Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Thomas McCauley a prisoner at HMP Thameside on 23 August 2017

A report by the Prisons and Probation Ombudsman

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

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

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr McCauley was found unresponsive in his cell on 23 August 2017 at HMP Thameside. Mr McCauley was 41 years old. I offer my condolences to Mr McCauley's family and friends.

The post-mortem report gave Mr McCauley's cause of death as drug toxicity as a result of methadone used together with benzodiazepines. Mr McCauley finished a benzodiazepine-based alcohol detoxification on 19 August and began a methadone treatment programme on 16 August, which would explain the presence of both in toxicology samples.

Although my investigation found that the decision to prescribe both was reasonable, I am concerned that poor communication between healthcare staff meant Mr McCauley was not monitored safely on the stabilisation unit as he should have been. I cannot say whether the failure to monitor affected the outcome for Mr McCauley, but it should not have happened.

This is the fourth in the last six investigations into deaths at Thameside, since 2016, in which we conclude that the healthcare provided was not of a standard equivalent to that that which could be expected in the community. I note that Her Majesty's Inspector of Prisons concluded in May 2017 that healthcare services at Thameside were insufficient to meet demand. The Head of Custodial Contracts at Her Majesty's Prison and Probation Service and NHS England South East should now address this highly unsatisfactory state of affairs.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman **February 2019**

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Summary

Events

1. Mr McCauley had a history of alcohol and substance misuse and had served several short sentences at Thameside before. He arrived there on 7 August and immediately started a ten-day alcohol detoxification programme on the stabilisation unit (known as A Lowers, part of Houseblock 1).

2. On 11 August, Mr McCauley told a nurse that he had been using opiates in the community and was feeling unwell. A urine test confirmed his opiate use and the substance misuse doctor started him on a methadone treatment programme on 16 August. (Methadone is a synthetic opiate prescribed by doctors as a substitute for heroin.)

3. Mr McCauley was moved to E Wing (a standard wing also on Houseblock 1), the next day. He moved to H Wing (a standard wing on Houseblock 2) on 21 August. On 22 August, Mr McCauley did not attend the medication hatch to take his methadone. He complained of feeling ill that afternoon and a nurse gave him methadone at 5.30pm.

4. At 9.10am on 23 August, Mr McCauley was found unresponsive in bed in his cell. Staff and paramedics gave him life support, but he was pronounced dead at 10.11am.

Findings

5. The management of Mr McCauley's alcohol dependence and detoxification was reasonable. The assessment of Mr McCauley's opiate dependence and the decision to prescribe methadone was also reasonable, including during the period when Mr McCauley was still receiving a benzodiazepine for alcohol detoxification.

6. On 16 August, the substance misuse doctor did not tell nurses that he had started Mr McCauley on methadone. As a result, he was moved to a standard wing the following day instead of remaining on the stabilisation unit for monitoring. Consequently, no one monitored Mr McCauley for the duration of his methadone treatment.

7. A nurse passed Mr McCauley fit for gym exercise the day before his death without making proper physical checks. Some entries by Addaction staff were insufficient to allow another clinician to understand the reasoning behind decisions or to safely take over the care of the patient. Mr McCauley was given his last dose of methadone at 5.30pm on 22 August, which was reasonable in the circumstances.

8. The first two officers on the scene went into a state of shock when they found Mr McCauley unresponsive and did not start CPR. A third prison officer decided not to start CPR because he believed Mr McCauley had died. There was therefore a four-minute delay between Mr McCauley being found and the nurses starting CPR. It is not possible to say whether the short delay in starting CPR affected the outcome for Mr McCauley, but every second is crucial to successful

resuscitation. In two deaths in August 2016 at Thameside, the first officers on scene did not begin CPR either.

9. The healthcare Mr McCauley received at Thameside was not equivalent to that which he could have expected to receive in the community. This is the fourth investigation of the last six investigations at Thameside to come to the same conclusion.

Recommendations

- **The Head of Healthcare and the Addaction manager should ensure that methadone is prescribed and monitored in line with national clinical guidelines for substance misuse prescribing and drug treatment. Including:**
    - **There are effective channels of communication between GPs, nurses and prison staff to ensure safe management of prisoners receiving opiate substitute treatment.**
    - **All prisoners started on opiate substitute treatment should remain in the stabilisation unit until stable on their dose.**
    - **Prisoners on opiate substitution treatment should remain on Houseblock 1.**

- **The Head of Custodial Contracts and NHS England South East should satisfy themselves that the healthcare provision at Thameside is sufficient to meet patient demand and that the services provided are fit for purpose.**
- **The Director should ensure that appropriately first aid trained staff are available to provide effective cover and that all staff are aware of the circumstances in which CPR is appropriate.**

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Thameside informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

11. The investigator visited Thameside on 12 September 2017. He obtained copies of relevant extracts from Mr McCauley's prison and medical records. The investigation was suspended in October pending the outcome of the post-mortem and toxicology reports.

12. NHS England commissioned a clinical reviewer to review Mr McCauley's clinical care at the prison.

13. Another investigator took over the investigation in February 2018. The investigator and an Assistant Ombudsman interviewed three staff on 29 March 2018. The investigator and clinical reviewer interviewed four staff on 19 April. The investigator spoke to two members of the Addaction team by telephone. The clinical reviewer also spoke to a nurse on the telephone. Another investigator interviewed a prisoner at HMP Belmarsh on 28 March. The investigator watched CCTV of the events of 22 and 23 August.

14. We informed HM Coroner for Southwark of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

15. One of the Ombudsman's family liaison officers contacted Mr McCauley's mother to explain the investigation and to ask if she had any matters they wanted the investigation to consider. Mr McCauley's mother received a copy of the draft report. She pointed out some factual inaccuracies. This report has been amended accordingly. They raised other issues which we have dealt with in separate correspondence.

Background Information

HMP Thameside

16. HMP Thameside is a category B prison in South East London managed by SERCO. It holds up to 1232 remand and sentenced adult men. Healthcare services are provided by Oxleas NHS Trust. Clinical substance misuse services are provided by Addaction and psychosocial support is provided by Turning Point.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Thameside was in May 2017. Inspectors reported that Healthcare services were not sufficient to meet demand. There was some poor communication between services associated with substance misuse treatment and healthcare. Insufficient oversight of medication queues increased the likelihood of medication diversion and medication was not always given at the optimum time for therapeutic effect. However, outcomes for prisoners with drug and alcohol problems were generally good and prisoners were more positive than in comparator prisons about access to drug and alcohol treatment.

Independent Monitoring Board

18. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to June 2017, the IMB reported that illicit substances were rife in the prison. Turning Point saw all new arrivals within 72 hours and ran a range of group sessions to help prisoners address their drug habits. However, some areas of cooperation had flagged during 2017, notably meetings with staff from across the prison and cooperation with the mental health team to support dual diagnosis prisoners.

Previous deaths at HMP Thameside

19. There were five deaths at Thameside in 2016, all from natural causes. In three of them we found that the healthcare provided was not equivalent to that which could have been expected in the community.

Integrated Drug Treatment System (IDTS)

20. The Integrated Drug Treatment System aims to improve the quality of substance misuse treatment available for prisoners, with particular emphasis on those in the early days of custody and improving the integration between clinical and other drug workers.

Key Events

21. Mr Thomas McCauley had a history of drug and alcohol dependency and had served several custodial sentences at Thameside and other prisons.

10 May – 23 June 2017

22. On 10 May, Mr McCauley was recalled to prison and was sent to Thameside. He underwent alcohol detoxification.

23. On 17 May, he told the specialist substance misuse doctor that he had been taking illicit buprenorphine (subutex - an opioid used for opiate withdrawal) in the community and in prison. After a positive urine test, the doctor offered Mr McCauley methadone to treat his opiate withdrawal. Mr McCauley asked for buprenorphine instead but the doctor declined, because the policy is to avoid the drug of abuse. Mr McCauley refused the offer of methadone and was released from Thameside on 23 June 2017 without any opiate withdrawal treatment.

Police custody 5 – 7 August

24. On 5 August, Mr McCauley was arrested and taken to a police station. He was charged with stealing three bottles of alcohol and assaulting a police officer. On 6 August, a nurse prescribed 5mg diazepam (a benzodiazepine, a type of sedative) for symptoms of alcohol withdrawal. He told the same nurse that he was being treated for pneumonia, but could not remember the name of his medication. Mr McCauley received two more doses of 5mg diazepam at 9.55pm and 5.54am on 7 August.

25. The same day he was sentenced to six weeks for breaching an anti-social behaviour order and assaulting a police officer and was sent to Thameside.

Houseblock 1 Thameside 7 – 17 August 2017

26. Mr McCauley told a nurse at an initial health assessment that he drank over ten units of alcohol a day and had suffered alcoholic seizures. A prison GP examined Mr McCauley and prescribed a ten-day alcohol detoxification programme of 5mg chlordiazepoxide (a benzodiazepine) and vitamin B supplements. Mr McCauley was monitored on the stabilisation unit (known as A Lowers on Houseblock 1) in accordance with the Integrated Drug Treatment System (IDTS) protocol.

27. On 8 August, a substance misuse nurse completed Mr McCauley's second day IDTS assessment. She noted that Mr McCauley was known to the drug treatment service in Thameside and appeared cheerful, cooperative and communicative.

28. On 11 August, Mr McCauley complained that his medication was not holding his withdrawal symptoms, he was not sleeping and was hearing voices asking where he was going to get drugs. He told a nurse that he had been using heroin and crack cocaine in the community in addition to drinking excessive alcohol. The nurse noted that Mr McCauley had not reported his drug use at his first health assessment and decided to test his urine. He also made Mr McCauley an appointment with the specialist substance misuse doctor. Mr McCauley's urine

tested positive for cannabinoids, buprenorphine and benzodiazepines, but negative for other opiates. (Buprenorphine stays in the system for three to seven days and cannabinoids for up to 28 days. It is therefore possible that Mr McCauley took both of these drugs in the community before his arrest on 5 August.)

29. On 12 August, a prison GP prescribed Mr McCauley an extra dose of 5mg chlordiazepoxide for three nights to help his alcohol withdrawal. On 14 August, Mr McCauley did not turn up for his appointment with the specialist substance misuse doctor.

30. On 15 August, Mr McCauley told a nurse prescriber that he was still experiencing withdrawal symptoms. The nurse noted that he was shaking and sweating. He made Mr McCauley an appointment with the specialist substance misuse doctor the following day. He also extended Mr McCauley's chlordiazepoxide for a further three days after he finished his ten-day detoxification on 17 August.

31. On 16 August, Mr McCauley told the specialist substance misuse doctor that he had taken illicit buprenorphine in the community. The doctor noted Mr McCauley had gooseflesh and dilated pupils which are symptoms of opiate withdrawal. He said because Mr McCauley had not shown symptoms of opiate withdrawal until a week after entering Thameside, he assumed that Mr McCauley had taken illicit buprenorphine in prison but not at the same dose he had managed to get in the community. He prescribed Mr McCauley 10mg of methadone that afternoon and then daily doses increasing to 40mg over ten days. He said that, as Mr McCauley had refused methadone on his previous sentence, he must have been feeling quite ill.

32. The specialist substance misuse doctor said he expected nurses to monitor Mr McCauley's withdrawal because this was IDTS policy and Mr McCauley was still on the stabilisation unit, but he did not specifically ask them to do so. Mr McCauley was moved to E Wing (a standard wing also on Houseblock 1) the next day and was therefore not monitored while on methadone at Thameside. He did not see him again before he died. On 19 August, Mr McCauley completed his alcohol detoxification.

33. The Addaction manager told the investigator that all prisoners undergoing alcohol detoxification are supposed to remain on the stabilisation unit for 28 days. However, there are 66 beds on the stabilisation unit and the prison receives about 50 new prisoners in need of some form of detoxification each week. Therefore, once prisoners complete their alcohol detoxification and are judged to be stable, they are moved to the standard wings on Houseblock 1. This means that they come into contact with IDTS nurses every day at the medication hatch. Prisoners receiving methadone are monitored daily for the first five days and stay on the stabilisation unit until they are stable on their dose and then move to the standard wings on Houseblock 1.

Houseblock 2 Thameside 21 – 22 August

34. On 21 August, Mr McCauley was moved to H Wing, a standard wing on Houseblock 2. The same day he attended a substance misuse psychosocial session for two hours with a nurse and a Turning Point worker. The nurse said

she knew Mr McCauley from previous sentences and he appeared to be his normal self. He took an active part in the session and challenged her when she said that it was not safe to use methadone and illicit buprenorphine at the same time.

35. The next morning, on 22 August, Mr McCauley did not go to the medication hatch for his methadone. On the balance of evidence, we believe that his cell was not unlocked. It is likely that he was not on the H Wing medication list because his change of location, a prison decision, had not yet been communicated to healthcare staff. A nurse said she bumped into Mr McCauley as he was going to activities. He reminded her that she had promised to fit him for the gym. She said she recorded on Mr McCauley's medical record that he was fit for gym later that day. She did not check him physically, as she should have done.

36. A peer mentor with Turning Point said he returned to H Wing at about 4.15pm that afternoon and saw Mr McCauley talking to staff in the wing office. He said Mr McCauley was pleading for staff to listen to him. He was also the H Wing healthcare champion, so other prisoners advised Mr McCauley to talk to him. Mr McCauley told him that he had not had his methadone that morning and felt very ill. He said Mr McCauley was restless and not entirely coherent. He suggested they go to Mr McCauley's cell so he could complete an emergency healthcare application, but after giving some brief details Mr McCauley left the cell and did not return. He went to look for him and managed to complete the form. He did not see Mr McCauley again before he was locked in his cell for the night.

37. The investigator viewed CCTV of H Wing Lower on 22 August from 4pm until Mr McCauley was locked in his cell for the night at 5.54pm. He was moved across the landing from Cell 8 (a shared cell) to Cell 20 (an empty cell). Mr McCauley repeatedly walked up and down the wing between his new cell and the wing office and talked to different staff and prisoners. At 5.09pm, Mr McCauley banged the door that leads off the wing and tried to attract someone's attention. At 5.11pm, he spoke to an officer and made frustrated gestures. Mr McCauley and an officer left the wing at 5.18pm. (We contacted the officers listed as on duty on H Lowers that afternoon but no one on duty responded.)

38. Mr McCauley's patient medication record and data from the methasoft machine (which automatically records doses of methadone dispensed from it) showed that a nurse gave Mr McCauley 35mg of methadone at 5.30pm. The nurse said he did not specifically remember giving Mr McCauley his methadone that afternoon; however, if prisoners missed their morning medication through no fault of their own, they would be given some later in the day. This happened in a variety of circumstances, for example if the prisoner had gone to court and left the prison before the morning medication round.

39. CCTV showed Mr McCauley returned to H Wing at 5.33pm. He was locked in his cell for the night at 5.54pm. Incident logs from the prison indicate that Mr McCauley was last seen alive in his cell, out of bed, at 6.30pm.

23 August

40. The investigator watched CCTV from 7.00am until 9.31am on 23 August. There is a six-minute difference between timings on the CCTV and timings on the control room log, but the gaps between events are consistent. According to CCTV, officers began unlocking cells for medication at 8.09am. At 8.53am a prisoner looked through Mr McCauley's observation panel and walked off. Mr McCauley was not unlocked for medication.

41. At 9.05am, PCO A opened Mr McCauley's cell to put a new prisoner in there. Mr McCauley was in bed laying on his back with his right arm out to one side. The PCO said, 'Good morning' to Mr McCauley but got no response, so he walked forward and shouted, 'You alright mate?' He noticed that Mr McCauley looked pale and he could not see him breathing. The PCO said he did not start cardio-pulmonary resuscitation (CPR) because he went into shock. He called PCO B, who entered the cell at 9.06am with PCO C. (PCO B has left Thameside and was not interviewed.) They checked for signs of life and PCO A radioed a code blue emergency indicating that a prisoner was unconscious or having difficulties breathing. London Ambulance Service records confirm that the control room called the ambulance a minute after PCO A first found Mr McCauley unresponsive.

42. PCO B did not start CPR. PCO C said PCO B told him to lock the other prisoners in their cells because a few were trying to look in to see what had happened, so he left the cell soon after he went in.

43. A PCO who at the time was an acting wing manager and was in charge of the wing that morning, arrived at 9.07am. He also checked Mr McCauley for signs of life. He said he had received nurse training as a teenager and he did not start CPR because he thought that Mr McCauley had died. He said Mr McCauley's pupils were fixed, he was cold to touch and his limbs were stiff. He said PCO B was also in shock so he asked him to help lock the other prisoners in their cells. At 9.08am he then radioed to see where the nurses were. Two nurses arrived with emergency equipment at 9.09am. PCO B said they arrived on H wing as he was radioing to see where they were.

44. Both nurses said Mr McCauley was not breathing and had no pulse but was not stiff, so they began CPR and attached a defibrillator. The defibrillator advised no shock. They continued with CPR and gave Mr McCauley oxygen via a bag and mask. Ambulance paramedics arrived at 9.31am and began advanced life support procedures but pronounced Mr McCauley dead at 10.11am.

Contact with Mr McCauley's family

45. The prison's family liaison officer and the Deputy Director drove to Mr McCauley's mother's house and arrived at noon. They broke the news of Mr McCauley's death to his mother and two sisters. The prison contributed to the cost of Mr McCauley's funeral in line with national guidance.

Support for prisoners and staff

46. After Mr McCauley’s death, operational managers debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

47. The prison posted notices informing other prisoners of Mr McCauley’s death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr McCauley’s death.

Post-mortem report

48. The pathologist gave the cause of death as:

“1a) Methadone use together with benzodiazepines

2) Bronchopneumonia.”

Findings

Management of Mr McCauley's alcohol and methadone treatment

49. The clinical reviewer concluded that the management of Mr McCauley's alcohol dependence and detoxification was reasonable. He also concluded that the specialist substance misuse doctor's assessment of Mr McCauley's opiate dependence and his decision to prescribe methadone was reasonable, including during the period when Mr McCauley was still receiving a benzodiazepine for alcohol detoxification.

50. According to Addaction policy DQ200, which covers national clinical guidelines for substance misuse prescription and drug treatment, opiate-dependant clients should be stabilised on a licensed opiate substitution therapy for a minimum of 5 days to enable control of withdrawal symptoms. Paragraph 5.1.6 says:

> "During stabilisation clients will be subjected to enhanced observation over the 5 days or however long is deemed necessary. These observations must include:
>
> i) a frequency of at least TWICE DAILY
> ii) Vital signs – BP and pulse
> iii) COWs withdrawal score
> iv) Objective withdrawal signs
> v) Signs of drowsiness, over-sedation"

51. The specialist substance misuse doctor did not tell healthcare staff that he had started prescribing methadone for Mr McCauley on 16 August as he should have done. This set off a chain of unintended consequences. First, Mr McCauley moved to E Wing on 17 August instead of remaining on the stabilisation unit for monitoring. Secondly, he was not formally monitored for the duration of his methadone treatment. Thirdly, Mr McCauley was moved from Houseblock 1 to Houseblock 2 on 21 August, which should not have happened while he was still on methadone. This appears to have resulted in him not being unlocked for morning medication on 22 and 23 August. CCTV shows officers began unlocking prisoners for medication on H Wing at 8.09am almost an hour before Mr McCauley was found.

52. We cannot say that the outcome would necessarily have been any different for Mr McCauley if he had been monitored as he should have been after he was prescribed methadone. However, he would have been monitored if healthcare staff had known he was on methadone, and this demonstrates that effective communication makes a vital contribution to ensuring prisoner safety. We make the following recommendation:

    The Head of Healthcare and the Addaction manager should ensure that methadone is prescribed and monitored in line with national clinical guidelines for substance misuse prescribing and drug treatment. Including:

- **There are effective channels of communication between GPs, nurses and prison staff to ensure safe management of prisoners receiving opiate substitute treatment.**
- **All prisoners started on opiate substitute treatment should remain in the stabilisation unit until stable on their dose.**
- **Prisoners on opiate substitution treatment should remain on Houseblock 1.**

The decision to give Mr McCauley methadone late on 22 August

53. Mr McCauley was given his last dose of methadone at 5.29pm on 22 August. Although the level of methadone in his post-mortem samples would have been fatal for a person unused to methadone, they were not sufficiently high to be fatal to someone with a tolerance, like Mr McCauley. We do not think it was unreasonable to give Mr McCauley methadone late in the afternoon of 22 August. This was common practice in the prison at the time for all prisoners who missed their morning medication through no fault of their own.

54. After Mr McCauley's death, Addaction decided that if prisoners missed their morning methadone, the latest time of day they would be given their dose is at 2.30pm. After that point, they would only be given symptomatic relief, such as paracetamol. This decision was taken in part because prisoners are locked in their cells from late afternoon, which limits monitoring for any adverse effects. Although we cannot say that the later dose on 22 August contributed directly to Mr McCauley's death, we welcome the Addaction response as an extra safety measure.

Healthcare at Thameside

55. Mr McCauley was passed fit to attend the gym without appropriate physical observations. The clinical reviewer also found that some of the record keeping was too brief to allow another clinician to "understand the reasoning or to safely take over the care of the patient".

56. The clinical reviewer concluded that the healthcare offered to Mr McCauley in Thameside was not equivalent to that which he could have expected to receive in the community. This is the fourth in the last six investigations at Thameside in which healthcare has failed this test.

57. In the light of this and Her Majesty's Inspector of Prisons conclusion in May 2017 that healthcare services at Thameside were insufficient to meet demand, we now consider it is appropriate to make a recommendation to the Head of Custodial Contracts and NHS England South East:

    The Head of Custodial Contracts and NHS England South East should satisfy themselves that the healthcare provision at Thameside is sufficient to meet patient demand and that the services provided are fit for purpose.

Emergency response

58. The first two officers to enter the cell went into a state of shock when they found Mr McCauley unresponsive and did not begin CPR. PCO C left the cell almost immediately to lock up the other prisoners. We consider this was reasonable in the circumstances because several prisoners had already gathered outside Mr McCauley's door.

59. PCO B decided not to start CPR because he believed Mr McCauley had died. There was therefore a four-minute delay between PCO A discovering Mr McCauley and the nurses starting CPR. The evidence from and subsequent actions of the nurses and the paramedics suggest Mr McCauley's situation was not as clear cut as PCO B thought.

60. It is not possible to say whether the short delay in starting CPR affected the outcome for Mr McCauley but every second is crucial to successful resuscitation. We note that in two deaths in August 2016 at Thameside the first officers on scene did not begin CPR either. We make the following recommendation:

The Director should ensure that appropriately first aid trained staff are available to provide effective cover and that all staff are aware of the circumstances in which CPR is appropriate.

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Independent Investigations

PO Box 70769
London, SE1P 4XY

Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100
F | 020 7633 4141