

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Paul Smith, a prisoner at HMP Hewell, on 3 February 2021

A report by the Prisons and Probation Ombudsman

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*



© Crown copyright, 2022

This report is licensed under the terms of the Open Government Licence v3.0. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

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 Paul Smith was found hanging in his cell at HMP Hewell on 3 February 2021. He was 45 years old. I offer my condolences to Mr Smith's family and friends.

Mr Smith arrived at Hewell on 19 December 2020, after being extradited from France. He told staff that he was prescribed pregabalin (used to treat epilepsy and anxiety, but also widely abused in prison). Although Mr Smith was initially prescribed pregabalin at Hewell, a prison GP started Mr Smith on a withdrawal programme at the beginning of January, and stopped the pregabalin completely two weeks before Mr Smith's death. Mr Smith was unhappy about this and complained.

I am satisfied that Mr Smith gave no indication to staff that he was at risk of suicide or self-harm during his time at Hewell. It is not possible to say what part, if any, the stopping of his pregabalin played in his death.

The clinical reviewer found that Mr Smith's clinical care at Hewell was not of the required standard and was not equivalent to that he could have expected to receive in the community. She found that while there were valid reasons for stopping Mr Smith's pregabalin, the process was not managed properly. Staff did not obtain Mr Smith's medical records from France or engage with Mr Smith to assess what support he might need while his pregabalin was being withdrawn.

I am also concerned that there were delays in the emergency response when Mr Smith was found hanging. We cannot say whether the delay affected the outcome, but we know that in a medical emergency, a delay of a few minutes can be critical.

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

Sue McAllister CB
Prisons and Probation Ombudsman

November 2021

Contents

| | |
|---------------------------------|----|
| Summary | 1 |
| The Investigation Process | 3 |
| Background Information | 4 |
| Key Events | 5 |
| Findings..... | 10 |

Summary

Events

1. On 19 December 2020, Mr Paul Smith arrived at HMP Hewell having been extradited from France to face dangerous driving charges. This was not his first time in prison.
2. Mr Smith told the reception nurse he was prescribed pregabalin (used to treat epilepsy and anxiety) by a GP in France. A prison GP prescribed pregabalin, along with his other medications (an antidepressant and an antipsychotic).
3. On 4 January 2021, a prison GP decided to stop Mr Smith's pregabalin. (Pregabalin is widely abused and traded in prison so it is not recommended that it is prescribed in a prison setting. There were also concerns that Mr Smith should not take pregabalin alongside his antipsychotic.) The GP reduced the dose, before stopping it completely on 17 January.
4. Mr Smith complained about the withdrawal of pregabalin. He said he was anxious and that he was finding it difficult to manage the side effects from his antipsychotic without pregabalin. On 31 January, he became angry at the medication hatch and said he was going to 'kick off big time'.
5. On the morning of 3 February, Mr Smith was moved to a cell on his own because his cellmate was moving to another prison. Both staff and prisoners said Mr Smith seemed happy with the move.
6. At approximately 4.15pm, an officer started taking the meals round and when he got to Mr Smith's cell, he found him hanging from the bed frame. He shouted to another officer for help. They removed the ligature and laid Mr Smith on the floor and began CPR. At 4.22pm, one of the officers called a medical emergency code over their radio. Healthcare staff and paramedics were unable to resuscitate Mr Smith. Paramedics pronounced his death at 5.03pm.

Findings

7. Mr Smith gave no indication to staff that he was at risk of suicide or self-harm during his time at Hewell.
8. However, his behaviour changed when his pregabalin was withdrawn and he complained of feeling anxious. We cannot be sure what role the pregabalin withdrawal played in Mr Smith's death, but it appears that he struggled with the change in his medication.
9. Mr Smith also raised concerns about the cost of phone calls to his girlfriend in France. Officers made attempts to help with this but the issue had not been resolved before his death.
10. The clinical reviewer found that the standard of care Mr Smith received at Hewell was not equivalent to that he could have expected to receive in the community. She noted that while there were valid reasons to stop Mr Smith's pregabalin prescription, the process was not managed correctly. Staff did not request Mr Smith's French medical records and did not consult or engage with Mr Smith

about the withdrawal of pregabalin. This meant that they did not assess what support he might need during the process. There were also delays in actioning mental health referrals for Mr Smith.

11. Staff delayed calling the medical emergency code when they found Mr Smith hanging. We cannot say whether the delay affected the outcome, but we know that in a medical emergency, a delay of a few minutes can be critical.

Recommendations

- The Head of Healthcare should ensure that overseas health records are requested for prisoners who have recently lived in other countries.
- The Head of Healthcare should ensure that the cessation of high risk prescribed drugs is based on a patient's individual needs and they are supported through the process.
- The Head of Healthcare should share this report with the relevant healthcare staff, including GPs, so they are aware of the Ombudsman's findings.
- The Head of Healthcare should review the internal task system, ensuring referrals and requests are processed efficiently.
- The Governor should ensure that staff establish whether British nationals with family living abroad are eligible for an international PIN phone account.
- The Governor should remind staff of the medical emergency response protocol and ensure they are clear that where codes are appropriate, they should be used immediately.
- The Governor should share this report with Officer A and arrange for a senior manager to discuss the Ombudsman's findings with him.

The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Hewell informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
13. The investigator obtained copies of relevant extracts from Mr Smith's prison and medical records.
14. The investigator interviewed nine members of staff and one prisoner in March 2021. NHS England commissioned a clinical reviewer to review Mr Smith's clinical care at the prison. The investigator and the clinical reviewer jointly interviewed healthcare staff. Due to coronavirus restrictions, all interviews were conducted by telephone.
15. We informed HM Coroner for Worcestershire of the investigation. He gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
16. One of the Ombudsman's family liaison officers contacted Mr Smith's next of kin to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not raise any concerns but asked to see a copy of our report.
17. Mr Smith's next of kin received a copy of the initial report. She did not raise any further issues, or comment on the factual accuracy of the report.
18. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Background Information

HMP Hewell

19. HMP Hewell is an amalgamation of two prisons, the former HMP Blakenhurst and HMP Hewell Grange. The Hewell Grange site continues to operate as an open prison and the Blakenhurst site is a secure, local prison. Practice Plus Group provides health services and there is a 20-bed inpatient unit.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Hewell was a scrutiny visit in August 2020. Inspectors reported that they did not consider Hewell to be a safe prison. Structures were not robust enough to identify and tackle violence and anti-social behaviour and key work had stopped for the majority of prisoners leaving little meaningful interaction. Two thirds of prisoners identified as having mental health concerns and many felt they were not supported at times of need.

Independent Monitoring Board

21. 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 30 September 2020, the IMB reported that the prison's efforts to minimise COVID-19 infections within Hewell had inevitably had an impact on prisoners' broader welfare including their mental health. However, they did feel Hewell had improved from the beginning of the reporting year and hoped that increased investment and leadership change might impact positively on the prisoners.

Previous deaths at HMP Hewell

22. Mr Smith was the tenth prisoner to die at HMP Hewell since February 2019. Three of the previous deaths were self-inflicted and six were from natural causes. There are no similarities between the findings from our investigation into Mr Smith's death and the findings from our previous investigations at Hewell.

Key Events

23. On 18 December 2020, Mr Paul Smith was extradited from France, having fled the UK three years earlier when bailed on dangerous driving charges. He arrived at HMP Hewell on 19 December.
24. A nurse carried out Mr Smith's initial health screen. She noted that Mr Smith was polite, jovial and engaged, and had no thoughts of suicide or self-harm. Mr Smith told her that he had epilepsy and was prescribed 600mg pregabalin (used to treat epilepsy and anxiety), 40mg fluoxetine (an antidepressant) and 150mg amisulpride (an antipsychotic). Mr Smith provided a photocopy of his French prescription. The nurse made a referral to the mental health team.
25. A prison GP saw Mr Smith and prescribed the medication detailed in the French prescription. Mr Smith kept his medication in his possession.
26. On 21 December, a nurse completed a medication reconciliation. She did not consult with Mr Smith or request his French medical records. She looked at his UK summary care record only, which said that on 10 August 2018, Mr Smith had been prescribed 150mg pregabalin, 40mg fluoxetine and 50mg amisulpride.
27. On 29 December, a mental health nurse saw Mr Smith. He told her he had built a life for himself in France where he had a girlfriend, friends and a business. He hoped he could return there but realised that would not be straightforward. He said he had Asperger's syndrome, depression and epilepsy and was on medication. He had no concerns about his mental health.
28. The nurse considered that Mr Smith was functioning well as he was chatty and displayed insight around his original offence, citing alcohol and cocaine as a cause. He said that he had self-harmed in the past by cutting. Mr Smith said he was speaking to his girlfriend on the phone and getting on well with his cellmate. The nurse noted that his mental health care and treatment planning would include Mr Smith being allocated a mental health nurse, and that he would be seen by a psychosocial practitioner about substance misuse issues which he said were ongoing. The referral to the mental health team was made but the psychosocial referral was not.
29. On 31 December, a nurse, a mental health keyworker, met Mr Smith. Mr Smith explained the background to how he came to be in prison and his Asperger's diagnosis. He said he was fine and had no thoughts of self-harm or suicide. He was worried about where he would live on release and the nurse explained to him that a referral had been made to the resettlement team. Mr Smith agreed that a distraction pack and a stress ball would be helpful.
30. On 4 January 2021, a prison GP reviewed Mr Smith's medication. He decided to stop the pregabalin because of a concern that it can cause respiratory depression when mixed with amisulpride. He also could not find any evidence of pregabalin being prescribed since 2018 and did not therefore consider it an established medication. (He did not see the photocopy of the French prescription that had been uploaded to Mr Smith's electronic medical record.) The GP prescribed 300mg pregabalin from 4 January; 150mg from 10 January; and none from 17 January.

31. On 12 January, a prison GP recorded he had received an application from Mr Smith for a face to face discussion with a GP about his pregabalin reduction as he had not been consulted. The GP sent a written reply saying that pregabalin and amisulpride was not a good combination.
32. On 18 January, a prison GP received an email from a pharmacy assistant, requesting that Mr Smith's amisulpride be changed to 'not in possession' as he did not want to have it in his cell. She said he often refused to take it because of side effects but that she always encouraged him to take it. The pharmacy assistant also made a referral to the mental health team, but the email was not picked up for ten days (it is unclear why).
33. On 26 January, an officer noted that Mr Smith had told her he was struggling to make contact with his family in France because of the cost of the calls and how much money prisoners were allowed to load onto their PIN phone accounts at any one time. She asked him if he had been told about an international PIN which allowed qualifying prisoners to load more money onto their PIN accounts. He said he had been told he did not qualify because he was British. The officer told him she would email the business hub and explain his situation, and Mr Smith said he was very grateful.
34. The officer emailed the business hub that day. An officer in the business hub replied that she would need governor approval to give Mr Smith an international PIN and that she would talk to a prison manager about it.
35. The officer emailed a prison manager the same day, pointing out that they had already approved an international PIN for a British prisoner whose wife lived in Germany. The prison manager asked for a copy of Mr Smith's calls and the costs, which the officer provided.
36. On 28 January, Mr Smith's PIN phone record shows that he tried to call his girlfriend but slightly misdialled, so it looked as if the number was not on the allowed list.
37. On 27 January, Mr Smith wrote to his girlfriend in France. On 28 January, Mr Smith wrote to his girlfriend again. He said he had asked the prison to allow him to put £50.00 on his PIN phone account. He implied that the maximum amount he was allowed to have on his general account was £25.00 a week and once he had bought his essentials that only left him £15.00 a week for phone calls. He said he had been told he needed to put in a written application to the Governor and that he had done this. At that time, he said he only had £5.00 left for calls as he had expected the £50.00 to be put on his PIN phone account.
38. On 29 January, a mental health nurse saw Mr Smith in response to the pharmacy assistant's referral, and recorded he was appropriately dressed, kempt and pleasant. Mr Smith asked to speak to a psychosocial worker about his substance misuse, and the nurse made a referral. Because Mr Smith specified which psychosocial worker he wished to see, it delayed the appointment. (It is not clear what had happened to the nurse's original psychosocial referral in December. The clinical reviewer has established that some members of the mental health team also cover the psychosocial role, so it is possible someone had missed that the nurse's referral was in fact for two different things.)

39. Mr Smith also told the nurse he was not happy about his pregabalin being reduced and taken off his prescription. He said the amisulpride was giving him muscle rigidity, headaches and a stiff neck. He also said he was not happy with the response he got when he complained about his pregabalin being stopped. He gave the nurse details of his French GP for his medical records in France because he wanted the healthcare team to have evidence of his Asperger's diagnosis.
40. On 29 January, a nurse sent a task to the duty doctor requesting a medication review. The doctor referred the matter back to the nurse because he considered a mental health intervention was required (specifically a psychiatrist appointment), but the request went to a team inbox and an administrator forwarded it to the nurse on 1 February. The nurse was not on duty at the time and not due back in until 3 February.
41. On 30 January, a nurse recorded that Mr Smith refused his amisulpride because of the situation with his pregabalin. He also refused to sign a disclaimer.
42. On 31 January, a pharmacy assistant recorded that Mr Smith had become irate at the medication hatch and had refused to take his amisulpride. She told him that he ran the risk of it not being re-prescribed if he did not take it and he said he would sue healthcare. He said he needed pregabalin to help him with the amisulpride side effects and threatened to 'kick off big time'. His behaviour surprised her as he was usually very polite. He refused to sign a medication refusal disclaimer.
43. The pharmacy assistant sent a task to the GPs and the mental health team about Mr Smith and on 1 February, she mentioned her concerns in the handover meeting.
44. On 1 February, an officer emailed a prison manager (copying in the business hub's general email address) asking for an update on Mr Smith's international PIN. She did not receive a response. The prison manager told the investigator that Mr Smith's account showed that he had received £330 from his cellmate's mother and that this required further investigation before it would be appropriate to authorise an international PIN. The prison manager had not completed those investigations by the time Mr Smith died.
45. The same day, Mr Smith made an application to the mental health team saying he was experiencing anxiety since coming off pregabalin and was not sleeping. The mental health team did not receive the application for a further week because of processing delays related to COVID-19 and the prison's reduced regime.
46. On 2 February, the pharmacy assistant saw Mr Smith and he apologised for his behaviour and said that the issues he was having were not her fault.

3 February

47. On the morning of 3 February, Mr Smith's cellmate was moved to another prison and Mr Smith agreed to move from the large twin cell they had shared to a slightly smaller cell with bunk beds on the same house block where he would be the sole occupant. According to Officer A, who oversaw the move, Mr Smith had

no issue with this. Mr Smith's cellmate did not recall anything unusual in Mr Smith's mood either the evening before or the morning that he left, although he said Mr Smith was a little subdued when they said their goodbyes.

48. Between around 2.45pm and 3.15pm, two prisoners spoke to Mr Smith. They said he seemed 'okay' to them, was not agitated and they had a bit of a laugh. One of the prisoners said that Mr Smith should be getting out of prison in a few weeks.
49. At around 4.15pm, Officer A and an officer in training started taking meals to prisoners in their cells. When they got to Mr Smith's cell, they found he was hanging from a ligature (a bed sheet) attached to the frame of the top bunk. Officer A shouted to Officer B on the landing below for assistance and a prisoner, who was helping with the delivery of the meals, ran in and tried to untie the ligature while Officer A took Mr Smith's weight.
50. Officer B arrived, asked the prisoner to leave and tried to cut the ligature with her fish knife. She was unable to do so as it was tied with five knots, and she asked Officer A to swap with her. She then took Mr Smith's weight and Officer A cut the ligature. Another officer came into the cell and Officer B told her to go and get the Supervising Officer (SO).
51. The two officers laid Mr Smith on the floor and Officer A called a code blue while Officer B checked for signs of life. The code blue was called at 4.22pm and staff in the control room called an ambulance straightaway.
52. Mr Smith was cold to touch, his eyes were rolled back, and he was not breathing, but he had made a gurgling sound when he was cut down. The officers took turns to give CPR. The SO arrived and observed while the officers carried out CPR.
53. Two prison paramedics were the first members of healthcare staff to arrive at the cell. One of the paramedics tried to tell the control room that CPR was in progress, but her message failed to transmit, so the custodial manager, who had arrived, radioed the message for her and told them the ambulance service needed to upgrade its response. The control room log shows this message was received at 4.27pm.
54. Two nurses and a healthcare assistant arrived to assist with life support. A nurse inserted an airway and staff continued with chest compressions. Nurses gave oxygen and glycolgen.
55. At 4.45pm and 4.46pm respectively, emergency services paramedics and air ambulance crew arrived at the cell and took over life support. Resuscitation attempts were not successful, and at 5.03pm, the air ambulance doctor pronounced Mr Smith's death.

Contact with Mr Smith's family

56. The prison appointed a prison manager as the family liaison officer and she told Mr Smith's next of kin of his death at 5.25pm the same day. She broke the news by telephone in line with the revised family liaison arrangements in place due to

the COVID-19 pandemic. The prison paid funeral costs in line with national policy.

Support for staff and prisoners

57. On 3 February, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
58. The prison posted notices informing other prisoners of Mr Smith'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 Smith's death.

Post-mortem report

59. The post-mortem report concluded that Mr Smith died as a result of hanging by ligature.

Findings

Assessment of Mr Smith's risk of suicide and self-harm

60. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*, provides guidance to staff on identifying prisoners who might be at risk of suicide and self-harm. It lists the risk factors and triggers that might increase a prisoner's risk and sets out the procedures (known as ACCT) that staff should follow when they identify a prisoner at risk of suicide and self-harm.
61. When Mr Smith arrived at Hewell, reception staff assessed that he was not at risk of suicide and self-harm and that ACCT monitoring was not needed. We agree that Mr Smith had no significant risk factors for suicide and self-harm and that staff's assessment that he was not at risk was a reasonable one.
62. We consider that Mr Smith gave no indication to staff that he was at risk of suicide and self-harm throughout his time at Hewell.

Clinical care

Pregabalin reduction

63. We cannot say what role the stopping of pregabalin had in Mr Smith's death, but it is clear he was frustrated and angry about the change in his medication.
64. The clinical reviewer noted that, under the Royal College of GPs' guidance *Safer Prescribing in Prisons*, pregabalin is not recommended for prescription in prison settings due to the high risk of abuse and diversion. She also noted the concerns about prescribing pregabalin alongside amisulpride, due to their respiratory depressive effects which could lead to over-sedation and accidental overdose.
65. However, although she considered it was understandable that the prison GP wanted to stop Mr Smith's pregabalin, she had several concerns about how this was managed.
66. Firstly, Mr Smith was not consulted on the decision. The *Safer Prescribing in Prisons* guidance says that clinical decisions to suspend medication should be considered on an individual basis, and not used to generically stop a specific medication without consultation with the patient.
67. In addition, the Local Operating Procedure (LOP) at Hewell on management of gabapentoid drugs (such as pregabalin) says there should be full consultation with the patient when reducing the medication. However, the LOP was not followed in Mr Smith's case because the GP considered that the pregabalin was not an established medication. This was because the medication reconciliation was done only by reference to Mr Smith's UK medical records and not his medical records in France. The clinical reviewer said that if the medicine reconciliation had been done in person, rather than as a paper exercise, it is likely that Mr Smith would have explained that the pregabalin had been prescribed in France. As it was this was not realised and healthcare staff did not request Mr Smith's French medical records.

68. The clinical reviewer noted that if the LOP had been initiated, healthcare staff would have consulted and engaged with Mr Smith, and considered what support he needed during the pregabalin withdrawal, including support from other healthcare services for his mental health.
69. For these reasons, the clinical reviewer concluded that the clinical care Mr Smith received at Hewell. was not equivalent to that he could have expected to receive in the community. We recommend:

The Head of Healthcare should ensure that overseas health records are requested for prisoners who have recently lived in other countries.

The Head of Healthcare should ensure that the cessation of high risk prescribed drugs is based on a patient's individual needs and they are supported through the process.

The Head of Healthcare should share this report with the relevant healthcare staff, including GPs, so they are aware of the Ombudsman's findings.

Mental Health

70. On 18 January, a pharmacy assistant made a referral to the mental health team because Mr Smith was refusing to take his antipsychotic. For unexplained reasons, it took ten days for the mental health team to pick up this referral.
71. In response, on 29 January, a nurse asked the GPs to do a medication review but this request was sent back on 1 February for a psychiatric intervention to be arranged first. The GP's response was sent to the mental health team's general inbox and an unknown person then forwarded it to the nurse who by this point was not due on duty until 3 February. We make the following recommendation:

The Head of Healthcare should review the internal task system, ensuring referrals and requests are processed efficiently.

72. On 1 February, Mr Smith made an application to the mental health team saying he was experiencing anxiety since coming off pregabalin and not sleeping. The mental health team did not receive the application for a further week. It appears that, because prisoners could not easily access the healthcare applications box because of COVID-19 regime restrictions, Mr Smith had sent the application via the prison's internal mail system through prison officers. The prison has since revised the locations of the healthcare application boxes so that prisoners can more easily access them during any extreme regime changes.

International PIN phone account

73. Mr Smith raised concerns with staff about the cost of phone calls to his girlfriend in France and he wrote to his girlfriend about his concerns a few days before his death. Staff were trying to clarify whether he was entitled to an international PIN phone account which would have helped with this.
74. Contact with family and friends has been particularly important for prisoners during the pandemic and we think it would be helpful if staff were able to clarify

whether British nationals are eligible for an international PIN phone account so that such applications can be resolved more quickly in future. We recommend:

The Governor should ensure that staff establish whether British nationals with family living abroad are eligible for an international PIN phone account.

Emergency response

75. PSI 03/2013, *Medical Emergency Response Codes*, requires prisons to have a medical emergency response code protocol, which should ensure that staff call an appropriate code to summon help immediately and to ensure an ambulance is also requested at once.
76. On 17 April, Hewell issued its emergency response protocol in the light of the COVID-19 pandemic. It said that an emergency ambulance should not automatically be called in response to a code red or a code blue. Healthcare staff should attend and decide whether an ambulance was necessary. However, there were some exceptions to this including where anyone is found hanging.
77. Shortly after 4.15pm on 3 February, Officer A entered Mr Smith's cell and found him hanging. However, he did not call the code blue until 4.22pm (around seven minutes later).
78. When interviewed and asked why he had not called an emergency code as soon as he realised Mr Smith was hanging, Officer A said that at the time he wanted to focus on taking Mr Smith's weight and getting the ligature off.
79. Although we understand that Officer A's first instinct was to help Mr Smith, we consider that the code should have been called straightaway, as soon as it was clear that it was a medical emergency. This would have avoided any delay in healthcare staff attending and an ambulance being called. We note that there were other officers nearby and that the officer could have called to one of them to radio a code blue while he supported Mr Smith's weight. We make the following recommendation:

The Governor should remind staff of the medical emergency response protocol and ensure they are clear that where codes are appropriate, they should be used immediately.

The Governor should share this report with Officer A and arrange for a senior manager to discuss the Ombudsman's findings with him.

**Prisons &
Probation**

Ombudsman
Independent Investigations