

Learning lessons bulletin

Fatal incident investigations | Issue 17

Post-release death investigations

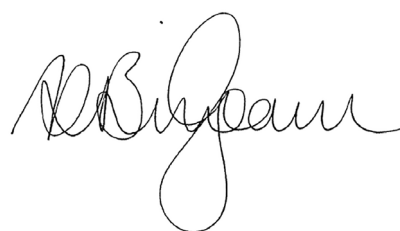
Foreword

This learning lessons bulletin summarises the learning from PPO investigations into the deaths of those who died within 14 days of release from prison. It covers investigations started between 6 September 2021 and 5 September 2022. We saw this as a pilot where we could test our approach. We have continued to investigate post-release deaths after this period but the findings from those investigations are not included in this bulletin.

When we started the pilot, over 12 months ago, we did not know exactly what our investigations would uncover. We have found that our investigations have identified some important findings about a range of themes which we explain further in this bulletin. It is clear from the investigations carried out so far that there is wider learning about areas

outside the PPO's remit. The acute vulnerability of those being released from prison became apparent during our investigations and more needs to be done to support prison leavers through that process. The learning identified by our investigations includes findings about homelessness, accommodation, substance misuse and mental health. Strong partnerships and joint working across all sectors and services are needed to address these important findings.

I hope that this bulletin will provide useful learning in an area that has previously had very little focus and attention.



Kimberley Bingham

Acting Prisons and Probation Ombudsman

Context

The PPO carries out investigations into the deaths of prisoners, young people in detention, approved premises' residents and individuals detained under immigration powers. We also have the discretion to investigate any death that raises issues about the care provided by prisons or probation. Although this means we have had the discretion to investigate post-release deaths for many years, we have only carried out a few of these investigations previously.

As a result of receiving additional funding, we started a pilot in September 2021 to investigate all post-release deaths that fell within the following definition:

Any death (except homicide) where the individual died within 14 days of release from prison into the community.^{1,2}

Alongside this bulletin, we have also published our full evaluation report of the pilot. You can find the full evaluation report, including learning for the PPO, on our website.³ The findings in the full evaluation report will influence our future investigations into post-release deaths and how we can maximise the impact and learning from these investigations.

The PPO issued 11 initial reports for investigations started during the pilot.⁴ This bulletin focuses on the learning from these 11 investigations into post-release deaths.

PPO data

Notifications and investigations started

During the 12-month pilot, the PPO was notified of 61 post-release deaths. We started investigations into 48 of those cases. All the cases of which the PPO was notified but did not investigate were due to the individuals dying more than 14 days after release from prison.⁵

Figure 1 shows the number of notifications we received every month during the pilot. Apart from May 2022 when we received no notifications, we received between two and ten notifications a month.

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- 1 The threshold of 14 days was considered the most reasonable (when considered against 7 and 21 days), as it would encompass both 'through the gate' care in early cases, and still touch on factors relating to integration into the community in later cases.
 - 2 The pilot did not include deaths that occurred in Approved Premises as these were already investigated by the PPO under our existing remit.
 - 3 <https://www.ppo.gov.uk/document/learning-lessons-reports/>
 - 4 This bulletin refers to initial reports. An initial report is a draft investigation report that is sent to the stakeholders involved in the investigation and next of kin. The initial report includes recommendations. Following a fact check process, initial reports may be subject to change.
 - 5 The PPO did open an investigation where the individual died after 14 days from release. We did this to determine whether additional learning could be gained from such a case, at an early stage where capacity was greater due to a smaller number of cases.

Monthly notifications

Frequency

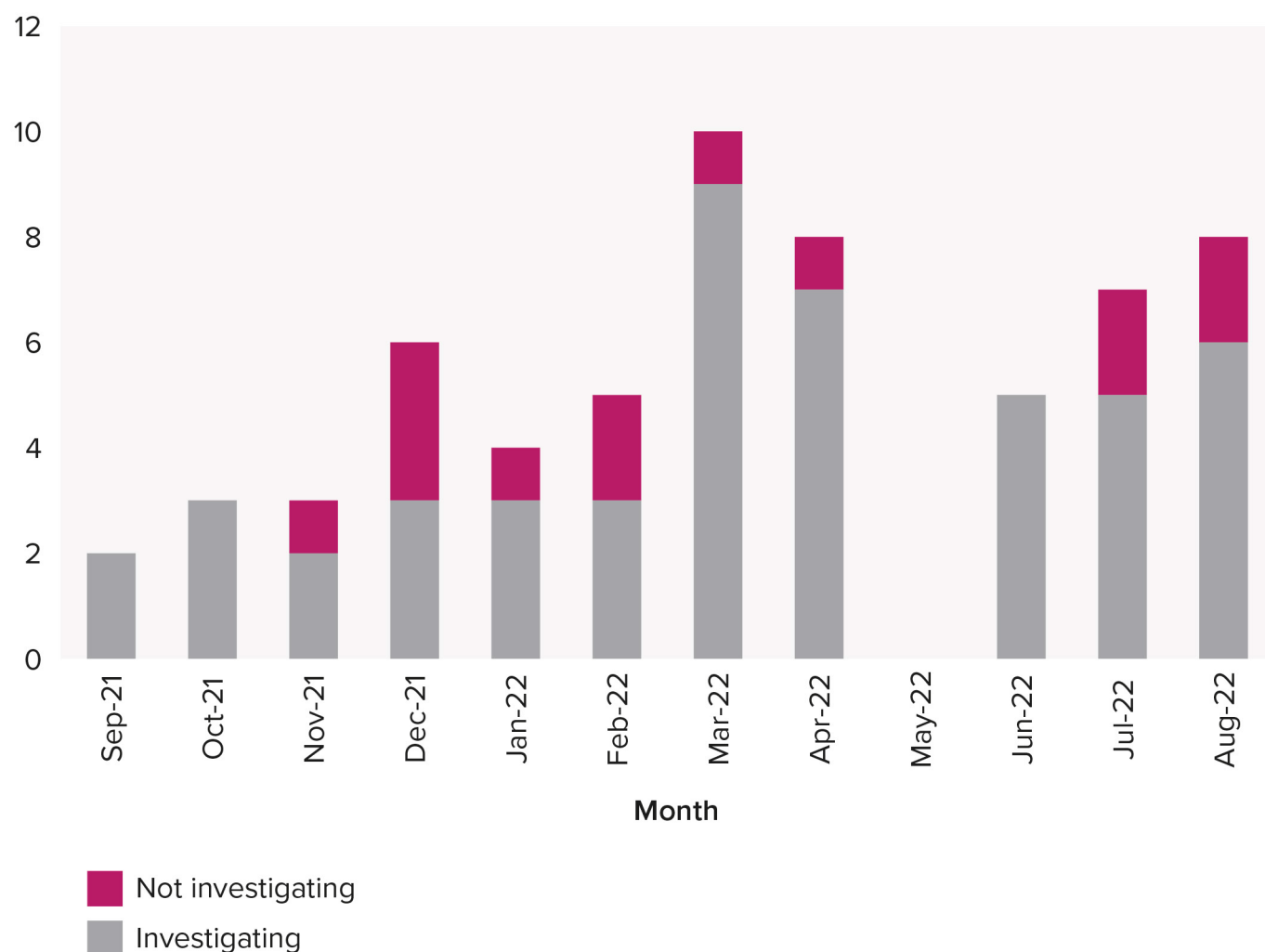


Figure 1. Monthly breakdown of notifications split by investigation decision. While the pilot's data range runs into September 2022, no notifications were received from 1 September 2022 to 5 September 2022, and so those five days are not represented.

Diversity data

Of the 48 post-release death investigations started, the majority of people were male (42) compared to female (6), and in 90% of cases the individual's ethnicity was reported as 'White-British'.⁶

In the 48 post-release death cases investigated, the age of the individual at the time of death ranged from 28 to 62 years. The graph at Figure 2 shows that other non-natural (including drug-related) deaths were seen across all age groups within the ages of 20-59. Of the self-inflicted deaths of which we were notified, deaths were seen in the 30-39 and 40-49 age groups with one case in the 60-69 age group.

6 Due to how and when data is collected, reported ethnicity may change at a later point in the investigation. 'White-British' was the majority reported ethnicity, with the ethnicities 'White – Irish', 'White – Other', 'Black or Black British – Other', 'Asian or Asian British – Indian, and 'Other – Arab' each reported once.

Age groups

Frequency

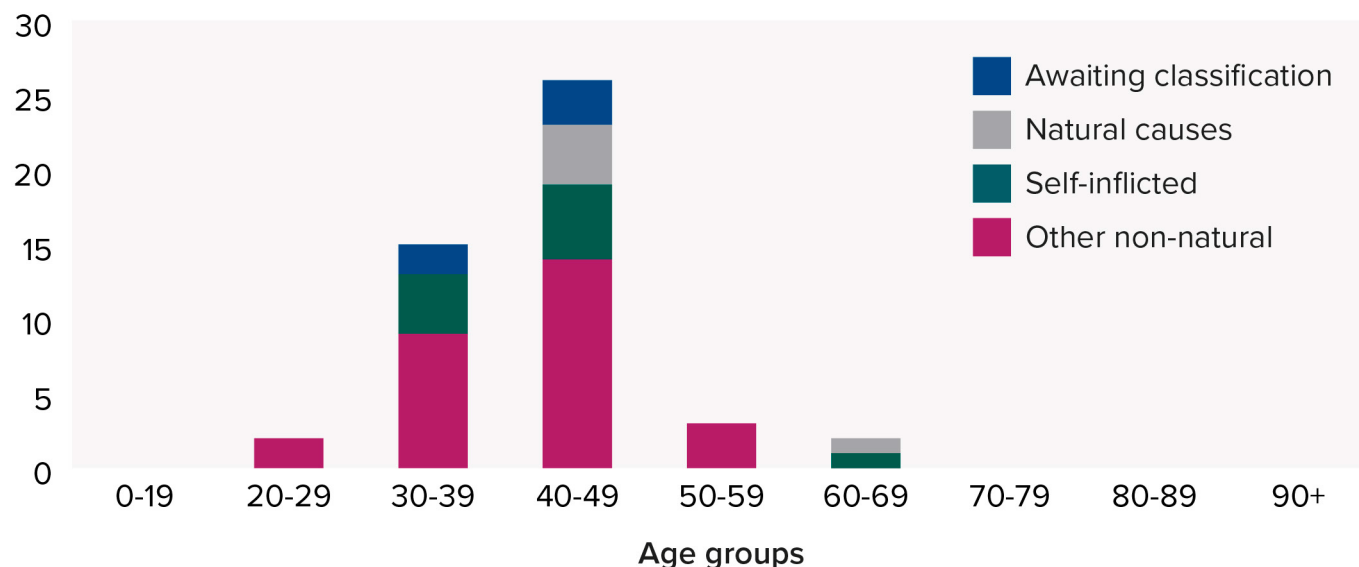


Figure 2. Age group breakdowns of all investigated cases.

Death classification

Table 1 shows the death category breakdowns for the 48 deaths that we started investigating.

This shows that exactly 50% of the investigations started into post-release deaths were drug-related deaths.

28 other non-natural deaths ⁷	10 self-inflicted deaths ⁸	5 natural causes deaths	5 deaths awaiting classification ⁹
<ul style="list-style-type: none"> 24 drug-related 2 accidents 2 classified as 'other'¹⁰ 	<ul style="list-style-type: none"> 5 classified as 'other' 3 hangings 1 self-strangulation 1 fall from height 	<ul style="list-style-type: none"> 3 circulatory system 1 respiratory system 1 classified as 'other' 	

Table 1. Death classification breakdowns for investigations started by the PPO.

7 Other non-natural: Deaths that have not happened organically; they are non-natural but cannot be readily be 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.

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

9 These are deaths where there is currently no indication of the cause of death.

10 Cases classified as 'other' can refer to instances where further information is required to determine the subcategory, or when multiple factors are identified and a single classification is not appropriate.

The charts at Figure 3 compare categorisation of deaths in prisons to deaths in the community following release in the same time period. This shows substantial differences. The majority of prison deaths are due to natural causes, whereas the majority of post-release deaths are other non-natural deaths (which are largely drug-related).

The percentage of self-inflicted deaths that occur in prison and within 14 days of release are similar. This demonstrates that as much attention needs to be given to identifying risk factors on release as it does when the individual is in prison.

Post-release deaths (n=48)

Prison deaths (n=306)

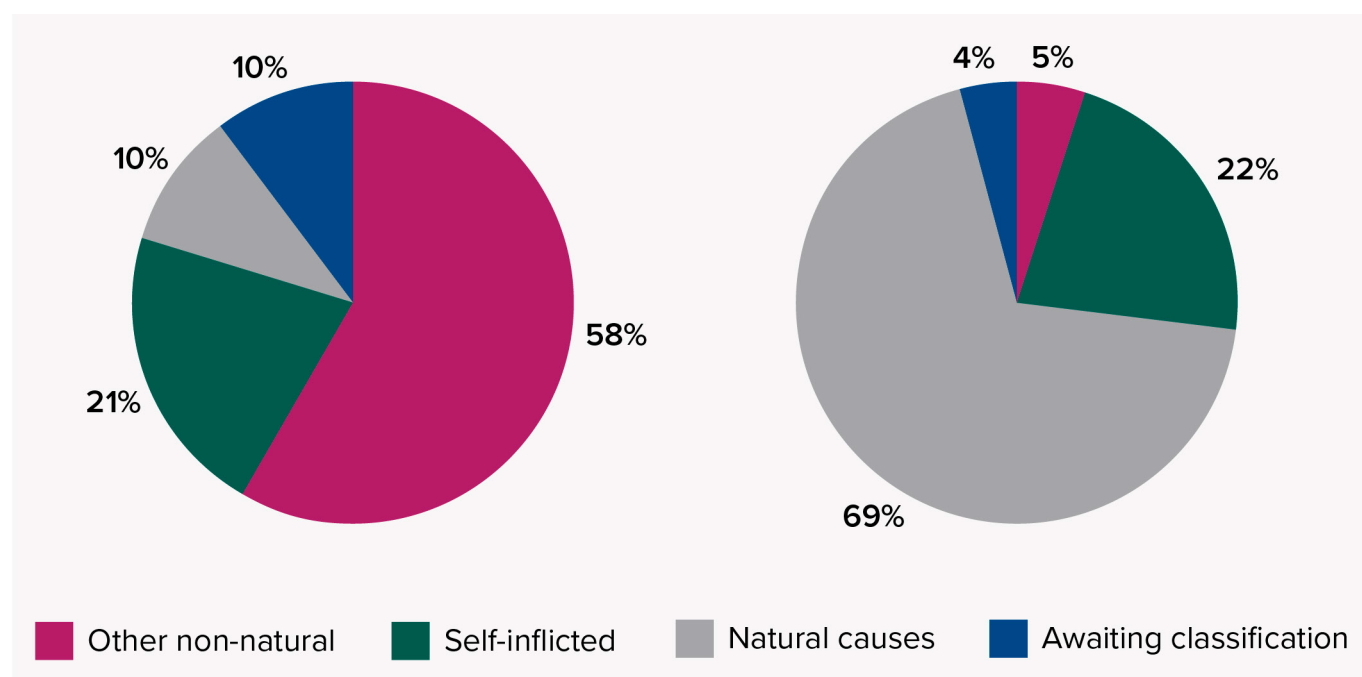


Figure 3. Death classification breakdown for investigations started from 6 September 2021 to 5 September 2022 for post-release and prison deaths.

Post-release deaths from natural causes

During the pilot, we started five investigations into post-release deaths from natural causes and one of these cases had reached initial report stage by the end of the pilot. The case of Mr A demonstrates the steps that can be taken to ensure that a prisoner with long-term health

conditions receives continuity of treatment and care after release from prison. Following our investigation into the death of Mr A, we did not make any recommendations. However, we have identified lessons from the good practice demonstrated in this case. We hope these lessons can inform future practice.

Case study 1

Mr A died from pneumonia thirteen days after he was released from prison. The clinical reviewer¹¹ concluded that the clinical care that he received in prison was equivalent to that which he could have expected to receive in the community. Mr A was offered support and monitoring for his long-term conditions in prison. He was released from prison with all the medication that he needed, his discharge summary was sent to his GP and an appointment was made for him to attend the GP surgery for a review. We did not identify any concerns about the care he received and were satisfied that there was nothing that prison or probation staff could have done to prevent his death.

Lessons to be learned:

- Healthcare staff should be aware of the steps they can take to ensure a prisoner receives continuity of care and treatment on release, such as providing all necessary medication on release and sharing a discharge summary with the community GP.

Self-inflicted deaths

We started investigations into 10 self-inflicted deaths during the pilot. Three of these investigations had reached initial report stage during the pilot. We issued a total of seven recommendations in these three reports

Handover and information sharing between prisons and probation

We made three recommendations about information sharing between prisons and probation. Two of these related to self-inflicted deaths.

It is vital that prison staff give a full handover to probation staff so that the community offender manager is aware of any important factors, risks and triggers, particularly if the prisoner was being managed under the Prison Service suicide and self-harm prevention procedures (known as ACCT) right up to the time of their release.

Case study 2

Mr B was found hanged at his home, two days after his release from prison. Before his release, prison staff had assessed that he was at risk of suicide and self-harm and had managed him under ACCT in the days before his release.

HMPPS policy says that prison staff should share relevant risk information with probation staff when a prisoner has been supported using ACCT monitoring within 12 months of release. We were concerned that this did not happen in this case which meant that probation staff were unaware that Mr B had been assessed as being at risk of suicide and self-harm at the time of his release.

¹¹ The clinical review for a post-release case looks at the care the person received in custody and is particularly focused on the pre-release planning, whether the person was prescribed medication on release and whether the clinical handover to community services took place and the relevant referrals and appointments were made.

Findings from our investigations have indicated that it can be difficult to establish exactly who is responsible for handing over key information from the prison to the community. This can become complex when there are a number of external agencies who could potentially be involved. There was also the suggestion that those involved in the release process can find it difficult to identify who or which service is responsible for a particular aspect of care, for example, mental health. This was an issue in relation to local prisons where there is a higher turnover of individuals who may not have had previous contact with these agencies in the community.

Lessons to be learned:

- Concerns about a prisoner's risk of suicide and self-harm should be shared with community probation staff before the prisoner is released.

Drug-related deaths

We started investigations into 24 drug-related deaths during the pilot. This amounts to exactly 50% of all the investigations we started into post-release deaths. Five of these investigations had reached initial report stage during the pilot. We issued a total of five recommendations in three of the reports.

Recommendations from investigations into drug-related deaths covered the lack of naloxone (a medicine that rapidly reverses an opioid overdose) provision at the point of release and the lack of 'through the gate' support for individuals who were at risk of substance misuse more generally.

Naloxone provision and uptake

The PPO made two recommendations about the provision of naloxone. The case of Mr C demonstrates the importance of ensuring that naloxone is at least offered and is available to a prisoner on release.

Case study 3

Mr C died from a heroin overdose, two days after his release from prison. Mr C had a long history of substance misuse, including heroin (an opioid). While healthcare staff at the prison gave Mr C training on how to use naloxone, they failed to give him a naloxone kit when he was released from prison. The Head of Healthcare accepted that this had been an oversight.

Lessons to be learned:

- NHS England (NHSE) should ensure that those who are assessed as being in danger of a drug overdose are provided with naloxone training and offered a naloxone kit when they leave prison.

In addition to ensuring that naloxone is made available to prison leavers, another issue is the lack of naloxone uptake by prison leavers who refuse to take it when offered, as shown in the case of Ms D. We do not know why Ms D refused the offer of naloxone as no reasons for the refusal were recorded. We recommend that more is done by NHSE and HMPPS to establish why prison leavers might refuse the provision of naloxone on release and whether more can be done to educate prison leavers on its benefits and reduce the stigma associated with naloxone provision.

Case study 4

Ms D died from the toxic effects of morphine and cocaine, the day after she was released from prison. Ms D had a history of substance misuse and frequent periods in prison. She seemed to do well in prison but relapsed as soon as she was released. Ms D was offered naloxone before she was released but she declined it. The reasons were not recorded. While she was in prison, she asked several times for medication that would help stop her drug cravings when she was released, but this was not actioned. An appointment with the community substance misuse service was not arranged before she was released.

Lessons to be learned:

- Healthcare staff should record the reasons why naloxone is refused so that NHSE and HMPPS can do more to establish and address the reasons why prison leavers might refuse the offer of naloxone on release.
- NHSE and HMPPS should consider whether more can be done to educate prison leavers on the benefits of naloxone and reduce the stigma associated with naloxone provision (to improve naloxone uptake).

Handover to substance misuse services

The importance of detailed handovers, information sharing, and timely referrals was raised in relation to self-inflicted deaths. However, this is just as important in relation to cases involving substance misuse as the case of Ms E demonstrates. It is also an example of where naltrexone medication, to help reduce drug cravings, was not prescribed prior to release.

Case study 5

Ms E arrived in custody with substance misuse, health and housing needs. The substance misuse service supported her in prison. Her substance misuse caseworker met her to discuss her drug recovery and she completed a 'rapid detox' to reduce her methadone dose to nil over a period of weeks. Ms E told her substance misuse caseworker that she wanted to be prescribed naltrexone before her release from custody. The process for prescribing and initially monitoring the impact of the medication takes over a week to deliver.

Ms E was eligible for early release on home detention curfew (HDC). The prison's Offender Management Unit referred her to the Bail and Accommodation Support Service (BASS)¹² as part of the HDC process and recorded that Ms E had no substance misuse needs. They did not record Ms E's long-term substance misuse or pattern of rapidly detoxing in prison.

12 This is now known as Community Accommodation Services (CAS2).

When Ms E was offered accommodation,¹³ staff had four working days to finalise plans for her release. The short timeframe and gaps in information sharing hindered release preparations and meant that naltrexone could not be prescribed. The prison resettlement team and substance misuse team only found out that Ms E was being released the day before her release date. Ms E died from the toxic effects of cocaine just three days after her release from custody.

We made a recommendation about the need to review how substance misuse information is shared internally and externally with partner agencies.

Lessons to be learned:

- HMPPS should consider how the issuing of naltrexone should work alongside the release process given the time needed to prescribe and monitor the medication.
- Prisons should ensure there is a process in place for substance misuse information to be shared internally within HMPPS, including with community offender managers and externally, with accommodation providers.

The case of Mr F identifies some good practice in relation to making the necessary referrals and involving other services. We hope this can inform practice going forward.

Case study 6

Mr F had a history of alcohol dependence. He was treated for alcohol dependence in prison and engaged with substance misuse services in custody. Mr F's prison offender manager referred him to a registered charity that provides drug and alcohol services in prison and support in the community after release. He also worked with another charity that supported local probation services to reduce reoffending on release. Workers from this charity met Mr F on his release and took him to an appointment at his local probation office.

Before Mr F's release, his offender manager referred him to community drug and alcohol services, which he agreed to work with. He attended an appointment with them after his release, at which it was planned that he would attend weekly sessions to assess and understand his substance misuse.

Mr F died a few hours after this appointment, having been hit by a train. Toxicology tests identified a high level of alcohol in his blood. Nevertheless, we found that he received appropriate support in prison and that he was referred to, and engaged with, appropriate support agencies on release.

Lessons to be learned:

- HMPPS, NHSE and treatment providers should make timely referrals and appointments for substance misuse services.

¹³ Previously known as 'BASS accommodation'.

Support for staff

In the 11 investigations that reached initial report stage, we made two recommendations relating to the provision of support for probation service officers and community offender managers following the death of a service user on their caseload.

Case study 7

Mr G died from multiple injuries after he was hit by a train, two days after his release. We found no evidence that probation staff who worked with him were offered any support after his death. The community offender managers in this case had little contact with Mr G and his probation service officer said that she had not needed support but this may not be the case following another death and support should have been offered in line with national instructions.

Lessons to be learned:

- All probation service officers and community offender managers should be offered support following the death of a service user on their caseload.

Accommodation

The issue of accommodation and homelessness emerged as a concern in post-release death investigations. This relates to the challenges of multi-agency involvement and in some cases, is the result of a lack of communication between external agencies and prisons and probation.

Although it is within our remit to investigate whether the prison leaver left prison with accommodation arranged or with no fixed abode, the handover often involves agencies which are external to the prison and probation service. While these agencies fall outside our remit, we have been recording our findings so that they can be shared with the relevant teams within HMPPS, as well as with other Departments, such as the Department for Levelling Up, Housing and Communities.

The case of Ms H demonstrates the importance of prison and probation staff being aware of their 'Duty to Refer'¹⁴ (in England) / Application for Help (in Wales)' anyone who is homeless or at risk of becoming homeless to a Local Housing Authority.

Case study 8

Ms H died of a drug overdose, the day after her release from prison. She was due to be released homeless. The day before her release, her community offender manager secured temporary accommodation for her. This was done belatedly and it appeared that the community offender manager was unclear about the accommodation referral processes and how to complete this. She also failed to communicate to Ms H that she had arranged accommodation for her. We were concerned that when Ms H was released, she was unaware that she had accommodation and was under the impression she was homeless.

We were also concerned that while Ms H's community offender manager shared with other professionals that Ms H was being monitored using suicide and self-harm prevention procedures in prison, she did not share appropriate details, including that Ms H had told staff that she planned to overdose on drugs when released.

14 HMPPS Policy Framework: The Homelessness Reduction Act 2017: The Duty to Refer (England only): https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1047472/duty-refer-pf.pdf

Lessons to be learned:

- All community offender managers need to be aware of the 'Duty to Refer (in England) / Application for Help (in Wales)' and the requirement to complete this referral as part of release planning for prisoners facing homelessness.

The case study of Mr I shows the complexity of securing accommodation on release for some of the most vulnerable prison leavers who have multiple risk factors. It also demonstrates the cycle of poor behaviour, offending behaviour, homelessness and prison.

Case study 9

Mr I was alcohol dependent. He was treated for alcohol dependency in prison and engaged with substance misuse services in prison. The prison substance misuse service appropriately referred him to community substance misuse services on his release.

Mr I had a history of homelessness and had deliberately offended in the past in order to return to prison when homeless. He had been evicted from several previous accommodation placements due to his poor behaviour. As a result, probation staff were not able to secure him release accommodation because his local housing authority declined to house him and he left prison homeless.

Mr I died after being hit by a train a week after his release. Toxicology tests identified a high level of alcohol in his blood.

We found that prison and probation staff appropriately referred Mr I to the local housing department, as well as other agencies and charities that provide housing advice and support. The provision of accommodation for people leaving prison is a complex challenge that extends beyond the remit of prison and probation services.

Lessons to be learned:

- It is important that there are strong communication channels between external housing / accommodation providers and HMPPS staff.

Day of release

Another emerging theme relating to prison leavers is the potential impact of being released from prison on a Friday. For those individuals at risk of substance misuse, being released towards the weekend was perceived to be a risk factor towards a drug-related death.

This is an issue that has been identified in the Prison Strategy White Paper¹⁵, with the proposal for HMPPS to allow prisoners at risk of reoffending to be discharged one or two days earlier at governor discretion where a Friday release can be demonstrated to be detrimental to an individual's resettlement.

The case study of Mr J also shows the impact that being arrested on release from prison can have on release plans.

15 Prisons Strategy White Paper: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1038765/prisons-strategy-white-paper.pdf

Case study 10

Mr J died from a drug overdose, two days after his release from prison. He was released homeless on a Friday but was arrested immediately at the prison gate due to a warrant for his arrest for outstanding charges. He was placed in police custody overnight before attending court the following day. He was subsequently released from court on the Saturday. Mr J had reporting instructions to attend an appointment with probation on the Friday afternoon, but he could not attend due to his arrest. A new induction appointment was not rescheduled for Mr J following his arrest and subsequent release on the Saturday. This meant that Mr J had no contact with the probation service on release.

In June 2022, several months after Mr J's death, the Ministry of Justice committed to look at releasing prisoners on a Friday or over the weekend as there are no opportunities for them to meet with service providers to arrange accommodation or put in place any other support measures. This would not necessarily have benefitted Mr J as he was arrested on release and was placed in police custody overnight. While court matters do not fall within our remit, we note that Mr J's court hearing and subsequent release on a Saturday meant that he was left homeless and without appropriate support in place over the weekend.

Lessons to be learned:

- Release plans need to be reconsidered in cases where a prisoner is arrested on release from prison.
- Detailed handovers should take place between the police and probation to ensure that appointments can be rescheduled.

Summary of lessons to be learned

Natural cause deaths

- Healthcare staff should be aware of the steps they can take to ensure a prisoner receives continuity of care and treatment on release, such as providing all necessary medication on release and sharing a discharge summary with the community GP.

Self-inflicted deaths

- Concerns about a prisoner's risk of suicide and self-harm should be shared with community probation staff before a prisoner is released.

Drug-related deaths

- NHS England (NHSE) should ensure that those who are assessed as being in danger of a drug overdose are provided with naloxone training and offered a naloxone kit when they leave prison.
- Healthcare staff should record the reasons why naloxone is refused so that NHSE and HMPPS can do more to establish and address the reasons why prison leavers might refuse the offer of naloxone on release.
- NHSE and HMPPS should consider whether more can be done to educate prison leavers on the benefits of naloxone and reduce the stigma associated with naloxone provision (to improve naloxone uptake).
- HMPPS should consider how the issuing of naltrexone should work alongside the release process given the time needed to prescribe and monitor the medication.

- Prisons should ensure there is a process in place for substance misuse information to be shared internally within HMPPS, including with community offender managers and externally, with accommodation providers.
- HMPPS, NHSE and treatment providers should make timely referrals and appointments for substance misuse services.

Support for staff

- All probation services officers and community offender managers should be offered support following the death of a service user on their caseload.

Accommodation

- All community offender managers need to be aware of the 'Duty to Refer (in England) / Application for Help (in Wales)' and the requirement to complete this referral as part of release planning for prisoners facing homelessness.
- It is important that there are strong communication channels between external housing / accommodation providers and HMPPS staff.

Day of release

- Release plans need to be reconsidered in cases where a prisoner is arrested on release from prison.
- Detailed handovers should take place between the police and probation to ensure that appointments can be rescheduled.

About the data

This bulletin refers to the notifications that we receive to inform us that a post-release death has occurred. The sample of notification data consists of deaths that we were notified of that occurred between 6 September 2021 and 5 September 2022.¹⁶

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 the course of an investigation. However, they are not altered following conclusion of the inquest. PPO classifications may differ from those used by HMPPS. Due to the quantity of data available in the pilot, recommendation data was pulled at initial report stage instead of final report stage. Therefore, this data can be subject to a small amount of change. Some totals may not add up to 100% due to rounding.



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¹⁶ Notification data was frozen on 13 September 2022 and the data for reports and recommendations was frozen on 28 September 2022.