitored quarterly to see if any patterns are developing. The research team also analysed our complaints and fatal incident investigations data to understand whether we receive a proportionate number of complaints from ethnic minority prisoners and to check whether prisoner deaths by ethnicity are proportionate to the population. For deaths in custody, we looked at cases from 1 January 2016 to 31 December 2025, alongside centralised ethnicity data. We found that deaths across the estate were consistently disproportionate to the relative prison population.

Fatal incident investigation data showed us that across death types, white prisoners were consistently overrepresented relative to the population, and ethnic minority prisoners (black, Asian, mixed and other) were underrepresented across death types (natural causes, other non-natural, self-inflicted).

In complaints, we receive a disproportionately high number of complaints from black and Asian prisoners relative to their population, and a disproportionately low number from white prisoners. Complaints are upheld at a similar rate across ethnicities with the exception of those from Asian prisoners which are upheld at a lower rate.

FOIs and SARs

The LABS team also supports the PPO in responding to all freedom of information (FOI) and subject access requests (SARs). In 2025 to 2026, we responded in time to 106 FOIs, a significant increase on the previous financial year. We responded in time to 115 SARs, which was a similar number to the previous financial year. This ensures we meet our data protection obligations and, where appropriate, provide information and personal data to those who make a request. In the past year, we have provided information on topics such as the deaths of prisoners on imprisonment for public protection sentences and our investigations into food, accommodation and equality complaints.

Appendices

Stakeholder feedback – emerging findings

We collect feedback from our stakeholders to understand how they engage with our work, gauge their level of satisfaction and seek suggestions on how we can improve. To obtain feedback, we issue five rolling stakeholder surveys:

- the general stakeholder survey (for those we engage with)
- the coroners' survey (for coroners involved in deaths in custody and post-release death investigations)
- the complainants' survey (for those who complain to us)
- the fatal incidents post-investigation survey (for those involved in deaths in custody and post-release death investigations)
- the bereaved families' survey (for the family members and next of kin of deceased prisoners)

Previously, the latter three feedback surveys were distributed monthly. This year, we decided to change distribution to twice a year to streamline data collection while maintaining regular opportunities for feedback. The time saved through this revised approach has been used to introduce and deliver impact sessions across both our complaints and fatal incident investigation functions. The aim of these sessions is to share key findings from our surveys, focus on priority issues highlighted by respondents, and bring investigators together to generate practical ideas for improvement, which we intend to implement over the next financial year.

Information about our past survey methods and reporting approaches can be found in previous annual report publications. Please see the 'About the data' section for further details about the new process.

General stakeholder survey

We ask a broad range of stakeholders for feedback on our performance over the previous year. This includes feedback on our investigations into both fatal incidents and complaints.

We received 87 responses this year which is the same number of responses received as the previous year. The survey ran through March 2026, and responses came from prisons (including operational staff, non-operational staff, and business or administrative staff), probation, healthcare services, MOJ, HMPPS, the Independent Monitoring Board and others (such as ex-prisoners, academics and third sector).

Overall satisfaction

- When asked about the overall quality of the services and work provided by the PPO during the last year, 94% rated it as satisfactory or better.
- Of those who experienced the PPO's research and policy work in the past year, 93% rated the quality of our services and work as satisfactory or better.

Reports

- Of those who had been involved in PPO investigations in the past 12 months (complaints, fatal incidents or both), 88%

found the investigation reports to be very clear or quite clear.

- Of those who had read or were aware of our anonymised fatal incident reports, 76% found them either very useful or quite useful.
- Of those who had read or were aware of our Epilepsy Learning Lessons Bulletin, 78% found it either very useful or quite useful.
- Of those who had read or were aware of the investigation into the failing of Medomsley Detention Centre between 1961 and 1987, 67% found it either very useful or quite useful.

Our website

- 77% of respondents said they had visited the PPO website in the last 12 months.
- 85% of the respondents who had visited the PPO website in the last 12 months said they found it very easy or quite easy to find what they were looking for.

Impressions of the PPO

Respondents were asked whether their experience reflected the PPO's values:

- 66% agreed we were ambitious thinkers
- 75% agreed we were professionally curious
- 69% agreed we were diverse and inclusive
- 78% agreed we were transparent
- 68% agreed we were teamwork-oriented

Coroners' survey

We sent surveys out to a sample of 71 coroners involved in fatal incident investigations that had a final report issued during this financial year. The response rate from this survey cycle was 20%.

Overall satisfaction

- 64% of respondents rated the communication they received from the PPO as satisfactory or better.
- 43% of respondents rated the timeliness of the PPO's fatal incident investigations as satisfactory or better.
- 86% of respondents rated the quality of the PPO's fatal incident investigations as satisfactory or better.

Post-fatal incident investigation reports

Regarding report quality and usability, respondents reported the following:

- 86% said they met their expectations
- 100% said they were easy to read and understand
- 93% said they had the right amount of detail

Regarding the usefulness of specific report sections:

- 100% found the main report either useful or quite useful
- 79% found the clinical review either useful or quite useful
- 86% found the interview transcripts either useful or quite useful

Impressions of the PPO

Respondents were asked whether their experience reflected the PPO's values:

- 36% agreed we were ambitious thinkers
- 86% agreed we were professionally curious
- 43% agreed we were diverse and inclusive

- 86% agreed we were transparent
- 43% agreed we were teamwork-oriented

Complainants' survey

We sent surveys to a sample of 179 complainants whose case was closed during the first half of this financial year. The response rate for this survey cycle was 29%.

Respondent breakdown

- 47% of respondents had eligible complaints. Of these, 71% had their complaints upheld or partially upheld, and 29% had their complaints not upheld.
- 22% of the responses came from those whose complaints were ineligible. These complaints were not investigated, and the complainants received letters explaining why.
- 31% of the responses came from those whose complaints were classified as an early case or were pushed back. These complaints were not ready to be investigated, and the complainants received letters explaining why.

Overall satisfaction

- 77% of respondents whose complaints were upheld rated the quality of IPCI's investigation as either good or satisfactory. Of those whose complaints were not upheld, 14% of respondents rated the quality of IPCI's investigation as satisfactory.
- 18% of respondents whose complaints were ineligible rated the quality of IPCI's service as good or satisfactory.
- Of those whose complaints were either classed as an early case or were pushed back, 44% rated the quality of IPCI's service as good or satisfactory.

Impressions of the PPO

Respondents were asked whether their experience reflected the PPO's values:

- 43% agreed we were professionally curious
- 37% agreed we were diverse and inclusive
- 45% agreed we were transparent

Improving prisoners' access to free photocopies and complaint paperwork

Survey responses showed that many prisoners struggle to access complaints paperwork and free photocopies, creating practical barriers that delay or prevent them from progressing their complaints. These difficulties were experienced by respondents regardless of their complaint outcome across the prison estate. Several respondents reported being charged for photocopies or facing increased inaccessibility depending on their location, for example while in segregation. One respondent noted that, due to this inaccessibility, they missed IPCI deadlines.

Key findings

- 35% of respondents found it difficult to access complaint forms.
- 61% of respondents were unable to get a free photocopy of their complaint paperwork.

Key actions committed to from our impact session:

- Raise awareness of the issue through the IPCI Ambassadors newsletter.
- Facilitate communication with IPCI Ambassadors via single points of contact to gain further understanding about the issue on a local level.

Increasing our use of Email a Prisoner

While only a small proportion of respondents reported having been contacted through Email a Prisoner, satisfaction among users was 100%, and additional respondents said they would prefer this communication method.

Key findings

- 8% of respondents reported being contacted by IPCI via Email a Prisoner.
  - Of those who reported having been contacted via Email a Prisoner, 100% were happy with us using the service.

Key actions we have committed to from our impact session

- Create clear guidelines on when it is appropriate to use Email a Prisoner, for example, to ask brief questions or to send quick updates about case progression.

Improving complainants' perceptions of timeliness

Although investigations are being completed within expected timelines, many prisoners still feel the process takes too long, suggesting that unclear communication about what timeframes to expect may be shaping their perception of delay. Responses were noticeably split according to complaint outcome, with satisfaction increasing if the complaint was upheld.

Key findings

- 39% of respondents were dissatisfied with the timeliness of IPCI's response/investigation.
- Of those who reported dissatisfaction:
  - 10% had their complaint upheld
  - 15% had their complaint not upheld
  - 35% had ineligible complaints
  - 30% had early case complaints
  - 10% had their complaint pushed back

Key actions committed to from our impact session

- Increase communication to complainants when dealing with a delayed or complex case to provide updates on expected timelines.

Helping complainants understand the outcome of their complaint and its impact

Many respondents indicated that they struggle to understand the outcome of their case and what impact the investigation has had. This issue has two linked elements: improving how we communicate the impact of investigations by ensuring outcome letters are clear and accessible, and setting realistic expectations by explaining the limits of our remit.

Key findings

- 24% of respondents with upheld complaints said IPCI did not help them with their complaint.
- 29% of respondents with upheld complaints said the investigation did not result in a change.

Key actions committed to from our impact session

- Add a flowchart to the back of our assessment letters to help explain the investigation process, potential outcomes, and expected timelines, using diagrams to aid the understanding of those with neurodiversity and people whose first language is not English.

- In future surveys, ask respondents if they'd be happy to participate in future research to better understand their experience.

Fatal incidents post-investigation survey

We sent surveys to a sample of 138 stakeholders who were involved in a fatal incidents investigation which had a final report issued during the first half of this financial year. The response rate for this survey cycle was 40%.

Overall satisfaction

- 85% of respondents rated the quality of the investigation as satisfactory or better.
- 91% of respondents rated the communication they had with the PPO as satisfactory or better.
- 82% of respondents rated the time it took the PPO to complete their investigation as satisfactory or better.
- Of those who had seen the PPO report:
    - 98% of respondents stated the report we issued met their expectations
    - 82% of respondents stated the PPO report contained about the right amount of detail

Impressions of the PPO

Respondents were asked whether their experience reflected the PPO's values:

- 76% agreed we were ambitious thinkers
- 89% agreed we were professionally curious
- 87% agreed we were transparent

Improving stakeholder awareness of recommendations and perceptions of investigation impact

Although respondents could select 'don't know' when unsure about the presence of recommendations, many still gave incorrect answers, suggesting confusion about whether recommendations had been made and what, if anything, changed afterwards. This uncertainty limits stakeholders' understanding of the investigation's impact and may leave them feeling that the process has had little effect.

Key findings

- 50% of respondents had misunderstood whether recommendations had or had not been made – some respondents incorrectly believed that recommendations had not been made when they had, and some respondents believed that recommendations had been made when they had not.
- Only 29% of respondents said the investigation had prompted change.

Key actions committed to from our impact session

- Set up a working group with fatal-incident investigators to discuss the survey content and explore whether it would be beneficial to:
    - ask respondents for more general rather than case-specific feedback to reduce recall bias
    - ask respondents about their desire to make change instead of actual change due to the small amount of time elapsed between the final report being issued and survey distribution

Bereaved families' survey

We sent surveys to a sample of 56 family members who had been in contact with the PPO during a fatal incident investigation in which a final report had been issued during the first half of this financial year. The response rate for this survey cycle was 13%.[12]

Overall satisfaction

- 86% of respondents rated the quality of the PPO's investigation as satisfactory or better.
- 71% of respondents were satisfied or very satisfied with the PPO's communication.

Impressions of the PPO

- Respondents were asked whether their experience reflected the PPO's values:
    - 29% agreed we were ambitious thinkers
    - 57% agreed we were professionally curious
    - 71% agreed we were transparent

Increasing the bereaved families' survey response rate

With our current case management system, it is difficult to identify which family members are comfortable being contacted by the PPO. Because this survey cycle involved sending the survey to all listed contacts, we cannot improve response rates by increasing the sample size. Instead, the issue points to possible gaps in how we record contact information or how we distribute the survey, both of which affect who we can reach and the subsequent insights we can gather.

Key findings

- Survey invitations were sent to all family members listed as previously being in contact with the PPO, and the survey response rate was 13%

Key actions committed to from our impact session

- Collaborate with the PPO's Family Contact Officer to gain a better understanding about how the PPO communicates with and records the contact information of family members and next of kin.
- Explore the possibility of distributing survey invitations alongside the final report to streamline communication.

12 Given the low response rate, these findings cannot be generalised to the experiences of all family members and next of kin in contact with the PPO during a fatal incident investigation.

Improving our interaction with family members and next of kin involved in deaths that occurred outside of prison

Survey results showed that family members' experiences differed noticeably, depending on whether the fatal incident occurred inside or outside of prison. Dissatisfaction with communication, unmet expectations, and poorer perceptions of quality were concentrated among families involved in deaths outside custody. These patterns suggest that families in these cases may require clearer, more tailored communication and support, prompting us to consider how their experience can be improved. When this finding was raised at the impact session, PPO staff explained a new process had recently been implemented to improve our timeliness of obtaining next of kin information and making first contact.

Key findings

- 100% of respondents who were dissatisfied with the PPO's communication, or who said the report did not meet their expectations, or who rated the quality of the information provided by the PPO as poor, related to deaths that occurred outside of prison.

Key actions committed to from our impact session

- Track progress of recent efforts to improve communication with these family members and next of kin by communicating with the PPO's Family Contact Officer and assessing any change in survey responses.

About the data

Corporate publications can be found on our website: **https://ppo.gov.uk/corporate-publications/**

Statistical data tables are published alongside the report. These tables are available for those without internet access by request.

Some totals may not add up to 100% due to rounding.

Some figures have been updated and corrected, and therefore do not match what was published in the previous annual report.

Complaints

Complaint categorisation is based on the substantive element of the complaint. Categorisation is carried out by the assessment team and may be edited by the investigator through the course of the investigation. This can lead to similar complaints being categorised differently.

A complaint is eligible if it is from a person who has been through the relevant internal complaints process (the two-stage prison process, or the immigration, or probation process) and the complainant brings it to us within three months of receiving the final stage reply from the service in remit. The complaint also must be about something which is within our remit.

A complaint can be pushed back to the prison if we assess there has been an insufficient attempt by them to resolve the matter. The outcome of these cases can either be pushback resolved or pushback returned. If a case outcome is pushback resolved, it means that our enquiries made to the service in remit have prompted appropriate action to be taken by them and therefore the complaint issue has been resolved. If a case outcome is pushback returned, it means that our enquiries made to the service in remit revealed that there is no evidence that the complainant has exhausted the full complaints procedure. The complaint is then returned to the complainant for them to complete the correct complaints procedure before we can consider the complaint for investigation.

A complaint is upheld if, after investigation, we find in favour of the complainant, i.e. we find the service in remit has acted contrary to their local and/or national policy, or otherwise inappropriately or unreasonably. Upheld cases are made up of cases which are upheld and partially upheld. A complaint is not upheld if we find that the service in remit has acted in keeping with policy, if there is no specific relevant policy, or if they have not acted unreasonably or inappropriately.

Complaints data contained in this report is frozen. Data for 2024 to 2025 was frozen in April 2025. Data for 2025 to 2026 was frozen in April 2026. Data for each section was frozen on different days, so represents different cohorts of cases.

A small number of cases received and completed will be counted in multiple years. This only happens when a previously closed case is subsequently reopened after we have received new information over different financial years.

Each case that is ineligible for investigation will be categorised with a reason for its ineligibility. This can happen several times if the complainant continues to send correspondence that would still render their case ineligible, but the reasoning for the ineligibility can change.

The number of assessments completed refers to the number of times that the PPO has examined the eligibility of a case. As above, this could happen several times for a single case if there is repeated correspondence. This measure has replaced the number of eligibility letters sent used in previous annual reports because it better captures the work done by the assessment team.

A completed case in 2024 to 2025 and 2025 to 2026 is defined as one where the draft outcome has been approved. This excludes withdrawn and Paragraph 20 cases.

For standard complaints, initial reports are counted as having been completed 'in time' when submitted within 12 weeks (60 working days) of accepting the complaint as eligible. For complex complaints, initial reports are counted as having been completed 'in time' when the investigation is completed, and the report is submitted within 26 weeks (130 working days) of accepting the complaint as eligible.

Timeliness calculations exclude the times when a case is suspended for reasons that are outside the PPO's control. Timeliness is calculated based on working days and excludes bank holidays.

Prison population data is taken from the March 2026 population bulletin.

Fatal incident investigations

Data is based on when the PPO was notified of the death.

The PPO does not determine the cause of death. This is determined by a coroner following an inquest. Cases are separated into administrative categories, but these categories may differ from a coroner's conclusions. Classifications may change during an investigation. However, they are not altered following the conclusion of the inquest. A small number of classifications for previous years have been updated for this publication, so may not match what has previously been published.

Self-inflicted deaths: The death of a person who has apparently taken their own life and the circumstances suggest this was deliberate, irrespective of whether this would meet the legal definition of intent (i.e. suicide).

Homicide: Where one person has killed another, irrespective of their level of intent.

Natural causes: Any death of a person as a result of a naturally occurring disease process that is organic and not triggered by something non-natural.

Other non-natural: These deaths have not happened organically; they are non-natural but cannot be readily classified as self-inflicted or homicide. They include accidents and drug-related deaths where there is not enough evidence to classify them as a self-inflicted death.

Unascertained classification: These are deaths where the inquest could not determine the cause of death.

Awaiting classification: These are deaths where there is currently no indication of the cause of death.

Fatal incident data was frozen in May 2026.

The PPO and HMPPS have different defining criteria for classifying cases. For this reason, the totals in each category may differ from what is published by HMPPS.

Initial reports are counted as having been completed 'in time' when the report is issued within 20 weeks of the date of notification for natural-cause deaths which were originally classed as natural causes, and 26 weeks for all others (including those that are unclassified at the time of notification). However, we must sometimes suspend our investigations while we wait for key information, such as the cause of death, toxicology tests or a clinical review.

Timeliness calculations exclude the times when a case is suspended for reasons that are outside the PPO's control.

Final reports are counted as having been completed 'in time' when the report is issued 12 weeks following the initial report.

Timeliness is calculated based on working days and excludes bank holidays.

Post-release deaths: On 6 September 2021, the PPO started to investigate the deaths of individuals who die within 14 days of release from custody from natural, self-inflicted, or other non-natural causes. Deaths where the cause of death was homicide are not investigated. The PPO may exercise its discretion to investigate deaths of individuals who die beyond the 14-day threshold – such investigations will still be categorised as post-release cases. However, we refer to our investigations of deaths, where an individual is released directly to hospital or where an individual was released into the community but died before 6 September 2021, as a discretionary case rather than a post-release case.

Stakeholder surveys

Throughout the surveys, some respondents did not answer all the questions, and depending on certain question responses, some respondents were not asked all questions.

Due to the time required to develop and implement the revised survey processes for the final three surveys, the survey results presented in this annual report, and discussed in the complaints and fatal incident investigation (FII) impact sessions in March 2026, reflect one survey cycle covering a six-month period. In a typical reporting year, we aim to hold an impact session following each survey cycle, which is twice a year.

The survey processes remain under review, and further refinements are expected to be introduced over the next survey cycle. From next year, the annual report will combine results from two survey cycles, providing insight into stakeholder, family member and next of kin, and complainant feedback across a 12-month period.

General stakeholder survey

The general stakeholder survey is an online survey that is promoted on our social media channels and our website, and sent to those on our stakeholder mailing lists. This means that we can only reflect the number of responses received. It was distributed at the beginning of March 2026, with a reminder email sent two weeks later. The survey was then closed at the end of March 2026.

Coroners' survey

The coroners' survey is an online survey sent to coroners involved in fatal incident investigations that had a final report issued between 1 April 2025 and 25 February

2026. Coroners are asked to reflect on their general experience with the PPO, rather than providing case-specific feedback. It was distributed at the beginning of March 2026, with a reminder email sent two weeks later. The survey was then closed at the end of March 2026.

In previous years, responses to this survey were merged with the fatal incidents post-investigation survey responses. However, due to the change in survey process for the latter survey, we kept them separate this year. See below for more information on the new survey process.

Complainants' survey

The complainant survey is distributed twice a year to a sample of complainants whose complaints have been closed. Complainants are grouped into five categories: men in prison, men on probation, women, people in IRCs, and young people. Where a group has a relatively small number of complainants, the survey is sent to everyone in that group. For larger groups, we take a sample. In these cases, sampling is designed to ensure we gather feedback from complainants regardless of their complaint outcome.

The survey results presented in this annual report and discussed in the complaints impact session in March 2026 cover cases closed between 1 April 2025 and 30 September 2025.

Additionally, due to our focus on changing the survey process this year, we did not change the content of the survey. As a result, probation complainants were excluded from this cycle due to the IPCI branding and content of the existing survey. We intend to address survey content ahead of the next survey cycle.

Ineligibility reasons are updated and overwritten every time a new eligibility assessment has been completed when new information is provided. Therefore, the outcome of the cases included in the sample may have changed after sampling.

Fatal incidents post-investigation survey

The fatal incidents post-investigation survey is distributed twice a year to those involved in fatal incidents for which a final report was issued in the previous six months. The stakeholders sampled include PPO liaison officers (the prison officer who has been the main point of contact for the PPO investigator), establishment heads and healthcare leads.

To ensure feedback reflects incidents that occur both inside and outside of prison, cases are grouped by incident location. Where the number of investigations within a group is relatively small, the survey invitation is sent to the stakeholders from every investigation. For locations with a larger number of investigations, a sample is used, with survey invitations sent to stakeholders involved in randomly selected investigations, to ensure a balanced and manageable representation of views.

The survey results presented in this annual report and discussed in the FII impact session in March 2026 cover final reports issued between 1 April 2025 and 30 September 2025.

Bereaved families' survey

The bereaved families' survey is distributed twice a year to family members or next of kin who have been sent a final report in the previous six months.

The survey results presented in this annual report and discussed in the FII impact session in March 2026 cover final reports issued to family members or next of kin between 1 April 2025 and 30 September 2025.

Recommendations

Complaint recommendations

Recommendations about complaints are those where we have issued the final report within the financial year.

Recommendations can be amended or removed at any point until the case is closed. This means that, until the case is closed, the data is changeable.

The data provided was frozen in May 2026.

Recommendations are categorised by investigators, which can lead to similar recommendations being categorised differently.

Accepted recommendations include partially accepted recommendations.

Fatal incident recommendations

Recommendation data provided covers recommendations which were made in cases where the final report was issued in the financial year.

The data provided was frozen in May 2026.

Recommendations are categorised by investigators, which can lead to similar recommendations being categorised differently.

Performance against the 2025 to 2026 Business Plan

Objective 1: Be visible, accessible and transparent to service users and stakeholders

Key deliverable

Continue to promote IPCI to those in prison and the youth estate.

Measure of success

IPCI awareness video for prisoners and a good practice in handling complaints video for prison staff produced, launched, and disseminated.

Youth-specific accessible IPCI promotional material developed and disseminated across the youth estate.

End of year update

An IPCI awareness video for prisoners on how to complain both internally to the prison and then to the PPO was created and made available on Content Hub/Launchpad and on National Prison Radio's section on Content Hub, WayOut TV and on the PPO website.

A video to help staff understand prisoners' complaints was launched to prison staff and governors, and was made available on the PPO website, on the PPO e-learning course on MyLearning and on the PPO YouTube channel.

The youth-specific IPCI materials have not yet been developed.

Key deliverables

Continue establishing IPCI Ambassadors across the prison estate (a scheme where volunteer prisoners support others in effectively using local complaints processes and escalating to IPCI when required).

Create an IPCI Ambassador community which will enable continued support to be provided to Ambassadors. This will support their training needs and strengthen the relationship between IPCI Ambassadors and the PPO.

Measure of success

There will be a further roll-out of the scheme in 2025 to 2026.

An IPCI Ambassador community established.

Two IPCI Ambassador newsletters produced and distributed.

Increased number of eligible complaints received from individuals in IPCI Ambassador prisons.

End of year update

The third roll-out of the IPCI Ambassador scheme took place in November 2025. Following this roll-out, a further three prisons joined the scheme. The Ambassador scheme is now supported by 62 prisons at the time of writing.

Ambassador and SPOC newsletters were produced and distributed in May 2025, August 2025 and January 2026. In January 2026, IPCI also introduced Ambassador certificates, enabling Governors/Directors to recognise and acknowledge the contribution Ambassadors are making to improving prisoners' understanding of the complaints process and supporting access to complaint routes.

For prisons with Ambassadors, the proportion of received complaints that were eligible increased from 34% in 2024 to 2025, to 38% in 2025 to 2026.

Key deliverable

Continue to reduce the proportion of ineligible complaints received by IPCI by rolling out a targeted programme of work to the 10 prisons with the highest numbers of ineligible complaints in the prison estate.

Measure of success

10 prisons identified using data on highest numbers of ineligible complaints.

Completion of programme of training and awareness raising with staff and prisoners in the 10 prisons.

A reduction in levels of ineligible complaints received from the 10 prisons in scope of the targeted work.

End of year update

17 prisons were identified for a targeted offer of support, with 13 prisons visited during the financial year. During these visits, IPCI delivered a day of training and awareness for staff and prisoners, focusing on the internal HMPPS complaints process and the escalation of complaints to IPCI. Each prison was supported to develop bespoke actions aimed at reducing the number of ineligible complaints.

For the 17 prisons identified, the proportion of received complaints that were eligible increased from 15% in 2024 to 2025, to 29% in 2025 to 2026.

Key deliverable

Consider the findings from our visits to IRCs and work with the authorities in remit so they better understand what we do.

Measure of success

Increased eligibility of complaints from detained individuals.

Improvements made to remove any identified barriers to complaining to the PPO.

Implement learning identified for the IRCs and PPO to improve detained individuals' access to the complaints process.

End of year update

An initial report has been drafted which summarises findings and suggestions for the next steps or recommendations. This will be considered by the new Deputy Ombudsman for complaints in the 2026 to 2027 financial year. The report will be shared with the Home Office.

Key deliverable

Consider the findings from our work with probation services and those under probation supervision so they better understand what we do.

Measure of success

Increased eligibility of complaints from those under probation supervision.

Improvements made to remove any identified barriers to complaining to the PPO.

Implemented any learning identified for probation and PPO to improve people on probation's access to the complaints process.

End of year update

In response to a PPO recommendation, probation services are currently reviewing their complaints policy to reduce the barriers to complaining. They are reviewing the complaints process including the number of stages required before the complainant can complain to the PPO.

Key deliverable

Using the findings from our engagement activities, implement a proactive and targeted communications strategy to increase awareness of the PPO to those under probation supervision and detained individuals.

Measure of success

Developed and implemented a communications strategy aimed at those under probation and those in immigration removal centres.

End of year update

These strategies were dependent upon the IRC and probation service initiatives being completed in 2025 to 2026. They will be carried forward into the next financial year.

Key deliverable

Enter the next phase of work in raising awareness of IPCI with young people and women in prison.

Measure of success

Learning and recommendations to be implemented.

All women and young people's prisons visited again in the 2025 to 2026 financial year.

Increased number of eligible complaints from those in the youth and women's estate.

End of year update

Four of the youth establishments were visited during the financial year. IPCI has quarterly meetings with Barnardo's advocate manager and the Youth Custody Service Deputy Director. In 2025 to 2026, IPCI investigated 33 complaints from the youth estate compared to 31 in 2024 to 2025.

Nine of the 12 women's prisons were visited this financial year. In 2025 to 2026, IPCI investigated 65 complaints from women in prison compared to 44 in 2024 to 2025.

Key deliverable

Publish a race action plan with a continued focus on service users.

Measure of success

Staff consider the impact of race in all investigations. Detail on the progress of workstreams will be provided in our annual report.

End of year update

The PPO published a Race Action Plan which focused on addressing racism within casework and improving investigator knowledge.

Detail on progress of the Race Action Plan is available separately within this annual report.

Key deliverable

Embed a robust and consistent approach to investigating issues relating to diversity and inclusion.

Measure of success

Investigators feel confident using an investigation methodology to identify discriminatory behaviour.

End of year update

The PPO has a framework for fatal incident investigators to investigate racism and is developing a framework for complaints investigators.

Key deliverables

Respond to all Freedom of Information requests within 20 working days.

Respond to all Subject Access Requests within one calendar month.

Measure of success

Success will be measured against a target of 100% of FOI and Subject Access Requests being completed on time.

End of year update

During 2025 to 2026, the PPO received 106 FOI requests and responded to all of them within the prescribed timescales. The PPO also received 115 Subject Access Requests and responded to all of them within the prescribed timescales.

Objective 2: We will deliver investigative excellence in a timely manner

Key deliverable

Meet the following timeliness targets for all **fatal incident investigations:**

Initial reports: Natural cause deaths – complete our investigation and issue our initial report within 20 weeks (100 working days) of the PPO being notified of the death.

All other fatal incident cases – complete our investigation and issue our initial report within 26 weeks (130 working days) of the PPO being notified of the death.

Final reports: Finalise all fatal incident investigation reports within 12 weeks (60 working days) of the initial report.

Publication: Produce and publish anonymised reports for fatal incident investigations within 10 working days of being notified that the inquest has concluded and the investigation report has been finalised.

Measure of success

Business targets will have been met if at least 90% of fatal incident reports are delivered to time and there is no longer a backlog of fatal incident investigations awaiting initial report.

Business target will have been met if at least 90% of anonymised fatal incident reports are published on the website on time.

End of year update

The PPO issued 508 initial reports, of which 83% were on time.

The PPO also issued 496 final reports, of which 72% were on time.

Between 1 April 2025 and 31 March 2026, there were 232 cases where the PPO had received the inquest results. Of these cases, 201 had the anonymised report published on the website by 31 March 2026. In approximately 58% of these cases, the anonymised investigation report was then published on the website within 10 working days of being notified that the inquest had concluded.

Key deliverable

Meet the following timeliness targets for all **complaints investigations:**

Eligibility: We will determine the eligibility of all complaints within 10 working days of receipt.

Standard complaints: Complete our investigation and submit our initial report for consultation for standard complaints within 12 weeks (60 working days) of accepting the complaint as eligible.

Complex complaints: Complete our investigation and submit our initial report for consultation for complex complaints within 26 weeks (130 working days) of accepting the complaint as eligible.

Publication: Produce and publish summaries of anonymised upheld or partially upheld complaints on a monthly basis.

Measure of success

Business targets will have been met if at least 90% of complaints assessments are completed on time.

Business targets will have been met if at least 90% of standard and complex complaints investigations are completed on time.

End of year update

The PPO completed 5,802 complaints assessments to determine eligibility, 92% were on time.

The PPO completed 2,150 complaints investigations of which 87% were completed on time. This timeliness metric does not include 95 pushback cases completed.

We have published 154 summaries of complaints in 2025 to 2026 on our website.

Key deliverable

Regular updating and reviewing of operational manuals for fatal incident and complaint investigations.

Measure of success

Operational manuals provide accessible and up-to-date guidance to support our staff in carrying out their work.

End of year update

A complaints team working group meets regularly to update the manual. The FII manual has been updated as necessary since publication.

Key deliverable

Embed the investigative approach to post-release death investigations.

Measure of success

Continuous improvement in investigation methodology for post-release death investigations.

Greater joint working with relevant stakeholders to maximise the impact of post-release death investigations.

Improved levels of wider stakeholder engagement beyond HMPPS.

End of year update

This work is now considered ‘business as usual’. The learning and training from our post-release death investigations is developed in line with the continuous improvement approach for all fatal incident types.

Key deliverable

Continue sharing learning internally with staff through newsletters and dashboards. Identify and share learning from prevention of future death reports and from PPO surveys. Operational teams to utilise learning.

Measure of success

Develop an intel dashboard for fatal incident investigations.

Prevention of future death reports are regularly reviewed, and any learning is shared directly and swiftly with investigators. Learning is shared from PPO surveys. Improved outcomes and feedback from surveys.

End of year update

An intel dashboard for fatal incident investigations was successfully developed. This has been added onto the existing governance and performance management dashboards. It provides further insight into the death rate from different prisons.

The survey process was changed this financial year, from sending surveys every month to every six months. This has allowed the research team to analyse the survey data effectively and ensure integration of findings into operational practices through impact sessions with operational staff. Impact sessions will be delivered twice a year after each survey cycle to both FII and complaints staff. The sessions are to explore good practice and areas for improvement. The first session took place in March 2026 (please see the stakeholder findings section of the annual report for more information).

We reviewed Reports to Prevent Future Deaths on a quarterly basis and shared learning directly with investigators.

Objective 3: Increase the impact of our work on the actions of services in remit and the day-to-day lives of those in custody

Key deliverable

Produce thematic learning publications and hold stakeholder engagement sessions to share learning from investigations and increase the PPO's impact.

Measure of success

The publication of six themed learning publications.

Recommendations from our learning lessons bulletins are accepted by the relevant services in remit.

Each learning product has a stakeholder engagement plan that is implemented in a timely manner to encourage a collaborative and problem-solving approach to the learning identified.

End of year update

The PPO held a property roundtable with governors and heads of business hubs in July 2025 to share learning from our thematic work.

The PPO published a Learning Lessons Bulletin on epilepsy in November 2025 and continues to work with HMPPS and NHS England to improve the care prisoners with epilepsy receive.

The PPO published Learning Lessons Bulletins on segregation and self-inflicted deaths in reception prisons in March 2026.

Key deliverable

Implement proactive and targeted communications plans to ensure publications are widely disseminated and have impact.

Measure of success

Each learning product has a unique, targeted and proactive communications plan and the success of each communications plan is measured.

End of year update

The PPO created a proactive, strategic and targeted communications plan for each learning product, publication and project. The engagement is assessed regularly to ensure best practice and find ways to be more creative and have impact.

Key deliverable

Continue to develop and establish effective partnerships with stakeholders to share expertise, learning and increase impact.

Measure of success

This may include:

- joint communications
- introduction of joint forums
- working with stakeholders to effect policy changes
- working with stakeholders to make improvements to working practices

End of year update

The PPO worked closely with colleagues from NHS England on the epilepsy bulletin and after publication to help create a framework on epilepsy in prisons to improve the care prisoners receive. Epilepsy Action was also consulted to ensure their input has been reflected.

The PPO liaised with the HMPPS segregation policy team as they consulted on a revised draft of the policy. Where requested, the PPO has provided HMPPS with its learning for example on restraints and escorts.

Key deliverable

Continue to use learning from our investigations to influence national policies within the services in remit. Respond to relevant parliamentary select committee and government inquiries.

Measure of success

PPO responds to relevant national policy consultations with influential evidence.

PPO provides valuable information to inquiries and calls for evidence.

End of year update

The PPO provided learning and evidence from our investigations in response to Home Office and HMPPS policy consultations. The PPO responded to eight policy consultations, resulting in changes to national policy.

The Ombudsman provided oral evidence to the Justice Select Committee on their Rehabilitation and Resettlement inquiry.

The PPO provided written and oral evidence to the Welsh Affairs Committee for their inquiry into Welsh prisons. The PPO provided written evidence to the Justice Select Committee on their inquiry into children and young adults in the secure estate.

Key deliverable

Continue reviewing our approach to making recommendations following a complaint investigation to identify systemic and endemic issues and improve the impact of our recommendations and drive system-wide change.

Measure of success

Increase in accepted and implemented complaints recommendations that result in policy changes.

Increase in accepted and implemented recommendations that address systemic and institutional issues across the prison estate.

End of year update

A new recommendations process was rolled out in August 2025. In July, a staff training session was held and the guidance was shared with investigators.

Objective 4: We will use our resources efficiently and effectively

Key deliverable

We will use our skills and expertise to carry out special investigations when commissioned to do so.

Measure of success

Conclude delivery of Operation Deerness (a special investigation into Medomsley Detention Centre).

End of year update

The report into abuse at Medomsley Detention Centre was published on 12 November 2025. The PPO held engagement events with victims and witnesses ahead of publication and a press conference on the launch day.

Key deliverable

Implement our knowledge management strategy that promotes effective and efficient knowledge sharing within the PPO.

Measure of success

Knowledge management strategy effectively embedded throughout the PPO.

Review the PPO's data retention policy.

End of year update

The PPO continued to implement its knowledge management strategy which includes a data erasure programme to adhere to data retention principles.

Monthly Freedom of Information request review meetings were also initiated to monitor volumes and identify potential knowledge trends in requests.

The PPO's data retention policy has been reviewed and expanded upon. It is due to be finalised with the Ministry of Justice.

Key deliverable

Continue developing our digital Learning and Knowledge Hub to promote and share training, learning and knowledge across the PPO.

Measure of success

Strengthening our Learning and Knowledge Hub and promotion across the PPO.

End of year update

The PPO internal Learning and Knowledge Hub has been strengthened with additional sections developed (Business Services and Information Technology) and further content developed for operational teams.

Key deliverable

Continue developing our performance management approach using our existing framework and tools.

Measure of success

Greater confidence and use of the performance management approach.

End of year update

Operational teams regularly use dashboards and management information to inform 1-2-1s with staff.

Key deliverable

Introduce a training programme for both new and existing staff.

Measure of success

Training needs identified from our review are successfully met.

Monitoring of any Continuous Professional Development or training that is undertaken.

Agree and deliver a training programme for investigators.

End of year update

The PPO launched the internal Learning and Knowledge Hub and devised modular training for investigators.

A module on investigative interviewing was rolled out to investigators in September to October 2025.

Key deliverable

Effective use of the model developed for reviewing the allocation of resources against demand.

Measure of success

Sophisticated and effective use of the model to help the PPO remain resilient when responding to fluctuations in workload.

End of year update

The Finance Officer used the model to predict our financial position in the financial year 2026 to 2027 and to update the Executive Committee on the PPO's financial situation.

Key deliverable

Continue to refine and improve our databases, data collection and data management to improve methods for monitoring casework and identifying trends/themes. This will involve exploring the use of new software or methods to support processes at the PPO.

Measure of success

Demonstrable improvements made to data recording, collection and management.

Use of data dashboards to become business as usual across the PPO.

New technical solutions implemented which maximise efficiencies within the PPO.

End of year update

Data collection and management processes have been streamlined to ensure efficiency.

An AI working group has been created to consider how AI could help the PPO become more efficient.

Key deliverable

Continue reviewing the PPO's approach to family liaison to further understand the needs of bereaved families and the resource allocation requirements.

Measure of success

Implement any changes from our review.

End of year update

The family liaison function has been reviewed and the role assessed as AO rather than HEO. A 12-month pilot has commenced to evaluate the impact of changes to the role and impact on others in the FII team.

Key deliverable

Continue to improve and embed the PPO’s approach to business continuity and risk management.

Measure of success

Production of a business continuity plan and raise and maintain staff awareness of business continuity principles.

Continue embedding tools and approaches for maintaining business continuity and risk management.

Undertake a business continuity exercise.

End of year update

The PPO continues to update its business continuity plan in response to internal changes and external threats.

In March 2026, the Ministry of Justice’s Corporate Business Continuity Team visited the PPO to review our business continuity plan and suggest improvements for the future.

A new business continuity exercise is being created, which is tailored to the PPO’s core functions.

Key deliverable

Continue exploring the use of new technology and digital working as a means of communicating with those who use our services.

Measure of success

Tangible uses of existing technology to communicate with those who use our services.

Introduction of new technology to communicate with those who use our services.

End of year update

The PPO has considered this and the use of Launchpad to digitise the complaints process in prisons. Unfortunately, HMPPS does not have the resources to make this possible.

Performance against the 2025 to 2026 Race Action Plan

Objective 1: Support our staff from ethnic minority backgrounds

Action

Facilitate mentoring opportunities and encourage participation from ethnic minority staff.

Measure of success

Participation from ethnic minority staff. Mentees feel the mentoring was valuable.

End of year update

The Equality, Diversity and Inclusion Group's Race sub-group facilitated a mentoring programme that was taken up by some staff. We received positive feedback from mentees.

Action

Celebrate and commemorate events which champion racial diversity and inclusion such as Black History Month and South Asian Heritage Month.

Measure of success

Participation from all staff.

Increased cultural awareness.

End of year update

Unfortunately, due to annual leave and work commitments the Race sub-group was unable to facilitate events for Black History Month or South Asian Heritage Month, however communications were shared to explain the significance and to signpost events.

Action

Continue our annual PPO Culture Day, showcasing the diverse cultures and ethnic backgrounds of staff.

Measure of success

An increased sense of belonging and engagement among ethnic minority staff and an opportunity for all staff to learn more about each other.

End of year update

The Race sub-group successfully organised a lunchtime event for PPO staff to celebrate World Culture Day.

Action

Share information on race-related issues with the organisation through Equality, Diversity and Inclusion Group briefings.

Measure of success

Staff engage with this information and are better informed about race issues.

End of year update

The Race sub-group shared information (for example on Ramadan and prayer areas within the building) through internal publications.

Objective 2: Improve investigator knowledge and address race in our casework

Action

Using research, data and through consultation with complaints investigators, develop guidance for complaints investigators to support their ability to detect the presence and impact of racism in the complaints they investigate.

Measure of success

Complaints investigators understand how to recognise and investigate more subtle forms of racism.

End of year update

Guidance for complaints investigators has been developed and will be rolled out within the next financial year.

Actions

Using research, data and through consultation with FII investigators, continue to develop and embed the guidance created for FII investigators to help uncover potential issues of racism.

FII to hold a forum for experienced stakeholders to discuss the guidance with investigators and to gather feedback. Investigators to also discuss FII case studies involving racism.

Measure of success

FII investigators better understand how to investigate potential issues of racism.

End of year update

A training session was held in December 2025 with FII investigators where the Independent Office for Police Conduct discussed their approach to investigating racism. Investigators discussed the guidance and case studies to consider what steps to take if they were investigating the case.

Action

Continue consulting with stakeholders on how best to consider racism during our investigations.

Measure of success

Our guidance for investigators is developed and refined by different approaches used by relevant stakeholders.

End of year update

Consultation with other stakeholders will begin next year.

Action

Complaints investigators to continue recording on our case management system any concerns about racism when investigating complaints.

Measure of success

Record of complaints where we felt racism was potentially an issue. Ability to spot trends and address issues systematically.

End of year update

17 complaints were recorded this financial year as also having issues relating to race. We did not find evidence of racism in any of these cases.

Action

Quarterly review of all complaints about racism and any complaints where investigators have flagged issues of racism.

Measure of success

Timely updates on any race-related issues arising in our complaints investigations.

End of year update

The Policy Officer reviewed these complaints on a quarterly basis and shared with the Complaints Deputy Ombudsman.

Action

To share operational knowledge throughout the office, deputies to summarise and circulate any issues of racism in casework to the office.

Measure of success

Staff are aware and well informed about issues relating to race arising in our casework.

End of year update

Deputies were reminded of this and will be asked to continue sharing relevant casework with the office.

Objective 3: Strengthen and analyse our data

Action

Assessment and support teams to continue cross-checking ethnicity on Public Protection Unit Database (PPUD) against National Offender Management Information System (NOMIS) and to amend accordingly.

Measure of success

Increased accuracy of ethnicity data on PPUD.

End of year update

PPO ethnicity data was reviewed for the 2025 to 2026 financial year. Generally, the accuracy of ethnicity data improved compared to the review conducted last year.

Action

Further and more in-depth analysis of our complaints data to understand whether we receive a proportionate number of complaints from ethnic minority prisoners, our uphold rates, and an analysis of certain complaints categories by ethnicity.

Measure of success

An understanding of our complaints data using a larger sample size so we can draw conclusions.

A breakdown of our complaints data over time to understand trends in our complaints data.

We have evidence to address any disparities if necessary and share information with HMPPS.

End of year update

The PPO analysed our complaints data from the past 10 years.

The PPO received fewer complaints from white prisoners and more complaints (than proportionate to the population) from black and Asian prisoners.

Reviewing complaints from 2025, the PPO upheld complaints at the same rate for each ethnicity. Using complaints data from 2016 to 2024, white, black, and mixed prisoners' complaints were upheld at the same rates. Asian prisoners' complaints were upheld at a significantly lower rate. This will be monitored going forward.

The research team analysed the proportion of complaints received by the PPO compared to the proportion of prisoner ethnicities using data from the past ten years. This highlights the complaints categories with the largest representation gap. Black prisoners were overrepresented in complaints about use of force and segregation.

Mixed prisoners were overrepresented in complaints about segregation and Asian prisoners were overrepresented in complaints about categorisation.

Action

Analysis of deaths in custody by ethnicity to check whether this is proportionate to the prison population, broken down by establishment type.

Measure of success

We understand whether ethnic minority prisoners are overrepresented and can share these findings with HMPPS.

End of year update

Prison deaths for ten years were analysed. Generally, white prisoners were overrepresented, and black, Asian, mixed and other ethnicity prisoners were underrepresented within prison deaths compared with their percentage of the prison population.

Financial data

	2024 to 2025	2025 to 2026	Movement 2024 to 2025 to 2025 to 2026	% change year-on-year
Budget allocation[13]	£7,651,002	£7,544,000	(£107,002)	-1%

Actuals	2024 to 2025	% of 2024 to 2025 budget	2025 to 2026	% of 2025 to 2026 budget	Movement 2024 to 2025 to 2025 to 2026	% change year-on-year
Staffing costs	£7,401,787	97%	£7,067,342	94%	(£334,445)	-5%
Non-staff costs	£387,530	5%	£314,569	4%	(£72,961)	-19%
Income[14]	£87,848	1%	£51,182	1%	(£36,666)	-43%
Net expenditure	**£7,701,469**	101%	**£7,330,729**	97%	(£370,740)	-5%
Underspend/ (overspend)[15]	**(£50,467)**		**£213,271**		**£263,738**	

13 The 2025 to 2026 budget allocation includes £160,000 for Operation Deerness (the PPO's special investigation into abuse at Medomsley Detention Centre) and £150,000 for the special investigation into the restraint of pregnant prisoners.

14 The PPO received £51,000 of income from the Home Office in 2025 to 2026.

15 The underspend reflects a combination of factors, including delays in commissioning the restraint of pregnant prisoners project, which limited our activity and reduced associated resource requirements during the year.

Terms of reference

Please visit our website for our full terms of reference:

www.ppo.gov.uk/about/vision-and-values/terms-of-reference

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ISBN 978-1-5286-6244-4

E03549573