Prisons & Probation Ombudsman
Independent Investigations

Annual Report
2024 to 2025

CP 1332

Prisons and Probation Ombudsman Annual Report 2024 to 2025

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by Command of His Majesty

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Any enquiries regarding this publication should be sent to the Prisons and Probation Ombudsman at:

Third Floor,
10 South Colonnade,
Canary Wharf,
London E14 4PU

020 7633 4100
mail@ppo.gov.uk

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Contents

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, the Home Office (Immigration Enforcement), HMPPS Youth Custody Service, and those local authorities with secure children's homes. 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.[1]

1 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


NOTICE TO PRISONERS
Need some extra support?
Nacro
SORT OUTSIDE
WHILE INSIDE
0800 0181 259
Need some extra support?

Adrian Usher
Prisons and Probation Ombudsman

The year 2024 to 2025 has been another in which the PPO has implemented significant internal change while meeting increased external demand. In the short term at least, this is likely to remain the case.

Capacity issues continue to challenge the services in remit, and the experience of the PPO during this year was that, as prisoner numbers approach the operational limit, the delivery of routine regime, education, work and meaningful activity becomes more difficult. This delivers a concomitant increase in prisoner and staff frustrations and the number of prisoner complaints rise. During the time covered by this report, we saw a 15% increase in complaints sent to us. Some of this will be attributable to the successful launch of IPCI and the prison visits of my staff to publicise that change. However, it is undeniable that some of the rise will be as a direct consequence of a system under strain.

The prison population is getting older, influenced by sentence inflation and a significant rise in historic sexual offence convictions. This, inevitably, gives rise to a greater number of people dying while in prison. This year, we started investigations into 84 more cases than in the previous year of the deaths of older people (aged 50 and over), and 486 deaths in total. This is an increase on the previous year.

The PPO is a demand-led organisation with little control of incoming workflow. Taking into account an across-the-board rise in that demand and no increase in resource, it would be reasonable to expect our timeliness to suffer. At the PPO we are acutely aware that when a prisoner dies, bereaved families want answers to their questions quickly so they can move forward in the grieving process. Behind every complaint investigation is a prisoner, and possibly a member of prison staff, for whom a swift resolution is incredibly important. It was for all those individuals that I took the decision in 2023 to increase our timeliness targets from 60% to 90% in both areas of investigation.

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During the time covered by this report, we saw a 15% increase in complaints sent to us ... it is undeniable that some of the rise will be as a direct consequence of a system under strain.

It is with great pride that this report details that my staff, far from buckling under the pressure, have made giant strides towards meeting those targets. They have innovated and designed new systems and processes, driving greater efficiency. They have used their knowledge and experience to identify and mitigate the most pressing risks, and they have been diligent and persistent in pursuing just outcomes for those for whom we provide a service.

An area which my staff have made an incredible achievement in this year is reducing the backlog of complaints cases. Twin pressures imposed by COVID-19 and the deployment of resources on the implementation of IPCI had impacted on the delivery of our complaints resolution work. However, I am pleased to say that our complaints investigation department cleared over 150 unallocated cases this year. This has been no mean feat as investigators worked hard to clear these cases alongside their day-to-day work, so I am grateful for their determination and persistence. Incoming cases in complaints are now dealt with swiftly and prisoners get the response they want faster. At the time of writing, fatal incident investigations have nearly cleared their backlog, which will mean our investigators will have more time to focus on newer deaths and produce reports more quickly.

The pages that follow provide the detail of our collective endeavours throughout 2024 to 2025. They outline not only the challenges but also the successes we have had in raising standards of safety and fairness for the services in remit. All departments contributed to those successes and I am proud of what we have achieved in this short time.

IPCI has doubled down on its focus to tackle ineligibility with the creation of IPCI ambassadors. This is a new scheme where volunteer prisoners can assist others in trying to get a resolution to their complaints, which is now present in 47 prisons, with the number of ambassadors set to increase again in 2025 to 2026.[2]

We have established a more mature and consistent approach to returning complaints to prisons where we assess that there has been an insufficient attempt by them to resolve the matter. It is our role to evaluate whether the investigation already completed by HMPPS or the Home Office was a fair one. It is not for the PPO to carry out the investigation for them and in 2024 to 2025, we pushed back 170 complaints received.

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2 Correct as of May 2025.

Fatal incident investigations have continued the trend of making fewer recommendations but at a more strategic level and in a more impactful way in 2024 to 2025. The fact that HMPPS now routinely use their own CCTV systems to ensure processes designed to ensure prisoner safety are carried out correctly is a direct result of the work of fatal incident investigations. They have also embedded efficient processes for the more rapid dissemination of learning from investigations back into the services in remit at an earlier stage, and our learning function has hugely stepped up the output provided to them this year.

Our thematic work on property complaints has led to recommendations that, if implemented, will lead to a reduction in our area of greatest demand. Along with the increase in learning lessons bulletins, we have increased the number of channels through which we can communicate examples of both poor and good practice that we find in our investigations more rapidly and regularly. This substantial increase in productivity has been achieved without increasing resource, which is worthy of recognition. I can confidently say that HMPPS are extremely engaged in these new forms of communication because they tell us monthly that our messaging is right at the top of their inbox.

Operation Deerness, the PPO's review into the physical and sexual abuse that occurred at Medomsley Detention Centre between 1961 and 1987, is drawing to a close. I intend to deliver my report later this year. It would be premature to allude to any of the findings at this moment in time, but I can put on record my continued gratitude to the whole of the investigative team who have been forced to confront truly horrific details throughout their work.

> "
>
> The pages that follow … outline not only the challenges but also the successes we have had in raising standards of safety and fairness for the services in remit.

It is hoped that the publication of the Independent Sentencing Review will have a positive impact on prison capacity. I am acutely aware that crowding in prisons results in more restrictive regimes, making the delivery of time out of cells to work and engage in rehabilitative activity more difficult. This has a knock-on negative effect on prisoners' mental health and increases the risk of suicide and self-harm, and I welcome any steps taken to significantly create capacity within the system. I also eagerly anticipate the results of the renegotiation of the contract for the provision of prisoner phone calls I have spoken so many times about publicly. Contact between prisoners and their loved ones is so vital for reducing reoffending and maintaining positive mental health. The current system has considerable room for improvement.

We will continue to contribute evidence that will improve how prisoners with chronic health conditions access care. I have long been concerned that epilepsy in particular is an area of risk that would benefit from greater focus and understanding. I plan to do more work on this area and I hope to report on this in the next annual report.

The work of the PPO should contribute to public confidence in the fairness and safety of the criminal justice system. However, as I said earlier, we never lose sight of the fact that our work has a real impact on the lives of individual people. I believe it is important that those people also have an impact on how we do our work.

I would like to thank all those people who have helped us shape our priorities and our processes. I thank prisoners and those in immigration detention, prison and probation staff at all levels, the hundreds of bereaved family members who I have spoken to, the charities, members of the press, peers and politicians, NHS England and healthcare professionals, concerned members of the public, and many others who have given up their time to educate myself and my staff on countless issues with the aim of seeing positive changes at the PPO.

The last word should go to my staff. None of the achievements outlined in this report would have been possible without the support of my three deputies and all of those at the PPO who work with passion and dedication towards our shared aims. I am grateful to them and am incredibly proud of the impact we have had in challenging times.

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We never lose sight of the fact that our work has a real impact on the lives of individual people. I believe it is important that those people also have an impact on how we do our work.

The year in figures

Complaints

In 2024 to 2025 we received **5,267 complaints**, an increase of 15% compared to last year. Of these:

5,100
were about prisons, 755 more than last year

160
were about probation services, 59 fewer than last year

4
were about immigration removal centres, 5 fewer than last year

3
were about secure training centres, 1 more than last year

We sent out
5,991
eligibility letters to complainants in 2024 to 2025,* a 21% increase compared to last year

In 2024 to 2025, we started investigations into
2,112
cases compared to 2,046 cases in the previous year, an increase of 3%

In 2024 to 2025, we pushed back
170
cases received to the relevant establishment. Of these cases, 81 were resolved and 89 were returned

*Timeliness for these letters is unavailable due to ongoing work with a new case management system. However, a process for calculating assessment timeliness has been established and will be officially implemented in the 2025 to 2026 business year. Refer to the 'About the data' section for definitions of eligibility, upheld and not upheld cases.

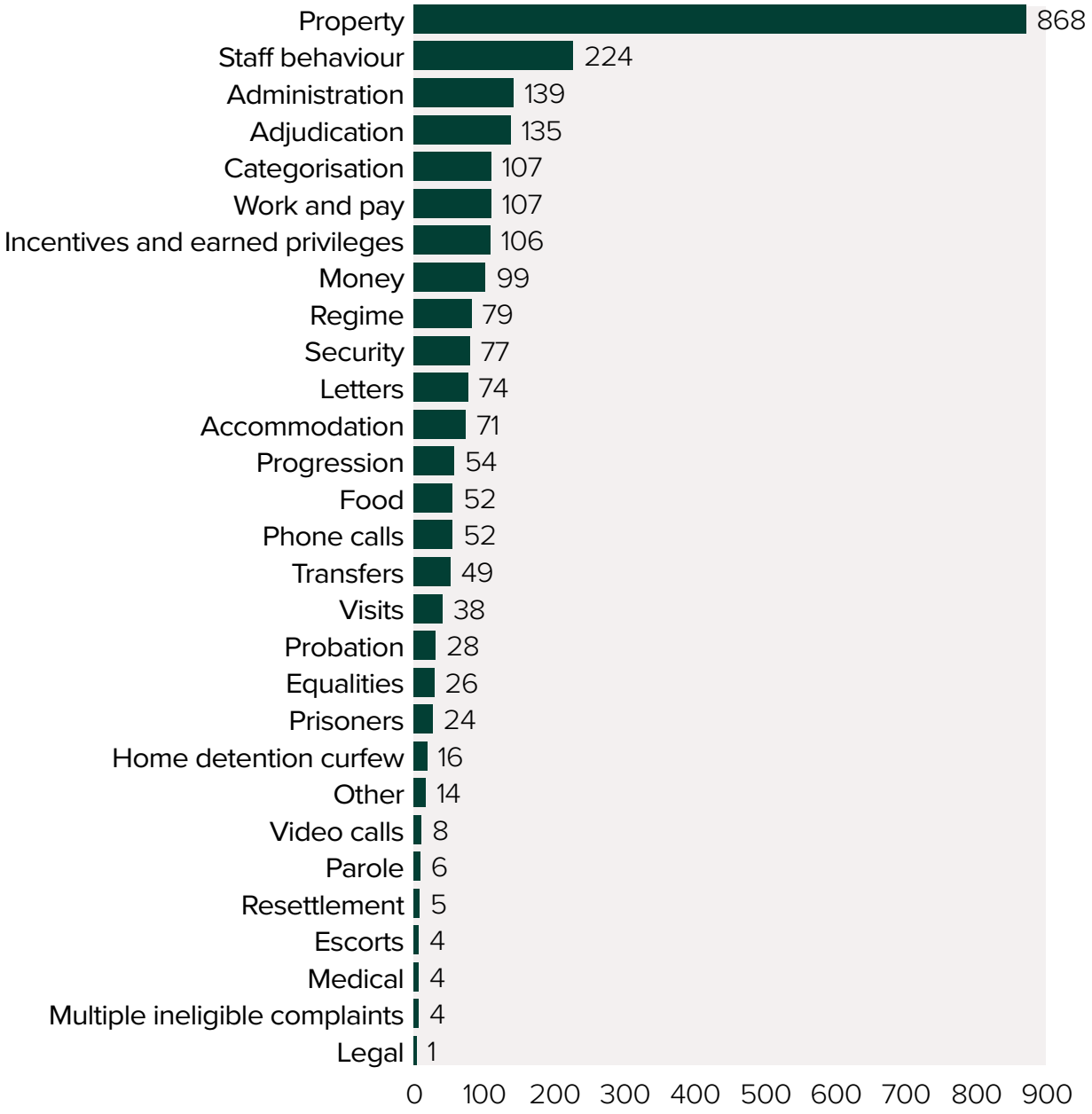
In 2024 to 2025, we completed **2,471 investigations** compared to 1,830 in the previous year, an increase of 35%. Of these:

†This timeliness metric does not include one suspended case and 202 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 closed in 2024 to 2025:

Complaints completed in 2024 to 2025 by category



Fatal incidents

In 2024 to 2025, we started investigations into **486 deaths**, a 35% increase compared to the previous year. We began investigations into:

256 **deaths from natural causes,** 67 more than last year

100 **self-inflicted deaths,** 1 less than last year

86 **other non-natural deaths,** 20 more than last year

However, it is important to note that at the time of writing, there are 36 deaths awaiting classification (which tend to be classified as other non-natural)

5 **apparent homicides,** 3 more than last year

3 **unascertained deaths,** 2 more than last year

Of the **486 deaths** in 2024 to 2025, the location of investigations started consisted of:

398 **deaths in prisons,** 106 more than last year

73 **post-release deaths,** 20 more than last year

12 **deaths of residents living in probation approved premises,** 2 more than last year

1 **death of a resident of the immigration removal estate,** the same as last year

2 **discretionary cases:**

- The death of an individual that occurred in the Isle of Man Prison
- The death of an individual who was found to be unresponsive while in a vehicle being transported from Reading Magistrates' Court to HMP Bullingdon

Fortunately, this year, we began **no investigations of fatal incidents in the Children and Young People's Secure Estate,** equal to last year.

This year we issued **412 initial reports and 417 final reports,** compared to 441 initial reports and 434 final reports last year.

In 2024 to 2025:

71%

of initial reports were on time, compared with 40% last year

67%

of final reports were on time, which is the same as last year

21 weeks

was the average time taken to produce an initial report for a natural cause death. For all other deaths it was 33 weeks

853

fatal incident investigation reports had not been published on our website as of 31 March 2025

This includes:

- investigations where we have not issued a final report and we are still investigating
- cases where we have issued the final report, but we are awaiting notification that the coroner's inquest has concluded before publishing the report
- a small number of reports waiting to be published

506

recommendations were made by the PPO following deaths in custody, of which:

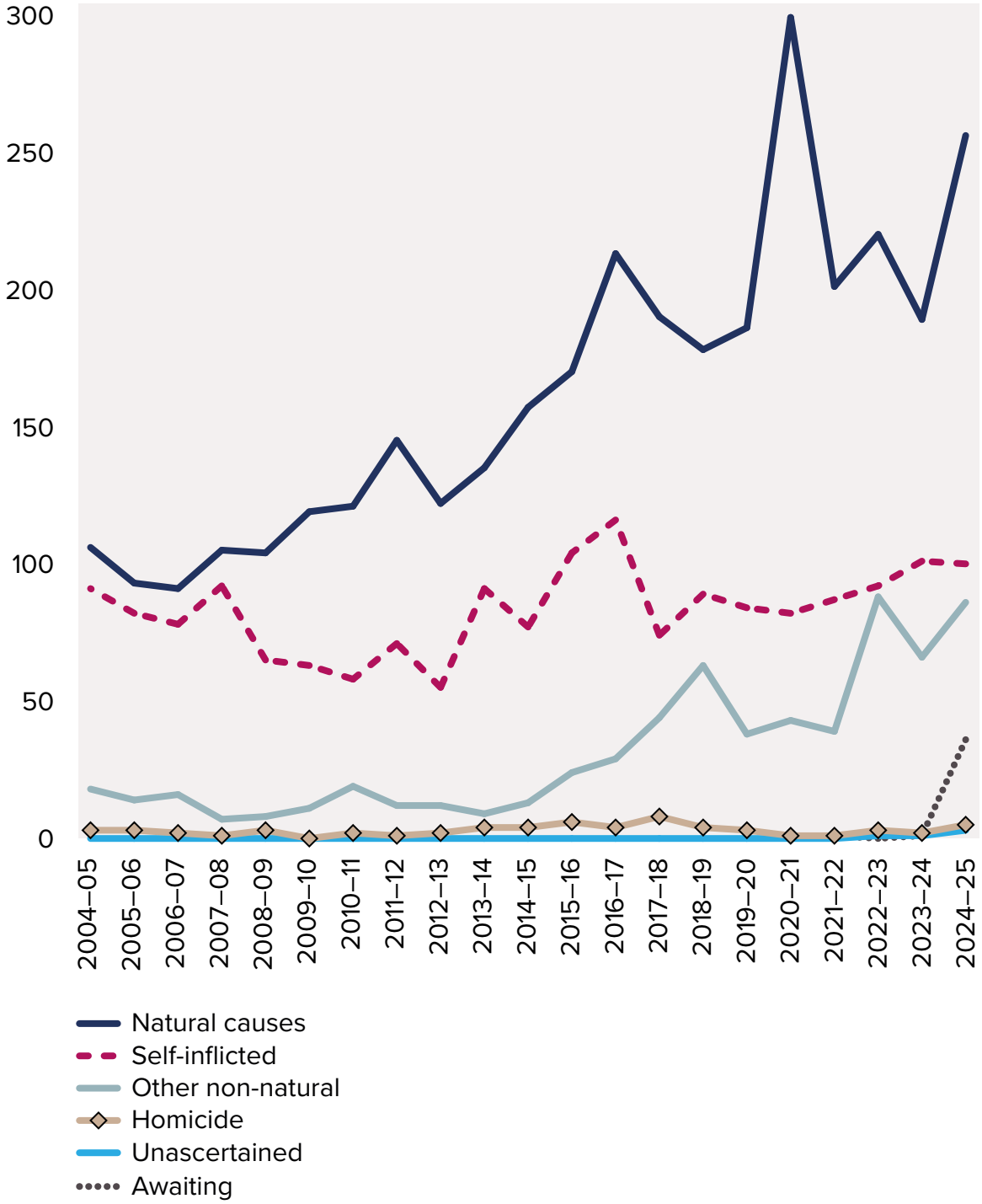
165 healthcare provision

62 general administration

62 suicide and self-harm prevention

37 emergency response

Fatal incidents investigated




FIRE
EXIT

Investigating complaints

Independent Prisoner Complaint Investigations

Miriam Minty
Deputy Ombudsman for Complaints and Director of Independent Prisoner Complaint Investigations

It's been a busy year for our complaint investigation and assessment teams. Following the successful launch of IPCI in November 2023, we have continued to promote it widely to prisoners and prison staff.

We developed IPCI to raise awareness of the complaints investigation work we do for prisoners, and importantly to address the large proportion of ineligible complaints we receive.

This continued to be a large focus for us in 2024 to 2025. We visited all 122 prisons in England and Wales to speak to prisoners and staff directly about what IPCI does, and how and when to use us.

We have seen some positive outcomes of this work including:

- increased correspondence from prisoners, from 500 to 800 pieces of correspondence received per month
- increased use of the newly created IPCI form helping prisoners to summarise their complaint and reminding them to use local processes first
- an increased number of complaints received – 755 more complaints were received from prisons this financial year

Other positive outcomes of this work included developing strong working relationships with business hubs in prisons. This has been particularly helpful when mediating cases. Our investigators can pick up the phone and speak directly to staff they know. These staff now know who we are, and why what we are asking for is important. This speeds up the whole complaints process, leading to quicker resolution.

Improving our timeliness

Prisoners often tell us that waiting for a response to their complaints takes too long. By the time they have navigated local complaints processes, they have already waited a number of weeks.

Earlier this reporting year, with tackling the COVID-19 backlog and our focus on launching IPCI, we were taking longer to investigate cases. The launch, and our awareness-raising work in prisons and prison press, saw us receive a large increase in letters from prisoners.

As Adrian mentioned in his foreword, during the summer of 2024, our teams worked hard to reduce the backlog of complaints and ensure that post received was assessed in a timely way. We worked hard this year to also speed up our assessment and investigation processes, balancing our responsiveness with the need to investigate matters thoroughly. This focus on timeliness has shown positive results and we are now typically assessing prisoner post within 72 hours, with our overall case timeliness increasing from 55% in the last financial year to 66% this financial year.

IPCI ambassadors

On the first anniversary of IPCI in November 2024, we took the opportunity to further promote our complaints investigation work through prison press and to announce plans to go further on tackling ineligibility. This included the launch of the IPCI ambassadors programme, recognising the valuable role that prisoner volunteers play in understanding local complaints processes and signposting others.

The IPCI ambassadors scheme aims to equip these volunteers with clear information about HMPPS complaints processes and how and when to use IPCI.

The scheme went live in 20 prisons in November 2024, and by the end of the reporting year there were 47 prisons with IPCI ambassador schemes.

We provided our ambassadors with information to help them undertake their roles, including a flowchart to navigate the internal complaints process and translated materials for those who do not speak English as a first language. We are monitoring the impact of the scheme and will report on this in next year's annual report.

IPCI Ambassador

Ensuring prisons investigate complaints properly first

In last year's annual report, I talked about our work with prisons to drive up the quality of their handling of prisoner complaints. Getting things sorted quickly, and locally, is the best outcome when things have gone wrong for prisoners.

When we assess prisoner complaints, we want to be assured that the prison has conducted a thorough and timely investigation first. Where this isn't the case, we have been pushing the complaint back to the prison, letting them know why the investigation wasn't sufficient and asking for quick remedial action. We let prisoners know this is happening and we will pick the case back up if their issue is not resolved following further attention from the prison. In the 2024 to 2025 business year, we pushed back 3% of complaints received, of which 81 were resolved.

Equally, in recognition that we are a publicly funded service, we are taking a proportionate approach to our work. Where we feel the matter can be resolved quickly by early engagement with the prison and/or a mediated approach, we will do so.

If we feel there is little to be gained from a lengthy investigation of a matter, we now let prisoners know. By deploying this proportionate approach, we can ensure our investigative resource is focused where it's needed and where we will get the best outcomes for prisoners.

Getting things sorted quickly, and locally, is the best outcome when things have gone wrong for prisoners.

Confidence in complaints processes for others in our remit

The PPO's remit includes oversight of complaints for those under community supervision (on probation) and in immigration removal centres (IRCs). Historically, for both, we receive significantly fewer complaints. Probation complaints had a higher proportion of complaints being ineligible for us to look into.

We recognised differences in the experiences of prisoners and those on probation or in IRCs, but we wanted to be assured that these service users understood:

- how to use local complaints processes
- the role the PPO plays in the complaints process
- how to contact us if they do want our help

We wanted to identify any barriers and consider what more we, and the services in remit, could be doing to improve practice and processes.

Deep dives

We undertook a series of visits to IRC and probation offices around the country, holding focus groups with staff and service users. Early findings of the deep dive focused on three key areas:

- **knowledge** – both of local processes and the role of the PPO in the complaints process
- **confidence** – concerns about confidentiality, fear of repercussions and the impact of making complaints on their status
- **processes** – were noted as complicated, hard to navigate and lengthy

Next steps

We will continue to analyse our findings from these deep dives in 2025 to 2026 and use these to develop recommendations and options for potential improvements.

Looking forward to the new reporting year

Driving down ineligibility

We will continue our targeted work on driving down ineligibility, as we know prisoners spend time and effort in getting their complaints to us and find it disappointing and frustrating when their complaint isn't eligible for us to investigate. Most of the time this is because they haven't followed the local complaints process first.

In the next reporting year we will be working with prisons that have the highest level of ineligible complaints to ensure prisoners and staff in those prisons understand the complaints escalation process. We will work alongside staff in considering the effectiveness of local processes and raising further awareness of IPCI.

Young people and women

Following on from the successful targeted work we did to raise awareness of IPCI in women's prisons and the youth estate in 2023 to 2024, we are taking this work further next year. This will see us continuing to be more visible in women's prisons and the youth estate and working collaboratively with HMPPS and third-party stakeholders to identify and address specific challenges for prisoners.

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In the next reporting year we will be working with prisons that have the highest level of ineligible complaints to ensure prisoners and staff in those prisons understand the complaints escalation process.

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 sometimes 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.

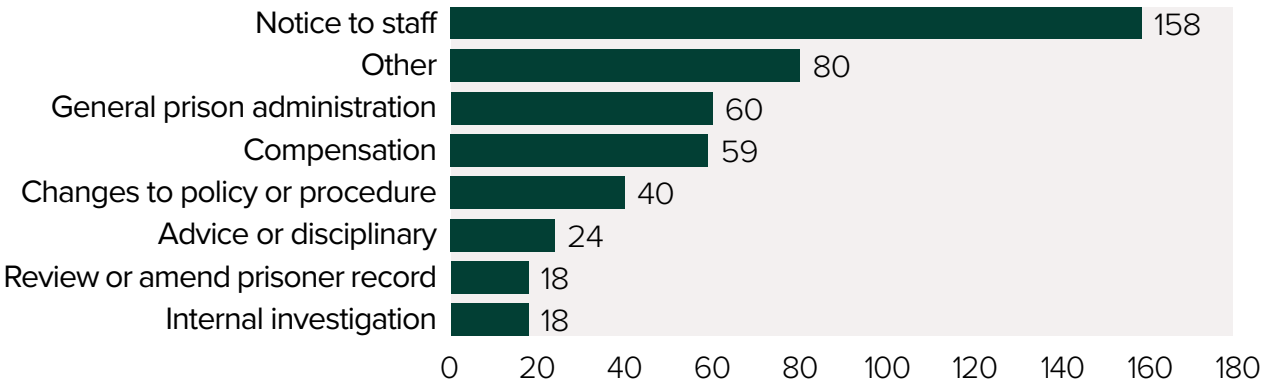
When a recommendation is made after a complaints investigation, the organisation must confirm whether they accept any recommendations and must provide evidence of implementation. In cases where the service in remit does not accept a recommendation, the director general operations at HMPPS must inform 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 2024 to 2025, we made 457 recommendations across 184 cases, with an average of 2.5 recommendations per case. At the time of writing, we are awaiting a response to 11 of these recommendations. 434 have been accepted. We have received evidence that 95% of these have been implemented.

Complaint recommendations, by action (2024 to 2025)



Investigating fatal incidents

By Susannah Eagle
Deputy Ombudsman for Fatal Incidents

In this reporting year, the fatal incident investigations function has focused on increasing the impact of our investigations and embedding the changes Adrian introduced when he took up post, while also dealing with an increase in reported deaths.

The change in approach to recommendations has been widely welcomed by stakeholders. This year we made 506 recommendations, demonstrating our continued commitment to addressing systemic and endemic issues. Many of our recommendations call for governors and directors to ensure they have robust quality assurance processes in place to drive improvements in the delivery of processes such as ACCT (the case management model to support people in prison or young people at risk of suicide and self-harm). Senior leaders in HMPPS should have in place the means to identify policy and practice failures to prevent deaths, rather than in the wake of a death.

“

This year we made 506 recommendations, demonstrating our continued commitment to addressing systemic and endemic issues.

The falsification of records

Our approach to investigating issues that appear to be systemic is also developing. This year, we have been disappointed to identify widespread falsification of records by staff, particularly relating to ACCT checks (intended to provide support to and monitoring of prisoners considered at risk of suicide and self-harm) and routine checks which also serve as an opportunity to check on prisoners' welfare.

In one case, a review of CCTV on the wing where the prisoner died identified that staff had falsified his ACCT document, recording that they had conducted checks when they had not. We requested a wider sample of CCTV from other wings across the prison to establish if there was a systemic issue of falsification. Our investigation identified that the issue was contained to the wing where the prisoner died and did not appear to be widespread.

In exercising our unfettered access to material, we have made clear that investigations into the circumstances of a single death may involve a broader review of available evidence in line with our terms of reference.

We were very pleased that Phil Copple, Director General of HMPPS at the time, not only supported our approach but instructed governors and directors to build reviewing CCTV evidence into their own quality assurance processes.

We remain deeply concerned about the prevalence of record falsification and have recommended that, in all but the most exceptional of circumstances, staff who have been found to falsify records should face disciplinary action.

Recommendations

We have made national recommendations this year, both identifying areas of concern and ensuring the spread of good practice. For example, we have recommended that all approved premises undertake a local investigation after a death, having found that one site conducted a swift and effective review, allowing them to make changes in advance of the PPO report.

In many cases, the prison's response to a local recommendation evidences the positive impact of the PPO investigation. In this reporting year, we issued a report on the death of a black man from a sickle cell crisis following restraint. The prison and healthcare provider's responses to the recommendations we made were positive, imaginative and clearly committed to driving improvement locally. The action plan highlighted excellent collaboration with local partners, including a sickle cell charity. We used our communication channels to share this example of good practice widely with HMPPS senior leaders.

Cluster site deaths

We have reviewed our internal processes when a number of deaths (particularly self-inflicted or apparently drug-related) happen at the same prison. In these cases, the value is clear of identifying systemic issues quickly, and briefing governors, directors and other colleagues in HMPPS to allow for prompt action to be taken. At the end of the last reporting year and into the beginning of this reporting year, five prisoners at HMP/YOI Parc died within the space of a few months and their deaths were all linked to substance use (we await the formal cause of death following inquest in some of the cases). Some involved the use of nitazenes, a synthetic opioid. As Ombudsman, Adrian took the unusual step of making a public plea to prisoners at HMP/YOI Parc to dispose of any drugs they had in their possession. PPO investigators with cases at the prison worked together to ensure joint interviews were conducted where appropriate and learning was shared to inform subsequent investigations. It is important that we not only reduce any emotional and administrative burden on staff but also maximise the opportunity for early learning and improvement.

Post-release deaths

We have maintained momentum with post-release death investigations after the publication of the second learning lessons bulletin.[3] The focus is now on how we can ensure that, in investigating deaths within 14 days of release, the PPO can have maximum impact. Drawing on the success of the emergency response roundtable

3 Prisons and Probation Ombudsman (2024). Learning lessons bulletin: Post-release death investigations 2. Available online at: **https://ppo.gov.uk/learning_research/learning-lessons-bulletin-issue-19-post-release-death-investigations-2/**

meeting we hosted in early 2024 (and reported on in last year's annual report), in March 2025, we brought together key stakeholders for a two-day symposium jointly hosted with HMPPS colleagues, focusing on accommodation and substance misuse issues in post-release deaths. The event enhanced collaboration and encouraged a problem-solving approach to some of the key issues our investigations pointed out. We are hopeful that the actions identified will be taken forward by partners and embedded over the coming months.

Collaboration with stakeholders

Collaboration has also been key in our focus on deaths from long-term conditions, such as epilepsy. Having identified what appeared to be a surprisingly high number of deaths of adult male prisoners from epilepsy, we have begun work with colleagues in NHS England to consider how the learning from our investigations combined with clinical expertise might lead to better guidance for HMPPS and healthcare staff in prisons on managing men with long-term conditions.

This reporting year, we have continued work with NHS England colleagues to drive consistency and quality in clinical reviews. The clinical review forms a key part of the PPO investigation, and it is vital that commissioners and clinical reviewers keep pace with changes in approach at the PPO.

In November 2024, we supported a learning event for NHS commissioners to clarify the process governing clinical reviews and worked with NHS England to update the guidance for clinical reviewers. In March 2025, the updated guidance was launched at a second event for clinical reviewers.

Improving investigation timeliness

Maintaining a focus on clinical reviews is important in the face of increased demand. April 2024 to March 2025 saw a 35% increase in deaths we began investigations into, compared to the previous financial year, with increases across all types of death (except self-inflicted deaths). However, we have continued to make inroads in our backlog of overdue cases. At the end of the reporting year, we had 15 overdue cases, with just two dating back to 2023 and six to 2024 – a considerably more positive picture than last year. We have increased the percentage of reports issued on time, with 85% of natural causes initial reports issued on time across the year, 63% of other non-natural initial reports and 53% of self-inflicted initial reports issued on time (but figures across the board were improving towards the end of the year). Improved timeliness in natural causes investigations has undoubtedly been a result of the streamlined report process we introduced in late 2023. In this reporting year, having evaluated the results of the pilot, we made the approach part of our business as usual.

We will continue to monitor incoming cases against staff resources. We remain committed to meeting our published timeliness targets while delivering investigative excellence that has impact and drives meaningful improvement across the services in remit.

Fatal incident recommendations

When we make recommendations in a fatal incident investigation, the service in remit must confirm where 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.

In 2024 to 2025, we issued 417 final investigation reports following deaths in custody and made recommendations in 205 of these cases.

We made 506 recommendations, with an average of 2.5 per case.

At the time of writing, most of our recommendations had been accepted (447) and we were awaiting the service response to 52 recommendations. Six of our recommendations were rejected: these all were by healthcare providers. The recommendations were rejected as clinical records showed appropriate care was provided in each case, including regular reviews, mental capacity assessments, timely referrals and up-to-date care plans. Each decision was based on documented evidence meeting required standards.

Health provision

Our recommendations about health provision highlighted the following issues:

- robust record keeping
- ensuring systems and guidance plans are in place
- following up on health tests, timely referrals and hospital appointments
- following National Institute for Health and Care Excellence guidance to manage health conditions, including thorough care plans and multidisciplinary case reviews
- accurate prescribing of medications, including conducting reviews of prescriptions and in-cell holds
- training of staff and making staff aware of the various types of assessments they must undertake in line with risk factors being presented
- reception and secondary health screenings taking place in line with national guidance
- information sharing between prison, healthcare and hospital staff

General administration

Recommendations about general administration highlight failures to meet guidelines and policy requirements in relation to prison systems, for example, failures to accurately record information:

- ensuring retainment of documents and providing them to the PPO in cases of a death in custody
- robust record keeping and information sharing
- addressing staffing shortages, staff training and staff support, and ensuring all staff understand various policies and services for prisoners
- adhering to, reviewing and amending policy frameworks when necessary
- ensuring staff manage prisoners held in segregation in line with national guidelines
- conducting roll checks at prescribed times and monitoring the challenging of blocked observation panels

Emergency response

Staff should understand their responsibilities during a medical emergency. These include:

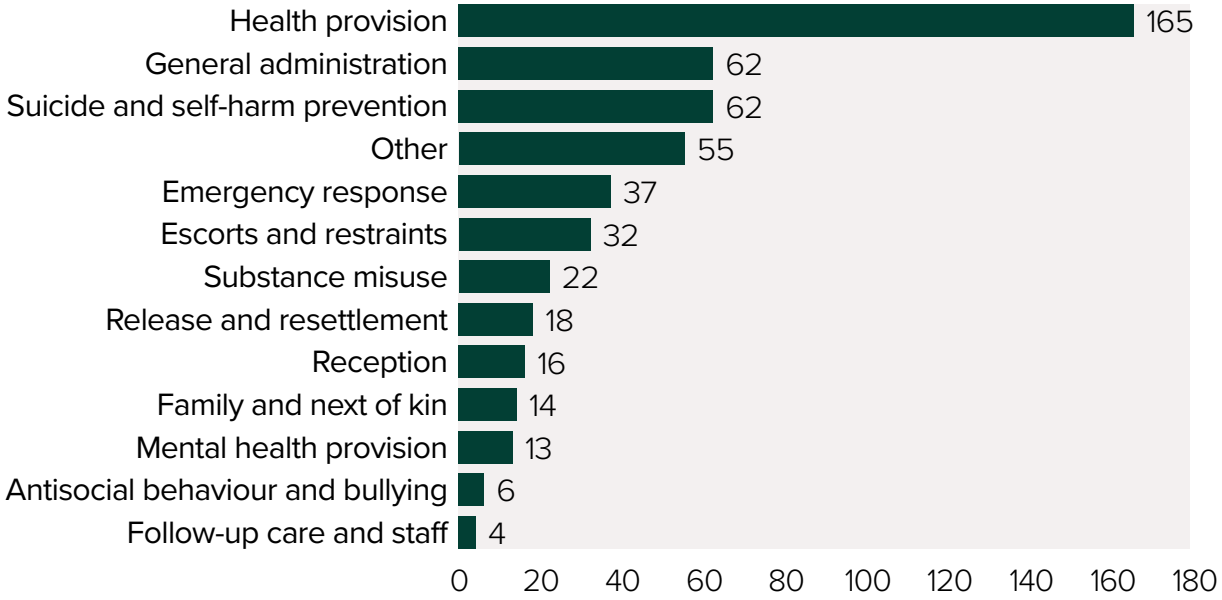
- radioing the correct emergency code immediately
- ensuring the control room calls an ambulance immediately and communicates all relevant information to the paramedics
- carrying and having access to the correct equipment, including emergency bags and radios
- being aware of the location of defibrillators and how to access them during an emergency
- being aware of the circumstances in which resuscitation is necessary
- satisfying themselves of the wellbeing of all prisoners during roll checks

Suicide and self-harm prevention

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

- assessing the level of a prisoner's risk of suicide and self-harm based on all known risk factors and not only on a prisoner's presentation
- staff managing prisoners at risk of suicide and self-harm in line with the national policies and guidance
- reviewing training provided to staff on assessing risk of suicide and self-harm
- opening an ACCT where there are risk factors, including if an ACCT is not open, and documenting the risk information considered and the reasons for not starting ACCT procedures
- attending case reviews, which should be thorough and multidisciplinary where needed
- carrying out meaningful welfare checks, including after court appearances, and observations at the agreed frequency
- reviewing and amending policies when necessary

Recommendations following death by category (2024 to 2025)




Chaplaincy
Centre
Fire exit
Keep clear

Operational learning and impact

Kimberley Bingham
Deputy Ombudsman for Learning, Analysis and Business Services

This year, the learning, analysis and business services (LABS) function has continued to draw on the PPO's casework to uncover thematic issues to bring to the attention of services in remit and other key stakeholders.

We did a deep dive into prison property complaints, conducted further analysis into our investigations of post-release deaths, provided evidence to HMPPS on the delays in prison emergency response procedures, and contributed to several inquiries.

Property has long been the most common prisoner complaint category investigated by the PPO and we wanted to examine it more closely to understand the issues and present recommendations for change.

Our LABS researchers, with input from a focus group of complaints investigators, looked at the PPO's property complaints received from prisons over the past five years, completing both qualitative and quantitative research. Our research highlighted that most issues occurred during cell clearances and prison-to-prison transfers. When issues did arise, some prisons didn't investigate complaints properly or swiftly, leading to escalation to the PPO and frustration for the complainant.

We published a learning lessons bulletin on property handling.[4] This set out our findings in detail and we also recommended operational improvements and policy changes which we believe would reduce the issues with property in prisons. We also published two policy into practice publications which are aimed at operational staff.[5,6] The publications discussed repeat issues we see where staff fail to handle property or property complaints appropriately and in line with policy requirements.

4 Prisons and Probation Ombudsman (2025). Learning lessons bulletin: Property complaints. Available online at: **https://ppo.gov.uk/learning_research/learning-lessons-bulletin-issue-11-property-complaints/**

5 Prisons and Probation Ombudsman (2025). Policy into practice: Handling of prisoners' property. Available online at: **https://ppo.gov.uk/learning_research/policy-into-practice-handling-of-prisoners-property/**

6 Prisons and Probation Ombudsman (2025). Policy into practice: Handling of property complaints. Available online at: **https://ppo.gov.uk/learning_research/policy-into-practice-handling-of-property-complaints/**

In September 2021, the PPO started to investigate deaths within 14 days of release from prison and in 2023, we published our early findings from those investigations.[7] In 2024, we did further research to understand more about these cases and the additional cases since the first publication.[8] We found that homelessness on release was a considerable issue in our investigations. During the period we researched, a stark 32% of people who died within two weeks of release had been released homeless. Just over 50% of people who died within two weeks died within the first four days of release, highlighting the acute vulnerability of prison leavers immediately after release. The research also highlighted that substance misuse issues are a significant factor of post-release deaths. Of the people who died within the first four days of release, 72% died of substance misuse. The PPO will continue to raise this issue with HMPPS.

In January this year, we published a policy into practice paper on emergency response in prisons.[9] The publication highlighted some changes to emergency response procedures and important policy requirements in the National Security Framework. It also summarised cases which illustrate the recurring issues we see in prisons' emergency responses.

We also fed our knowledge on emergency response procedures in prisons into the Home Office's consultation on emergency response in IRCs, providing information on how prisons respond to emergencies.

The LABS team contributed to policy consultations throughout the year. Working with the PPO's fatal incident investigations team, we provided feedback to the HMPPS Women's Group on their proposal to strengthen governance around the use of anti-ligature clothing for women. We also helped share learning from fatal incident investigations with the HMPPS segregation policy team to suggest changes to the segregation health screen, so it better considers a prisoner's physical conditions. At the time of writing, HMPPS is currently considering these changes with healthcare staff. We also provided feedback on the draft Prevention of Escape – External Escorts Policy, providing practical advice on the risk assessment forms and re-emphasising the importance of the Graham judgement.

We provided the call for evidence to the Independent Sentencing Review with data on self-inflicted deaths we have investigated in the past two years by sentence length. We also responded to the Justice Select Committee's inquiry into rehabilitation and resettlement services, criticising the current provision of phone call minutes to prisoners and flagging our concerns with licence recall conditions and the drastic increase in the recall prison population. We responded to the Justice and Home Affairs Committee's inquiry into

7 Prisons and Probation Ombudsman (2023). Learning lessons bulletin: Post-release death investigations. Available online at: **https://ppo.gov.uk/learning_research/learning-lessons-bulletin-issue-17-post-release-death-investigations/**

8 Prisons and Probation Ombudsman (2024). Learning lessons bulletin: Post-release death investigations 2. Available online at: **https://ppo.gov.uk/learning_research/learning-lessons-bulletin-issue-19-post-release-death-investigations-2/**

9 Prisons and Probation Ombudsman (2025). Policy into practice: Emergency response. Available online at: **https://ppo.gov.uk/learning_research/policy-into-practice-emergency-response/**

prison culture, highlighting the current lack of training for officers and senior leadership. We also provided evidence to the Justice Select Committee's inquiry into tackling drugs in prison, raising our concerns about synthetic opioids and the increased use of drones to bring drugs into prisons.

The LABS team evaluated the launch of IPCI, one year on. This project aimed to understand the impact that the first year of the rebrand has had on prisoner complaints, the views and experiences of prisoners and prison staff, and the views and experiences of PPO staff through analysis of quantitative data as well as focus groups and surveys.

The team also led the production of the PPO's published race action plan, which sets out our aspirations to invest more resource into ensuring race-related issues are better considered within our casework and allows stakeholders to hold us to account. We worked with staff in the PPO and stakeholders in HMPPS and the Independent Office for Police Conduct to determine achievable aims. The PPO has developed a framework for handling issues of race equality that might emerge in our fatal incident investigations.

Our complaints investigators have also started to record any race-related issues on our case management system when investigating complaints. We have looked at PPO investigation outcomes for minority ethnic prisoners and found that there is no disparity based on race. We have also put in place procedures to improve the accuracy of our race data so we can use it more confidently for our evidence-based analysis of outcomes for different groups.

Alongside our outward facing work, the LABS team supports the PPO's internal processes to help make the organisation perform at its best. This year, LABS researchers and a cross-PPO working group undertook a comprehensive learning needs analysis. We have been implementing the findings, producing a tangible, relevant set of learning offers for staff across the organisation using a new learning and knowledge hub platform.

Our new knowledge strategy, also produced this year, complements this work, making it more straightforward for the PPO to retain and share information which in turn helps our investigators deliver their work more effectively.

The LABS team has embedded the process for asking coroners for inquest results. This more systematic approach allows us to publish our anonymised fatal incident reports more swiftly. We have also improved our approach to transcribing, improving the quality of our transcripts and, ultimately, improving what is seen by families, services in remit and coroners.

The LABS team also supports the PPO in responding to all freedom of information and subject access requests. In 2024 to 2025, we have promptly responded to 91 freedom of information requests and 117 subject access requests, which ensures that we meet our data protection obligations and provide information and personal data to our requesters.

We have also made it easier for operational staff to make better use of data. Our new suite of data dashboards presents our case information in a simpler way. This has allowed the office to be more engaged with the data we hold, giving the opportunity to spot trending issues and manage their workload.

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 the feedback, the PPO runs four rolling stakeholder surveys:

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

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 fatal incidents and complaints.

We received 87 responses in 2024 to 2025, compared to 86 responses in 2023 to 2024.[10] The survey ran throughout March 2025 and responses came from prisons (including operational staff, non-operational staff, business staff and other services such as chaplaincy), probation, healthcare services, MOJ, HMPPS, and others such as academics and the third sector.

Overall satisfaction

- 77 of the 83 respondents who had some experience of the PPO's investigations in the past year rated the overall quality of their experience as satisfactory or better.

Reports

- Of the 53 respondents who had read PPO reports (complaints, fatal incidents or both), 44 found these reports to be very clear or quite clear.
- 44 of the 87 respondents who answered the question found anonymised fatal incident reports very useful or quite useful.
- Regarding the research and policy publications the PPO released this year, 59 of the 87 respondents who answered the question found the learning lessons bulletin on post-release death investigations very useful or quite useful.
- 48 of the 87 respondents who answered the question found the policy into practice publication on emergency response very useful or quite useful.

Our website

- 64 of the 87 respondents who answered the question said they had visited the PPO website in the last 12 months.
- 58 of the 63 respondents who answered the question said they found it very easy or quite easy to find what they were looking for on the website.

10 We include partial survey responses only where sufficient information has been provided (please see the 'About the data' section for more detail). This is also the case for the post-investigation surveys.

Impressions of the PPO

- Of the 87 respondents who answered the question, 52 agreed we were 'diverse and inclusive', 59 agreed we were 'ambitious thinkers', 60 agreed we were 'teamwork-oriented', 66 agreed we were 'professionally curious' and 65 agreed we were 'transparent'.

Post-investigation survey

Following each fatal incident investigation, we send our post-investigation survey to prison liaison officers, establishment heads and healthcare leads within the establishment. We ask that these stakeholders respond to the survey about specific investigations. We also survey coroners at the end of the year about their overall experiences with fatal incident investigations.

We received 147 responses (from 636 surveys sent) in 2024 to 2025. This is a 29% decrease from last year, when we received 208 responses (from 560 surveys sent). We received responses from liaison officers, establishment heads, healthcare leads and coroners.

Overall satisfaction

- 85% of respondents (of the 147 who answered the question) rated the quality of the investigation as satisfactory or better.
- 88% of respondents (of the 147 who answered the question) rated the quality of the communication with the PPO as satisfactory or better.
- 79% of respondents (of the 147 who answered the question) rated the time it took the PPO to complete their investigation as satisfactory or better.

Reports and recommendations

- 84% of respondents (of the 147 who answered the question) stated the report we issued met their expectations.
- 92% of respondents (of the 128 who answered the question) stated that the PPO report contained about the right amount of detail.
- 89% of respondents (of the 119 who received recommendations and answered the question) said they found the recommendations made by the PPO very worthwhile or quite worthwhile.

Impressions of the PPO

- Of the 136 respondents who answered the question, 76% agreed we were 'ambitious thinkers', 80% agreed we were 'professionally curious' and 88% agreed we were 'transparent'.[11]

Bereaved families' survey

We also send surveys to families or the next of kin of the deceased following our investigations of deaths in custody. A questionnaire is usually sent to bereaved families three months after the final investigation report is issued. Please see the 'About the data' section for further details.

We have received 16 responses (from 161 surveys sent) during this data collection period, compared with 25 responses (from 177 surveys sent) in 2023 to 2024. This includes substantial partial responses.

Overall satisfaction

- 9 of the 16 respondents who answered the question felt that the overall quality of the PPO's investigations was very good or good. 5 deemed it poor or very poor.

11 This includes those who agreed and strongly agreed.

- 8 of the 16 respondents who answered the question felt satisfied or very satisfied with the PPO's communication. 5 felt dissatisfied or very dissatisfied.

Reports

- 7 of the 15 respondents who answered the question felt the initial (draft) report met their expectations.
- Of the 15 respondents who answered the question, 7 thought there was about the right amount of detail, with 7 respondents thinking there was not enough.

Impressions of the PPO

- Of the 16 respondents who answered the question, 9 agreed we were 'ambitious thinkers', 9 agreed we were 'professionally curious' and 11 agreed we were 'transparent'.[12]

Complainants' survey

We send surveys to a sample of those whose complaints we have investigated in the past year – both upheld and not upheld complaints. We also sample those who have contacted us, but whose complaints were ineligible. A questionnaire is usually sent to complainants two months after the case has been closed, to allow for a rest period where any potential final changes may be made.

We received 214 responses (from 800 surveys sent) in 2024 to 2025, in comparison with 348 (from 889 surveys sent) in 2023 to 2024.

- 70 responses came from those whose complaints were ineligible. These complaints were not investigated, and the complainants received letters explaining why.
- 144 respondents had eligible complaints. 66 had their complaints upheld or partially upheld, and 78 had their complaints not upheld.[13]

Complaint handling

Previously during the COVID-19 pandemic, the PPO agreed with HMPPS that complainants could get free photocopies of their complaint forms.

- 53% of respondents whose complaints were upheld (of the 64 who answered the question) said they were able to get free photocopies of their complaint form.
  - 42% of respondents said they could not, and 5% said they did not know.
- 42% of respondents whose complaints were not upheld (of the 78 who answered the question) said they were able to get free photocopies of their complaint form.
- 37% of respondents whose complaints were ineligible (of the 68 who answered the question) said they were able to get free photocopies of their complaint form.

Quality of investigation and service

- 58% of respondents (of the 65 who answered the question) whose complaints were upheld rated the quality of investigation as either satisfactory or better.
- Of those whose complaints were not upheld, 29% of respondents (of the 77 who answered the question) rated the quality of investigation as either satisfactory or better.

12 This includes those who agreed and strongly agreed.

13 Please see the 'About the data' section for definitions of an eligible, upheld and not upheld case.

- For those whose complaints were ineligible, we asked their opinion about the overall quality of the service they received. Of the 66 who answered the question, 30% of respondents rated the service they received as either satisfactory or better.

Reports and letters

- 88% of respondents whose complaints were upheld (of the 65 who answered the question) said they understood the report or letter they received. 5% of respondents stated they had not received a report or letter.
- 88% of respondents whose complaints we did not uphold (of the 74 who answered the question) said they understood the report or letter they received. 4% of respondents stated they had not received a report or letter.
- 61% of respondents whose complaints were ineligible (of the 67 who answered the question) said that our letter explaining why their complaint wasn't eligible was clear. 3% of respondents stated they had not received this letter.

Outcome

- 55% of respondents whose complaints were upheld (of the 64 who answered the question) stated that the PPO helped them with their complaint.
- In contrast, 14% of respondents whose complaints we did not uphold (of the 76 who answered the question) stated that the PPO helped them with their complaint.
- In addition, 27% of respondents whose complaints were upheld (of the 64 who answered the question) said they were satisfied with the time it took the PPO to complete their investigation.
- For those respondents whose complaints were not upheld, 18% (of the 77 who answered the question) stated they were satisfied with the time it took the PPO to complete their investigation.
- For those whose complaints were ineligible, we asked if they had done anything differently after contacting us. 30% of respondents stated they had (of the 63 who answered the question).
    - Respondents were asked what they were planning to do with their ineligible complaint. Of the 70 who answered the question, 21% said they would send it to a different body. 9% stated they would send it back to the PPO and 36% stated they would do nothing further.

Impressions of the PPO

- Of the respondents who answered the question, 36% agreed we were 'diverse and inclusive', 34% agreed we were 'professionally curious' and 40% agreed we were 'transparent'.[14]

14 This includes those who agreed and strongly agreed. There were different numbers of respondents who answered each question: 184 for diversity and inclusion, 208 for professional curiosity and 185 for transparency.

About the data

Statistical data tables can be found on our website with the report which will be published here: **https://ppo.gov.uk/corporate-publications/**. 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 has to be about something which is within our remit.

A complaint can be pushed back to the prison if we assess that 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 enquires 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, meaning we find the service in remit has acted contrary to their local and/or national policy, or otherwise inappropriately or unreasonably. Upheld cases comprise 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 2023 to 2024 was frozen in May 2024, while data for 2024 to 2025 was frozen in April 2025. 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 update and change.

The number of eligibility letters sent in 2023 to 2024 and 2024 to 2025 refers to letters of eligibility that the PPO sent to complainants in both eligible and ineligible cases. In some cases, the PPO sent multiple eligibility letters about the same case. This happens when a case does not initially meet the eligibility criteria but is later deemed to be eligible when we receive further information. This includes the number of eligibility letters prepared and not sent. This only happens in a small number of cases when we receive a complaint and we are unable to send the eligibility letter – for example, if we do not have access to the complainant's release address.

A completed case in 2023 to 2024 and 2024 to 2025 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 submitted within 26 weeks (130 working days) of accepting the complaint as eligible. However, we must sometimes suspend our investigations while we wait for key information, such as cell clearance certificates and property cards.

Timeliness calculations exclude the times when a case is suspended for reasons that are outside the PPO's control. We are continuing to explore ways to collect this data in the future.

Timeliness is calculated based on working days and excludes bank holidays. Prison population data is taken from the March 2025 (except for Dartmoor as it temporarily closed in July 2024, and the population has been given as an average for the financial year up until its closure) population bulletin published on GOV.UK: **www.gov.uk/government/publications/prison-population-monthly-prison-figures-2025**

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: This is 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 (suicide).

Homicide: This is where one person has killed another, irrespective of their level of intent.

Natural causes: This is 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 cases where the post-mortem has not ascertained a cause of death. This category also includes drug-related deaths where there is not enough evidence to classify them as a self-inflicted death.

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

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

COVID-19-related fatal incident investigation: This is a death in a person where COVID-19 is mentioned on the death certificate or post-mortem report. Deaths are recorded as COVID-19 from the outset of the investigation if there appears to be a COVID-19 element. If information provided later shows the death does not fit our definition, it will be re-categorised. It is important to note that death certificates are not always consistently filled in.

Fatal incident data was frozen in May 2025.

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.

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.

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.

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. This year, we included partial survey responses, only where sufficient information had been provided – where respondents had completed a minimum of five questions. In the previous two years, we included all partial survey responses in the data.

General stakeholder survey

The general stakeholder survey is an online survey that was 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 sent out at the beginning of March 2025, with a reminder email being sent two weeks later. The survey was then closed at the end of March 2025.

Bereaved families' survey

The survey is sent monthly to family members or next of kin who have been sent a final report three months previously. Survey results presented in this annual report are reflective of cases where a final report was issued in December 2023 to December 2024.

Complainants' survey

The survey is sent monthly to a sample of complainants who have had their complaints closed. This includes:

- a sample of eligible cases
- a sample of ineligible cases
- a sample of ineligible probation cases
- all eligible probation cases
- all eligible and ineligible cases from women
- all eligible and ineligible cases from those in IRCs
- all eligible and ineligible cases from those aged 21 and under

We send our surveys up to two months after the case has been closed, to allow for a rest period where any potential final changes may be made.

Survey results presented in this annual report are reflective of cases closed between February 2024 and January 2025.

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.

Post-investigation survey

The post-investigation survey is sent to PPO liaison officers (the prison officer who has been the main point of contact for the PPO investigator) once the draft report has been issued, and to establishment heads and healthcare leads after the final report has been issued. It is sent out at the beginning of each month, for the previous month.

The results presented include cases which had their reports issued between March 2024 and February 2025. It is also sent to coroners at the end of the financial year (March 2025) who have been involved in fatal incident investigations that had a fatal incident final report issued in 2024 to 2025, with a four-week allowance for completion. These results are then combined.

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 2025.

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 2025.

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

Performance against the 2024 to 2025 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

Launch of an IPCI video for prisoners and a good practice in handling complaints video for prison staff.

Development of further IPCI promotional material.

End of year update

IPCI staff visited all 122 prisons in the adult and youth custodial estate during the business year.

Visits included raising awareness with staff and prisoners, and engagement with the governor, senior team and business hubs.

We promoted the scheme through five advertisements and one article in Converse, three advertisements and one article in Inside Time, one article in Women in Prison's magazine, and an interview with the Ombudsman on National Prison Radio to reach prisoners through other channels.

The launch of IPCI has seen an increase of 755 in the number of complaints received this financial year.

Key deliverable

Launch IPCI ambassadors across the prison estate (a scheme where prisoners support others in effectively using IPCI).

Measure of success

The IPCI ambassador scheme launched with 10 pilot sites operating by the end of the second quarter, and the scheme expanded to 47 sites by the end of the business year.

End of year update

In November 2024, the PPO launched IPCI ambassadors in 20 prisons across England and Wales.

A second wave of IPCI ambassador areas was rolled out in March 2025 with a further 27 prisons signing up. This means that IPCI ambassador schemes are now in nearly 40% of eligible prisons.

Key deliverable

Carry out a programme of visits to IRCs and run workshops with detained individuals to raise awareness of the PPO complaints process and understand any barriers.

Measure of success

Increased number of complaints from those in IRCs.

Increased eligibility of complaints from detained individuals. Identified and implemented any learning for the IRCs and the PPO to improve access to the complaints process.

End of year update

The programme of visits to IRCs has been completed.

Feedback from detained individuals and staff in the centres regarding their awareness of PPO and their use of the complaints process has been considered to establish next steps.

Key deliverable

Carry out a programme of engagement with probation services and those under probation supervision to raise awareness of the PPO complaints process and understand any barriers.

Measure of success

Increased number of complaints from those under probation supervision.

Increased eligibility of complaints from those under probation supervision.

Improvements made to remove any identified barriers.

Identified and implemented any learning for probation and the PPO to improve access to the complaints process.

End of year update

The programme of visits has been completed.

Feedback from those on community supervision and probation staff regarding their awareness of the PPO and their use of the complaints process has been considered to establish next steps.

Key deliverable

As part of the 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 IRCs.

End of year update

The PPO's project and communications teams have completed all IRC visits and are collating the information gathered to plan next steps.

Investigators continued to take PPO complaint materials with them on visits to help raise awareness and share information.

Key deliverable

Continue to raise awareness of IPCI with young people and women in prison.

Measure of success

Learning and recommendations from IPCI's work within the youth and women's estate to be shared and discussed with services in remit.

Learning and recommendations to be implemented.

End of year update

100% of IPCI visits have been completed in the women's estate. A new round of visits has started. The PPO has quarterly engagement meetings with the prison group director for the women's estate.

The number of complaints received from the women's estate has risen by 40 when compared to the last financial year.

Following the programme of visits to all the youth custodial estate in 2023 to 2024, the PPO held a symposium to bring the establishments together with HMPPS to understand findings and agree actions to address the challenges identified.

Quarterly meetings have been established with independent advocacy services within establishments to discuss thematic issues related to complaints.

Complaints received from Youth Custody Service establishments have increased from 27 in the 2023 to 2024 financial year to 38 this financial year.

Key deliverable

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

Measure of success

Demonstrable understanding of how PPO services are affecting minority ethnic groups.

End of year update

The PPO published a race action plan which focused on addressing racism within casework and improving investigator knowledge.

Key deliverable

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

Measure of success

Development of a consistent investigation methodology to identify discriminatory behaviour.

End of year update

The PPO has developed a framework for investigators to use in fatal incident cases. Investigators will also record complaint cases that show evidence of racism. More details are provided in the update on the PPO's race action plan 2024 to 2025.

Key deliverable

Respond to all freedom of information and subject access requests within the prescribed timescales.

Measure of success

Success will be measured against a target of 100% of freedom of information and subject access requests being completed on time.

End of year update

During 2024 to 2025, the PPO received 92 freedom of information requests and responded to 91 within the prescribed timescales. The PPO also received 118 subject access requests and responded to 117 within the prescribed timescales.

Key deliverable

Launch a new PPO website, providing accessible and transparent information.

Measure of success

New PPO website launched.

End of year update

A new PPO website was successfully launched in July 2024, making information more transparent and accessible. In January 2025, the Silktide league table ranked the PPO as the fifth most accessible government website.

Key deliverable

Publish information and guidance about how the PPO carries out investigations.

Measure of success

Publish the PPO's investigation methodology for complaints and fatal incident investigations.

End of year update

The PPO published a monthly summary of upheld and partially upheld prison complaints, which described the complaints and their outcomes.

The PPO has provided up-to-date information on the PPO website about the process for assessing and investigating complaints, making the process more accessible and easier to understand.

The PPO has also updated promotional materials which provide information about investigative processes.

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 on time and there is no longer a backlog of fatal incident investigations awaiting initial report.

Business targets 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 412 initial reports, of which 71% were on time.

The PPO also issued 417 final reports, of which 67% were on time.

Between 1 April 2024 and 31 March 2025 there were 385 cases where the PPO had received the inquest results. Of these cases, 332 had the anonymised report published on the website by 31 March 2025. In approximately 73% of these cases, the anonymised investigation report was then published on the website within 10 working days.

Key deliverable

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

Eligibility: 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.

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 2,471 complaints investigations of which 66% were completed on time. This timeliness metric does not include one suspended case and 202 pushback cases completed.

This year, 5,991 eligibility letters were sent. A process for calculating assessment timeliness has been established and will be officially implemented next financial year.

At the beginning of this reporting year, complaints staffing resources were deployed on the introduction of IPCI, which had an impact on overall timeliness and led to a backlog of complaints. Following remedial action taken during the late summer and early autumn, complaint timeliness began to increase, going from 55% of complaints in time last financial year to 66% in time this financial year.

Key deliverable

Continue to review the investigation approaches and report templates for all types of fatal incident investigations to ensure they are proportionate and we are delivering investigative excellence.

Measure of success

Report templates reviewed.

End of year update

The PPO has amended the template for natural cause investigations to identify non-clinical learning to ensure proportionality and clarity.

The PPO also continues to review the template for self-inflicted and other non-natural deaths and remains committed to continuous refinement and improvement of report templates.

Key deliverable

Develop operational manuals for fatal incident and complaint investigations to provide more accessible and up-to-date guidance to support our staff in carrying out their work.

Measure of success

Production of operational manuals for fatal incident and complaint investigations.

Process in place to ensure operational manuals are kept up to date.

End of year update

Both fatal incident investigations and complaints teams launched operational manuals in the reporting year.

Key deliverable

Extend and 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

The PPO remains committed to continuously improving its approach to investigating post-release deaths and has held additional training and information sessions for fatal incident investigations staff with input from external stakeholders.

Key deliverable

Develop and embed an approach for identifying and sharing learning internally with staff, including learning from prevention of future death reports and PPO surveys.

Measure of success

Prevention of future death reports are regularly reviewed, and any learning is shared internally.

Process embedded for identifying and sharing learning from PPO surveys.

End of year update

Learning from the prevention of future death reports is routinely shared with staff.

Survey data has been used to improve PPO services – for example, survey feedback from complainants was used to inform the evaluation of the IPCI launch.

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 four themed learning publications and two policy into practice 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

During 2024 to 2025, the PPO published the following publications:

- Learning lessons bulletin: Post-release death investigations 2
- Learning lessons bulletin: Property complaints
- Policy into practice: Property handling
- Policy into practice: Property complaints handling
- Policy into practice: Emergency response

The PPO is scheduling a roundtable with governors to discuss findings on property complaints. This will take place early in the financial year 2025 to 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 or project. The engagement with these has been assessed regularly to ensure best practice and find ways to be more creative and have an impact.

Publications and projects include but are not limited to:

- IPCI ambassadors scheme
- 2023 to 2024 annual report
- Operation Deerness
- learning lessons bulletins on post-release death investigations 2 and property complaints
- policy into practice publications on emergency response, handling prisoners' property and handling property complaints
- media interviews

Where relevant, publications were shared with criminal justice press, national and regional press where appropriate, prison staff and senior leaders across HMPPS including policy makers and healthcare staff, and academics.

Publications were promoted across our social media channels and website.

Key deliverable

Carry out a review of findings from prison property complaint investigations and share learning with HMPPS, with a view to improving property handling in prisons.

Measure of success

Publication of the learning from property investigations and discussions with HMPPS to demonstrate how and where improvements could be made.

End of year update

The research team undertook in-depth analysis of property handling in prisons and property complaints from 2019 to 2024. The PPO issued three publications to share this learning with HMPPS and will hold a roundtable with governors to discuss findings.

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

Examples of effective partnerships to share learning include:

- preparing a report for the Chief Medical Officer for England to provide learning on the health of prisoners and those under probation
- providing learning to HMPPS on the Person Escort Record and the repeat issues the PPO sees
- sharing learning from our research into property complaints at an event for Independent Monitoring Board members from across England and Wales
- providing evidence in response to the Independent Sentencing Review call for evidence

Key deliverable

Continue to use learning from our investigations to influence national policies within the services in remit.

Measure of success

The PPO responds to relevant policy consultations with influential evidence.

End of year update

The PPO has provided learning and evidence from our investigations in response to Home Office and HMPPS policy consultations. The PPO responded to 13 policy consultations, resulting in changes to national policy.

Key deliverable

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

Measure of success

Increase in complaint recommendations requiring policy changes.

End of year update

Following a review of complaint recommendations, the PPO has drafted new guidance for investigators which changes the way complaint recommendations are constructed. The guidance sets out the different types of recommendations the PPO can make at different levels, including outcomes for complainants, and actions to be addressed locally and nationally.

Staff will now receive training on the guidance, and it will be rolled out in the business year 2025 to 2026.

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

Effective and efficient delivery of Operation Deerness (a special investigation into Medomsley Detention Centre).

End of year update

The PPO has undertaken a special investigation into abuse which took place at Medomsley Detention Centre. The PPO investigation looked into what the authorities knew about the abuse over this period, if there were opportunities for them to take action or intervene, and what action they took, if any. The final report is nearing completion and will be sent to stakeholders for feedback.

Key deliverable

Develop and implement a knowledge management strategy that promotes effective and efficient knowledge sharing within the PPO.

Measure of success

Knowledge management strategy embedded.

End of year update

The PPO devised a knowledge management strategy which was shared with staff and is being implemented.

Key deliverable

Develop and introduce a digital learning and knowledge hub to promote and share training, learning and knowledge across the PPO.

Measure of success

New internal site introduced and promoted across the PPO.

End of year update

The learning and knowledge hub has been launched and will enhance PPO staff's skills development and provide a repository for important information.

Key deliverable

Establish an effective performance management approach.

Measure of success

Performance management framework embedded.

End of year update

A performance management framework has been developed and implemented. Regular performance meetings are held using the framework.

This work is supported by the data dashboards.

Key deliverable

Identify training needs across the organisation and develop a training programme for both new and existing staff.

Measure of success

An evaluation of current training needs for existing staff carried out with any recommendations implemented.

Development of a training programme for new and existing staff.

Development of a process for monitoring continuous professional development and training that is carried out.

End of year update

The PPO has built on a comprehensive learning needs analysis and identified training offers for new and existing staff.

Key deliverable

Establish an approach for reviewing allocation of resources against demand to enable the PPO to remain resilient to and respond to fluctuations in workload.

Measure of success

Development of a model to understand resource requirements against incoming workload.

End of year update

The PPO has developed a model for planning resource allocation and associated costs.

Key deliverable

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

Measure of success

Demonstrable improvements made to data recording, collection and management.

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

End of year update

The PPO has implemented two new data collection methods for investigators to complete before and after a fatal incident investigation. From this the PPO has created a new database with details of an investigation. This will soon be put into a dashboard form which will help monitor trends over time.

The PPO has built on data management processes throughout the year to make them more efficient and accurate. This involves new measures, fewer process steps and ensuring accuracy of our data by creating data entry manuals for investigators.

As part of the race action plan, the PPO has assessed the accuracy of our race data. This has allowed us to determine the caveats the PPO will need to use when publishing any data on ethnicity.

The research team is beginning to use R as a new analysis software.

This will give a better insight into our data.

Key deliverable

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

Measure of success

Review carried out and any changes implemented.

End of year update

The family liaison role has been reviewed, and further work is now underway to consider the correct resource allocation.

Key deliverable

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

Measure of success

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

Introduce tools and approaches for maintaining business continuity and risk management.

Undertake a business continuity exercise.

End of year update

The PPO has produced a business continuity strategy and has adopted new approaches for considering risk prevention and mitigation.

Key deliverable

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

Measure of success

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

End of year update

During the reporting year 2024 to 2025, the PPO worked with the HMPPS content hub team to agree PPO and IPCI content for Launchpad (the new name for in-cell technology). The content explains IPCI, what prisoners can complain about, how to complain and where to send their complaint to.

Performance against the 2024 to 2025 race action plan

Objective 1: Supporting black, Asian and minority ethnic staff

Action

Continue the existing PPO mentoring scheme and encourage participation from black, Asian and minority ethnic staff.

Measure of success

Black, Asian and minority ethnic staff take up the opportunity to be involved in the mentoring scheme. This leads to increased confidence, job satisfaction and engagement. Mentees report a positive impact on their career development.

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. The Race Group will be aiming to increase mentee engagement with the programme planned for the next financial year.

Action

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

Measure of success

Increased awareness among all staff, and for black, Asian and minority ethnic staff to feel valued by the PPO.

End of year update

To celebrate Black History Month, the Race Group hosted various events including a discussion on black people in Tudor England and inviting Professor Hindpal Singh Bhui OBE from HM Inspectorate of Prisons to discuss his report on racism in prisons.

To celebrate South Asian Heritage Month, the Race Group circulated various communications raising awareness about the month and how staff could celebrate it.

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 black, Asian and minority ethnic staff and an opportunity for all staff to learn more from and about each other.

End of year update

The Race Group successfully organised a lunchtime event to celebrate World Culture Day. Approximately 60 members of staff attended.

Objective 2: Improving investigator knowledge and addressing race in our casework

Action

Develop training for complaints and fatal incident investigators on how to detect more subtle forms of racism within casework.

Measure of success

Investigators have an increased understanding of how indirect and subtle racism can be experienced within the services in our remit.

End of year update

The PPO is arranging for the Independent Office for Police Conduct to discuss their approach to investigating racism with fatal incident investigators. More experienced fatal incident investigators will also be discussing any cases where they felt there were issues of racism. These sessions will take place at the start of the next financial year.

Action

Develop questions for fatal incident investigators to ask in death investigation interviews to help uncover any potential issues of racism, working with stakeholders and drawing on relevant wider research.

Measure of success

Fatal incident investigators feel comfortable to ask probing questions.

Increased competency within the PPO to uncover issues which may be related to race.

End of year update

The PPO met stakeholders to discuss how they investigate racism. It was decided that a framework would be most helpful for investigators. This has been created and will be developed further and rolled out in the next financial year.

Action

Complaints investigators to begin recording on our case management system any evidence of racism when investigating complaints.

Measure of success

The complaints function has a record of complaints cases where race was an issue.

End of year update

Complaints investigators have been asked to start recording this evidence on the PPO's case management system. This will be monitored throughout the next financial year.

Action

Complaints team to review use of force data (including reviewing race disproportionality), and fatal incidents team to contribute evidence to feed into expert advisory panels.

Measure of success

Complaints and fatal incident investigations teams contribute valuable information on our use of force data to help benefit the panel.

End of year update

The PPO provided data on use of force for a panel on equalities. This data from both PPO operational functions will continue to be captured.

Objective 3: Reviewing, strengthening and analysing our data

Action

Review a sample of our race data. If necessary, amend processes at the PPO to help strengthen our data on race.

Measure of success

Our data on race is robust and we can draw conclusions from it.

End of year update

The PPO reviewed a sample of fatal incident investigations and complaints cases and cross-checked the ethnicity data against the National Offender Management Information System (NOMIS).

The aggregated and specific ethnicity categories recognised by the MOJ and HMPPS were used. For aggregated ethnic groups, the percentage of the Public Protection Unit Database (PPUD) data matching NOMIS was higher. The accuracy of our ethnicity data was lower when those broader aggregated groups were broken down.

The PPO is checking a prisoner's ethnicity on the PPUD system against the HMPPS NOMIS database for any new complaints and fatal incident investigations. Any discrepancies will be amended on PPUD.

Action

Analyse our complaints data to understand:

- how many black, Asian and minority ethnic prisoners complain to the PPO and whether this is proportionate to the estate
- our complaints uphold rates for black, Asian and minority ethnic prisoners and whether there are any discrepancies
- whether there are discrepancies between ethnicities for certain complaints categories, such as adjudications, the incentives and earned privileges scheme, and segregation

Measure of success

We understand the outcomes we produce for service users based on race and are empowered to address any disparities if necessary and share information with HMPPS.

End of year update

The PPO carried out analysis of complaints data from the financial year 2023 to 2024.

For this period, it seems black and Asian prisoners sent the PPO a greater number of complaints proportionate to their representation in the prison estate.

For our uphold rates, the only statistically significant difference found in uphold rates by prisoner ethnicity was for Asian prisoners (the PPO upheld a higher rate of their complaints).

For certain complaint categories, minority ethnic prisoners were overrepresented. Black prisoners were overrepresented in our adjudications and segregation complaints, Asian prisoners were overrepresented for complaints about incentives and earned privileges, and prisoners with ethnicity recorded as 'Other' were overrepresented for use of force complaints.

The PPO will be analysing our complaints data over a longer period next financial year so stronger conclusions can be drawn.

Action

As a result of anti-immigration riots in summer 2024, monitor race-related complaints and any increases.

Measure of success

We understand whether the riots in summer 2024 had any impact on the prison estate.

End of year update

The PPO reviewed the number of complaints about racism received before and after summer 2024. There was a decrease in the number of these complaints. Complaints about racism will also be monitored next year.

Financial data

	2023/24		2024/25		Change 2023/24 to 2024/25	% change year on year
Budget allocation[15]	£6,727,000		£7,651,002		£924,002	14%

Actuals	**2023/24**	**% of 2023/24 budget**	**2024/25**	**% of 2024/25 budget**	**Change 2023/24 to 2024/25**	**% change year on year**
Staffing costs	£6,049,930	95%	£7,401,787	96%	£1,351,857	22%
Non-staff costs	£436,279	7%	£389,260	5%	-£47,019	-11%
Income[16]	-£103,000	-2%	-£89,578	-1%	-£13,422	13%
Total spend	**£6,383,209**	**100%**	**£7,701,469**	**100%**	**£1,318,260**	**21%**
Underspend/ overspend	**£343,791**		**-£50,467**		**£293,324**	**115%**

15 The budget allocation for 2024 to 2025 includes £775,000 allocated for Operation Deerness (the PPO's special investigation into abuse at Medomsley Detention Centre).

16 In 2023 to 2024, the PPO received income of £103,000 from the Home Office and in 2024 to 2025, the PPO received income of £55,000 from the Home Office, as agreed at the start of the financial year. The accounting system provided by the MOJ set our expected income from the Home Office at £106,000 rather than the actual £55,000 received, and the MOJ was unable to correct this for the PPO's budget in its accounting system. It emerged late in the financial year that this would cause a corresponding reduction in the PPO's overall budget, which then led to the PPO's overspend.
In 2024 to 2025, the PPO also received income of £34,578 for investigating two deaths at the Isle of Man prison.

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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Prisons and Probation Ombudsman
10 South Colonnade
Canary Wharf
London
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