

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Investigating deaths after release from prison – a pilot evaluation**

## **January 2023**

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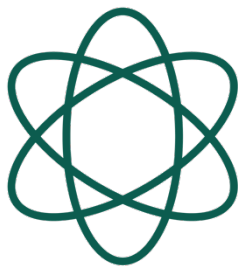
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# 1. Executive summary

## 1.1. Introduction

This report presents the findings from the Prisons and Probation Ombudsman's (PPO) evaluation of its post-release death investigations pilot. The pilot commenced on 6 September 2021 and the evaluation draws on data from this date until 5 September 2022. The specific aim of the pilot was to identify what lessons could be learnt from investigating post-release deaths and to what extent the PPO should commit to carrying out post-release death investigations, taking into account impact. This evaluation consequently looks at the processes implemented in completing post-release death investigations, and the impact generated from them, both within and outside of the PPO's remit. The evaluation uses a mixed methods approach, looking at data from different points in the investigation process: notification, initial report stage, and recommendations issued, while also gaining qualitative insights from all stages from both internal and external stakeholders.

Findings will have an impact on how the PPO continues to conduct post-release death investigations and how the PPO can maximise impact and learning from these investigations. This report is split into distinct chapters, with Chapter 1 concluding with an overview of the key findings. Chapter 2 will provide the policy and data background to the project, both within the PPO and a broader overview. It will also outline the research objectives of the evaluation, with the methods used to achieve them listed in Appendix 5.1. It will provide information around the data, sampling, and notes on interpreting findings. Chapter 3 will set out the findings from this evaluation. Chapter 4 will present the conclusions of the evaluation, including the process and impact of the pilot. Chapter 4 will conclude with further research that will be conducted, and potential avenues of research that could be explored. Section 1.2. summarises the key findings and actions from the report, with the comprehensive list presented in sections 4.1. and 4.2.

## 1.2. Key findings and actions

### **Notification process:**

1. During the 12-month pilot the PPO was notified of 61 post-release deaths and started investigations into 48 of these. Notifications received during the pilot skewed heavily towards other non-natural deaths, specifically drug-related deaths.
2. We received the majority of notifications within 10 days of the death; however, PPO staff did raise concerns that any relative delay between the death and the

notification made collating relevant information more difficult. The PPO should be aware that post-release death notifications will be more delayed compared to prison death notifications and consider the impact of this.

3. Lateness of notifications could not be predicted by death category, when in the pilot the PPO received the notification, or when an individual died within the 14-day time period.
4. The volume of PPO notifications was similar to the Ministry of Justice's (MoJ) data on deaths of offenders in the community<sup>1,2</sup>.
5. PPO staff highlighted concerns over gaps in the notification information they received, with external stakeholders sharing difficulties in obtaining information prior to notifying the PPO. The PPO should engage with probation to identify if information gathering is the only barrier to substantial information being provided to the PPO.

### **Decision to investigate:**

6. The PPO opened investigations into 79% of the deaths notified, a single case where the death occurred after 14 days was investigated to assess additional learning<sup>3</sup>.
7. External stakeholders questioned whether there would be learning from post-release natural causes deaths. The PPO should assess, when greater data is available, whether post-release natural causes deaths provide substantial learning.

### **Investigation process and reports:**

8. Timeliness of 73% was reported for 11 initial stage reports and 100% for 5 final stage reports, exceeding operational timeliness targets for the PPO.
9. In-pilot changes to processes such as requesting clinical reviews and obtaining a probation liaison officer resulted in more efficient investigations.
10. Initial training materials and internal sources of knowledge allowed investigators to quickly adapt to a new area of work. The PPO should continue to identify internal and external sources of knowledge and experience to aid the transition to investigating post-release deaths for new investigators.

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<sup>1</sup> Deaths of offenders supervised in the community, England and Wales, 2021/22. Ministry of Justice (2022). Available at: [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/1113566/deaths-of-offenders-in-the-community-2021-22-bulletin.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1113566/deaths-of-offenders-in-the-community-2021-22-bulletin.pdf)

<sup>2</sup> The PPO would also investigate deaths of individuals released following remand or not into probation supervision in the community, although these numbers would be considered minimal as the PPO is less likely to be informed about deaths that occur outside of probation supervision.

<sup>3</sup> See 3.1.2. Investigation Decision.

11. Both PPO staff and external stakeholders stressed the importance of PPO staff having access to the probation case management system (nDelius). The PPO should ensure all post-release death investigators have access, with a refresher training session.
12. Concerns were expressed over how external stakeholders could be supported during the investigation process. The PPO should consider whether external sources of support for probation staff could be more effectively signposted by Probation Service managers.
13. External stakeholders highlighted how terminology differences can cause difficulties, with PPO staff voicing how introductory conversations can aid this. The PPO should continue to engage with probation to ease initial concerns and explain the expectation and purpose of the investigative process, where possible.
14. External stakeholders also voiced concerns around engagement and communication with the PPO, and familiarity with the PPO investigative process. The PPO should consider if outreach such as a communications campaign will aid stakeholder support, stronger working relationships, reduce terminology differences, and increase awareness of the PPO.
15. PPO staff questioned whether the current process for allocating investigations was sustainable, including how to ensure staff continued to develop the knowledge required to investigate deaths which present more complex, interacting factors. The PPO should consider allocation plans after the pilot.

### **Learning generated from investigations:**

16. The PPO issued a total of 13 recommendations in 7 investigations that reached initial report stage, and no recommendations in 4 investigations.
17. PPO staff frequently highlighted issues with the handover of information that related to Assessment Care in Custody Teamwork framework (ACCT: the care planning process for prisoners identified as being at risk of suicide or self-harm) and mental health support. The PPO made 4 recommendations that concerned information sharing with probation, with 3 of these mentioning risks around suicide, management of ACCT, and substance misuse respectively.
18. The lack of naloxone<sup>4</sup> provision at point of release and lack of through the gate support for individuals at risk of substance misuse were also raised as points for concern by PPO staff. The PPO made 2 recommendations on the provision of naloxone.
19. PPO staff also highlighted an issue around the lack of naloxone uptake by prison leavers, with PPO staff identifying that post-release investigations could help to reduce the stigma associated with naloxone uptake.

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<sup>4</sup> Naloxone is a medication used to reverse or reduce the effects of opioid drugs.

20. PPO staff voiced the importance of effective communication with the released individual to help aid resettlement.
21. The PPO also made recommendations on provision of support for staff, effective exploration of incidents of concern with service users, clear record keeping, and appropriate offender management referrals.
22. PPO investigations also contributed to highlighting good practice in probation, which allowed external stakeholders to inform approaches in other cases.

**Learning outside of PPO's remit:**

23. PPO staff and external stakeholders identified a lack of communication between external agencies and probation as a key issue in factors such as accommodation and homelessness.
24. The day of release was also identified as an impactful qualitative finding.
25. PPO staff highlighted differences in how probation policy is applied in comparison with prison policy. The PPO should consider how its reference to policy in investigations can be better tailored for probation practices.
26. External stakeholders highlighted the benefit of the PPO's investigations encompassing the handover from custody to the community. The handover process was also highlighted as a potential barrier for impact, as it was difficult to establish who was responsible for the continuity of care when external agencies were involved.

## 2. Introduction

### 2.1. Background

Deaths of prison leavers have traditionally been less understood compared to deaths that occur within custody. Research in 2010 conducted by the Howard League for Penal Reform<sup>5</sup> first highlighted the need for more accurate data collection and maintenance for deaths that occur under probation supervision. The same limitations in recording practices were highlighted in research conducted by the Equality and Human Rights Commission in 2016<sup>6</sup>. Both early pieces of research, despite the lack of data, were able to produce statistics of deaths of prison leavers. Authors highlighted the greater level of vulnerability of individuals who have contact with the criminal justice system through increased rates of mortality, in addition to a general level of neglect in both policy and analysis.

The MoJ first published data on deaths of offenders in the community in 2016<sup>7</sup>, with the data range starting from 2010. The publication also highlighted the effect of the Offender Rehabilitation Act (ORA, 2014)<sup>8</sup> which among a number of reforms ensured that offenders released from custodial sentences would be supervised in the community for a minimum of 12 months. This consequently increased the recording of deaths of prison leavers that previously were unknown. Prior to the introduction of the ORA, prison leavers would only be subject to supervision as stated in their licence conditions. The ORA created 23 Community Rehabilitation Companies (CRCs), creating further supervision for medium and low-risk offenders in the community. This, alongside the creation of the National Probation Service (NPS) in 2014 for the supervision of higher risk offenders, encompassed community supervision which remained until 2021 when all supervision was absorbed by the NPS, and all CRC contracts were terminated.

As a result of the development of community supervision, the increased data of deaths of prison leavers and the availability of it, research has recently developed further

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<sup>5</sup> Deaths on probation: An analysis of data regarding people dying under probation supervision. Howard League (2016). Available at:

<https://howardleague.org/wp-content/uploads/2016/05/Deaths-on-probation-summary.pdf>

<sup>6</sup> Non-natural deaths following prison and police custody. Equality and Human Rights (2016).

Available at:

[https://www.equalityhumanrights.com/sites/default/files/non-natural\\_deaths\\_following\\_prison\\_and\\_police\\_custody\\_2.pdf](https://www.equalityhumanrights.com/sites/default/files/non-natural_deaths_following_prison_and_police_custody_2.pdf)

<sup>7</sup> Deaths of Offenders in the Community 2015/16 Annual Statistics Bulletin. Ministry of Justice (2016).

Available at:

[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/563124/deaths-of-offenders-in-community-2015-16.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/563124/deaths-of-offenders-in-community-2015-16.pdf)

<sup>8</sup> Offender Rehabilitation Act 2014. Available at:

<https://www.legislation.gov.uk/ukpga/2014/11/enacted#:~:text=An%20Act%20to%20make%20provisions,orders%3B%20and%20for%20connected%20purposes.>

insights into such deaths. Researchers at Nottingham Trent University<sup>9</sup> used MoJ data to conduct a profiling analysis of deaths under probation supervision illustrating that risk, timing, and cause of death are not all equally distributed across factors such as gender, age, ethnicity, socio-economic status, and physical and mental health needs. It stands to reason that if rates of deaths across such factors are not equal, then potential learning and recommendations from investigations may also differ across such factors.

The publication of the government's Prisons Strategy White Paper in 2021<sup>10</sup> outlined the £200,000,000 a year funding strategy, by 2024-25, to transform the approach of rehabilitation. In relation to prison leavers, it specifically highlights the need for reform around employment, accommodation, mental health, and substance misuse. Such factors, and the disparity in which they occur in the prison population compared to general society have regularly been reported on in publications such as the Prison Reform Trust's Bromley Briefings<sup>11</sup>.

The PPO has traditionally carried out investigations into the deaths of prisoners, young people in detention, approved premises' residents, and individuals detained under immigration powers due to any cause<sup>12</sup>. The PPO does additionally have the discretion to investigate any fatal incident that raises issues about the care provided by prisons or probation. However, due to levels of resourcing and without a robust notification process in place, the PPO has carried out relatively few of these investigations; for instance, 4 discretionary deaths in 2020-2021. Under the 2021 Spending Review settlement, the PPO received funding for resources to conduct fatal incident investigations into post-release deaths. This paper presents the findings of the evaluation into the PPO's post-release death investigations pilot.

The specific aim of the evaluation is to identify what lessons can be learnt from investigating post-release deaths and to what extent the PPO should commit to carrying out post-release death investigations, taking into account impact. For the purposes of the pilot, the PPO has defined a post-release death as any death where the individual died within 14 days of release from prison. This specifically refers to release into the community. Other pathways of release are defined in the 'About the Data' section of this report. Prior to the pilot, the PPO considered the different thresholds and related implications. The threshold of 14 days was considered against

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<sup>9</sup> Analysis of profiles for deaths under probation supervision. Nottingham Trent University (2022). Available at: <https://core.ac.uk/download/491716612.pdf>

<sup>10</sup> Prisons Strategy White Paper. Ministry of Justice (2021). Available at: [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/1038765/prisons-strategy-white-paper.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1038765/prisons-strategy-white-paper.pdf)

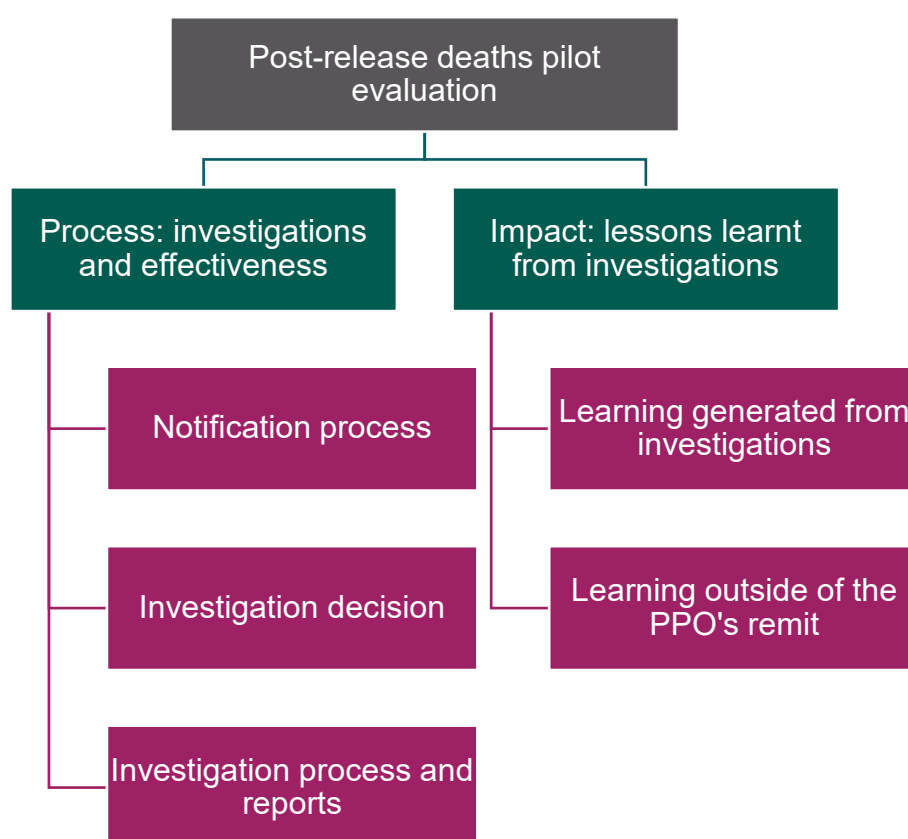
<sup>11</sup> Bromley Briefings Prison Fact file. Prison Reform Trust (2022). Available at: <https://prisonreformtrust.org.uk/wp-content/uploads/2022/02/Winter-2022-Factfile.pdf>

<sup>12</sup> Terms of Reference. Prisons and Probation Ombudsman (2021). Available at: <https://s3-eu-west-2.amazonaws.com/ppo-prod-storage-1g9rkjhkjmngw/uploads/2021/12/PPO-2021-Terms-of-Reference-with-cover.pdf>

both 7 days and 21 days. The threshold of 14 days was considered the most reasonable across all options, 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. The threshold of 14 days is also compatible with the MoJ breakdowns of deaths of offenders in the community<sup>13,14</sup>. The outline of the evaluation is presented in Figure 1.

## 2.2. Research aims and objectives

Figure 1 outlines the aims of the evaluation, splitting the broader areas into a process focused section (investigations and effectiveness), and an impact focused section (lessons learnt from investigations). Outlined beneath each of the broader sections are the specific sections this evaluation will seek to assess. The full methodological outline is presented in Appendix 5.1.



**Figure 1. Evaluation approach for the investigation process and impact.**

<sup>13</sup> Deaths of offenders supervised in the community, England and Wales, 2021/22. Ministry of Justice (2022). Available at: [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/1113566/deaths-of-offenders-in-the-community-2021-22-bulletin.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1113566/deaths-of-offenders-in-the-community-2021-22-bulletin.pdf)

<sup>14</sup> Justification for MoJ breakdowns revolve around creating an even split across all categories, so also have implications for resourcing around the pilot.

## 2.3. Research methodology

### 2.3.1. About the data

The sample of notification data consists of deaths of which the PPO was notified that occurred between 6 September 2021 and 5 September 2022. While the criteria for the pilot relied on date of death, notification data is organised in this report by date of notification to the PPO to align with other publications and internal reporting. In addition to deaths that fall within the remit of the pilot – deaths of individuals who die within 14 days of release from prison – the PPO was also notified of a number of other deaths<sup>15</sup>:

- Deaths of individuals that occurred after 14 days of release from prison: the PPO accepted one case for investigation in the preliminary stages of the pilot<sup>16</sup>. This case is highlighted in Figure 4 and is included in all breakdowns and comparisons. All other notifications after 14 days of release are explicitly referred to where appropriate, but not included in breakdowns or comparisons.
- Homicide deaths of individuals after release from prison: the PPO was notified of 3 homicides. These are not included in any findings as they fall outside the remit of the pilot. Learning for the services in remit from the PPO investigating post-release homicides would be limited, as individuals are not monitored continuously on release, even if at known risk of violence in the community.
- Discretionary investigations: the PPO was notified of 4 deaths which are being investigated using the PPO's discretion as outlined in their Terms of Reference. These are not included in any findings as they represent cases that the PPO would have investigated prior to this pilot and therefore do not constitute new potential learning. Discretionary investigations include deaths where individuals were granted temporary bail or compassionate release due to terminal illness, or were released, but not into the community, for instance, into a care home.

Notification data was pulled and frozen on 13 September 2022 and the data for reports and recommendations was pulled and frozen on 28 September 2022. Justification for the latter date was to capture as much data as possible. Once data was frozen, no new data concerning notifications or recommendations was included. All data from reports and recommendations are from notifications that fall within the pilot timeline. Recommendations data was taken from initial stage reports to create a bigger sample size. There is a small tendency for recommendations to change from initial stage to final stage, where stakeholders are asked to fact check the report. Conclusions around

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<sup>15</sup> This list does not detail deaths that the PPO investigate outside of this pilot; the deaths of prisoners, young people in detention, approved premises' residents, and individuals detained under immigration powers due to any cause.

<sup>16</sup> This case was investigated at an early stage in the pilot, where capacity was greater, see section 3.1.2. Investigation Decision.

recommendations should therefore be treated with caution. Qualitative interviews were conducted from 7 September 2022 to 6 October 2022.

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. Death classification definitions are as follows:

- Other non-natural: Deaths that 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.
- 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).
- Natural causes: Any death of a person as a result of a naturally occurring disease process that is organic and not triggered by something non-natural.
- Awaiting classification: These are deaths where there is currently no indication of the cause of death.
- Homicide: Where one person has killed another, irrespective of their level of intent.

The PPO and HMPPS have different defining criteria for classifying cases. For this reason, comparisons across datasets and conclusions should be carried out with caution. 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 classified as natural causes, and 26 weeks for all others (including those that are unclassified at the time of notification). However, the PPO must sometimes suspend its investigations while awaiting key information, such as the cause of death, toxicology report 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 within 12 weeks following the initial report. Timeliness is calculated based on working days and excludes bank holidays. Additional findings were also qualitatively analysed for any common themes, these findings were used by investigators to record additional important aspects of the investigation that fall outside the PPO's remit for making recommendations. Findings were entered at the initial report stage, and thus sampled at this stage. Some totals may not add up to 100% due to rounding.

### 2.3.2. Qualitative sampling approach

Selection of the samples for the internal and external interviews was completed through purposive sampling. Internal and external stakeholder contact details were first pulled from cases that had reached initial report stage, as potentially more information could be gleaned from cases that had reached this later milestone in the investigative process. Any remaining interview slots were filled by contacting internal and external stakeholders from the remaining cases that had reached the furthest investigative milestones. All contacts were emailed with the offer to voluntarily participate, with an accompanying information sheet detailing participation information such as interview procedure and assurance of anonymity. Only cases that fell within the notification data were sampled, so interview themes relate only to investigations within this pilot. Sample size for the interviews totalled to 20, with a total of 9 internal stakeholders, and 11 external stakeholders. These included, 3 prison establishment stakeholders, 5 probation stakeholders, and 3 other stakeholders<sup>17</sup>.

Sample groups were separated into the following:

- Internal stakeholders: members of staff at the PPO who were involved in the investigation process. When referred to as interviewees, they are given the label of 'PPO staff' in Chapter 3 and onwards to aid clarity.
- External stakeholders:
  - o Prison establishment stakeholders: liaison officers assigned to PPO investigations with variation in their listed prison establishment role.
  - o Probation stakeholders: liaison officers assigned to PPO investigations with variation in their listed probation role.
  - o Other stakeholders: individuals from HMPPS who were involved in varying stages of the PPO pilot.

### 2.3.3. Qualitative analysis approach

Interviews were conducted virtually over MS Teams and were recorded without transcription. The videos were converted to an audio format and sent for transcription; these were then re-sent to interviewees to confirm there were no issues with the sentiment of what was transcribed. Analysis was conducted independently by two researchers, with transcripts initially read, coded using macros in Microsoft Word, and themes generated in Microsoft Excel. Themes across questions were then identified by combining the coding for each question and organising them into initial themes. The two researchers consolidated and agreed the final themes together and identified quotes that best encapsulated them. It is important to note that while each theme has been presented and expanded on separately, they are not mutually exclusive. The

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<sup>17</sup> Exact roles cannot be given to protect anonymity.

quotes cited for the purpose of this report form a representative sample of participant responses. Due to the sampling technique employed, with greater priority given to cases that had reached the initial report stage, there is potential for views to represent earlier processes and impact within the pilot. This was mitigated by sampling interview contacts in other cases that had not yet reached the initial report stage.

PPO investigators also recorded findings that they thought were of interest during the investigations, but could not make recommendations on, due to them being outside of the PPO's remit. These findings were analysed by two researchers who independently read the findings across the small sample to identify themes for each finding, as a single post-release death investigation was not limited to a single finding. Any reoccurring themes were then identified, with examples highlighted through agreement of the researchers. These findings are presented as footnotes where applicable in the report.

#### **2.3.4. Interpreting quantitative findings**

Quantitative data within this pilot is separated into four categories:

- Notification data: data that the PPO receives when notified of a death
- Initial stage reports: an initial investigative report sent out to relevant stakeholders for fact check
- Final stage reports: a final investigative report that is sent to relevant stakeholders and following the inquest is published on the PPO's website
- Recommendations at initial stage: recommendations to services in remit in the initial stage report

Each category represents a separate but overlapping set of data. All report and recommendation data are directly linked to notifications received in this pilot, with the same true for themes from interviews and findings. Due to the differences in sample sizes, caution should be taken for any inferences across samples. Sample size also affects the nature of inferences made within a sample; percentage breakdowns are only given where the total sample is over 20. Comparison to prison data was also only made when sample sizes were above 20, with exact sample sizes stated. Percentages for timeliness and category breakdowns for reports and deaths respectively were stated throughout the findings section.

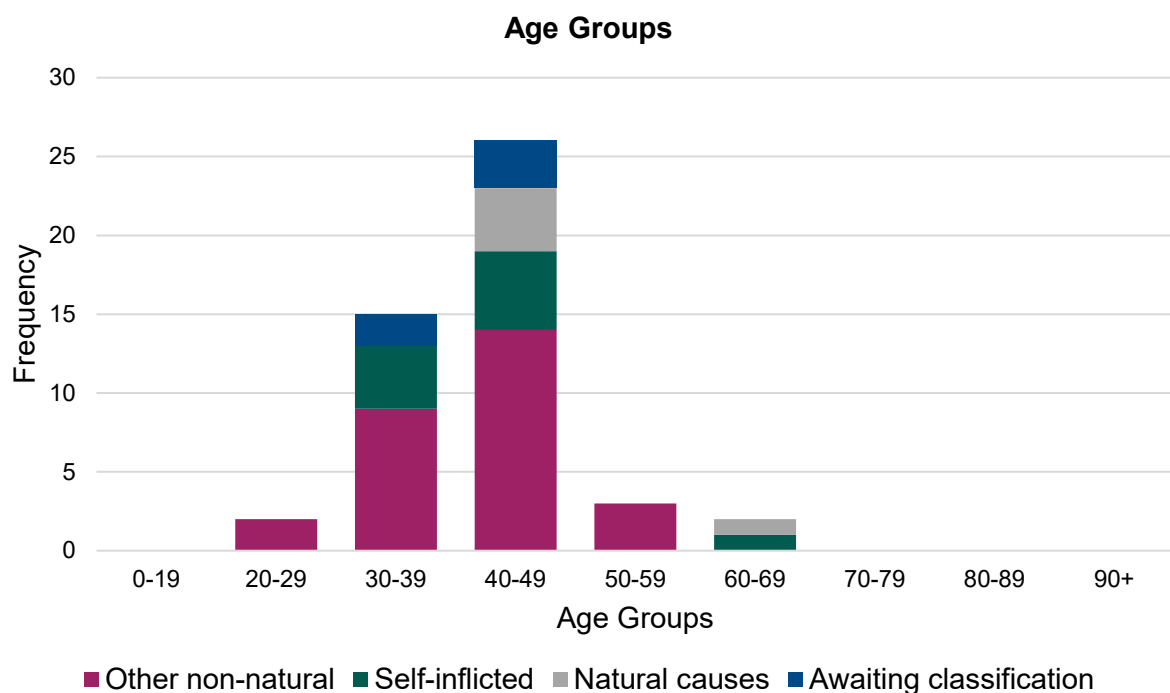
## 3. Findings

### 3.1. Post-release death investigations effectiveness

#### 3.1.1. Notification process

##### Number of post-release notifications

Over the 12 months, the PPO was notified of 61 post-release deaths, of which investigations were started in 48<sup>18</sup>. Out of the 48 post-release death investigations started, the majority were male (42) compared to female (6), with 'White – British' as the majority reported ethnicity<sup>19</sup> (43), with the ethnicities 'White – Irish', 'White – Other', 'Black or Black British – Other', 'Asian or Asian British – Indian', and 'Other – Arab' each reported once. Age breakdowns, presented in Figure 2, for other non-natural post-release deaths show a similar pattern to those that occur in the same classification within prisons, with numbers clustering around the 30-39 and 40-49 age brackets<sup>20</sup>.



**Figure 2. Age group breakdowns of all investigated cases.**

<sup>18</sup> See section 3.1.2. Investigation Decision for the criteria on opening investigations.

<sup>19</sup> Due to how and when data is collected, reported ethnicity may change at a later point in the investigation.

<sup>20</sup> Other death classification categories do not contain enough numbers to compare across age groups.

The 48 post-release deaths occurred following release from 34 different prisons. A full list of release establishments is detailed in Appendix 5.2. The death classifications are presented in Table 1:

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

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

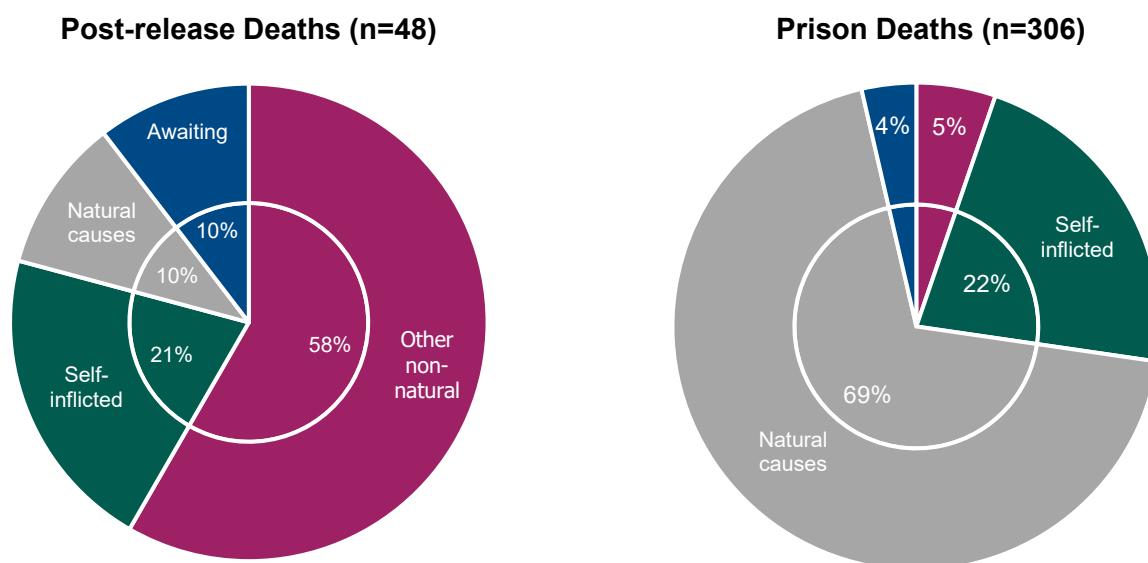
The death category breakdowns skew heavily towards other non-natural deaths, specifically drug-related deaths, which make up exactly 50% of the deaths the PPO opened investigations into<sup>21</sup>. This pattern can be assumed to continue based on similarities in recent yearly trends in MoJ data on deaths of offenders in the community<sup>22,23</sup>. However, while notification data is similar to MoJ data on offenders in the community, the death breakdowns constitute a different internal demand for the PPO when compared to prison deaths. Death category breakdowns for prison deaths over the same period of the pilot show substantial differences. While the self-inflicted category represents a similar percentage across both prison and post-release notifications, the vast majority of prison death investigations are due to natural causes. This contrasts with post-release death investigations which show the aforementioned skew towards other non-natural causes. The comparison is influenced by the PPO's 14-day threshold between release and death. Post-release deaths due to natural causes do occur in greater number, but at a greater distance between release and death<sup>24</sup>.

<sup>21</sup> Correct at the date of freezing (13/09/2022), cases that were awaiting classification will therefore change this percentage and the overall breakdowns.

<sup>22</sup> Deaths of offenders supervised in the community, England and Wales, 2021/22. Ministry of Justice (2022). Available at: [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/1113566/deaths-of-offenders-in-the-community-2021-22-bulletin.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1113566/deaths-of-offenders-in-the-community-2021-22-bulletin.pdf)

<sup>23</sup> Direct comparisons cannot be made due to differences in category definitions, and differences across time periods of data. Similarity is assumed on a five-year average of total notifications.

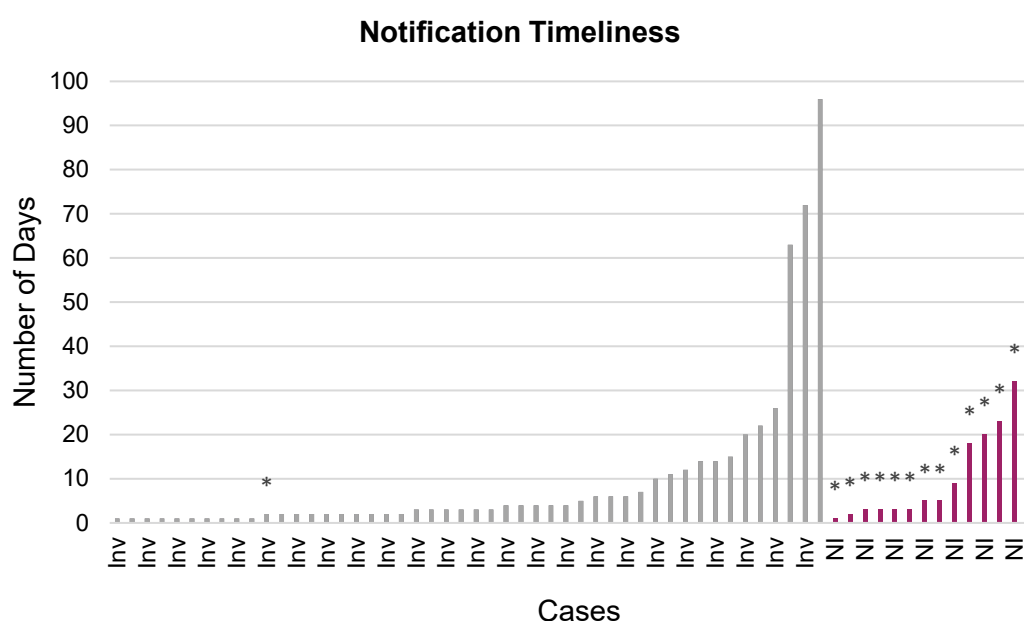
<sup>24</sup> Analysis of profiles for deaths under probation supervision. Nottingham Trent University (2022). Available at: <https://core.ac.uk/download/491716612.pdf>



**Figure 3. Death classification breakdown for investigations started from 6 September 2021 to 5 September 2022 for post-release and prison deaths, category colours are consistent across both charts. Prison homicides (2) are not included for a direct comparison.**

### Timeliness of post-release notifications

Notifications for accepted investigations averaged a mean of 10 days between date of death and notification to the PPO, with 77% of notifications arriving at 10 days or under. This is suggestive of a fairly robust notification system for a new process, one where the majority of cases fell under the average mean time. This can be seen in Figure 4, where there is a skew towards shorter times between death and notification to the PPO, with a minority of cases on the right with greater periods of time.



**Figure 4. Timeliness of notifications:** grey bars denote cases the PPO opened investigations into, pink denote those that were declined. Asterisks above particular bars denote cases where the individual died after 14 days from release from prison.

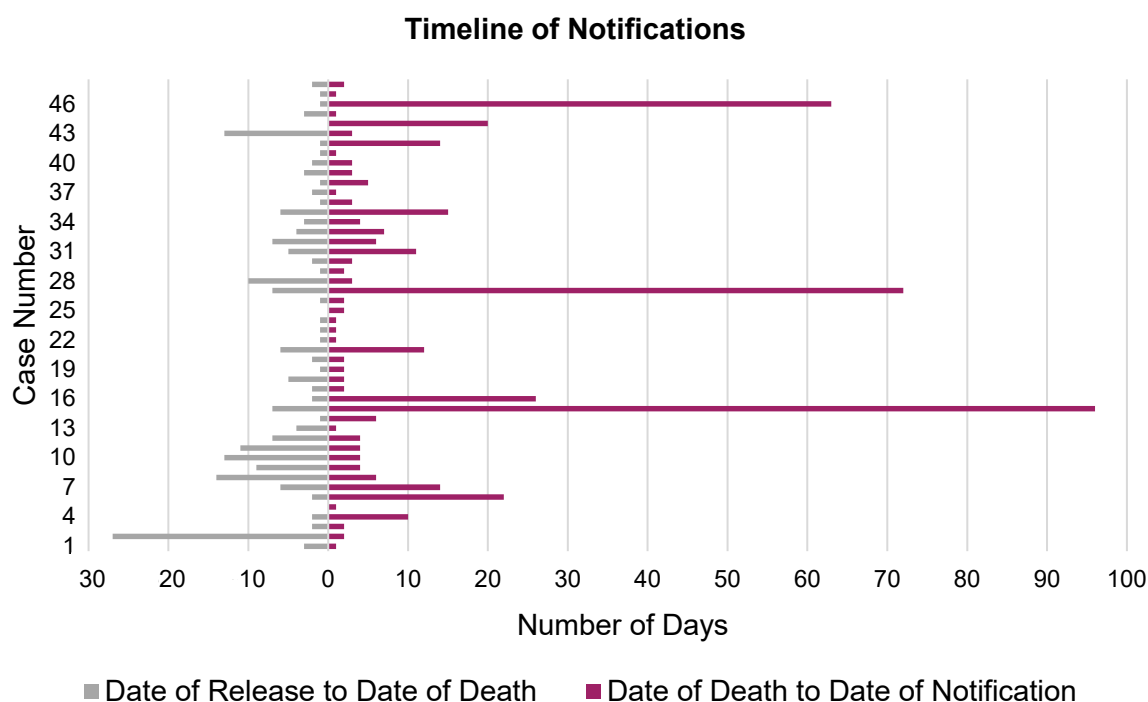
### Reasons for late notifications

Timeliness of notifications were not affected by death category:

	Number of cases	Average number of days between death and notification	Standard deviation
Other non-natural	28	13	23
Self-inflicted	10	7	6
Natural causes	5	5	5

**Table 2. Average days between death and notification to the PPO broken down by death classification.**

While a higher mean for the number of days between death and notification can be seen in other non-natural cases, the standard deviation is approximately 4 times compared to the other categories. The open nature of the post-release deaths, where a multitude of factors can affect the notification process, for instance the time before an individual is found, may be more of an influencing factor. As other non-natural deaths make up the majority of the PPO's cases in this pilot, it can be assumed that the variation in death circumstances can be seen more prominently here as opposed to self-inflicted and natural causes deaths. Furthermore, there are no contextual reasons why one death category would incur longer notification times over another, namely, a drug-related death does not necessarily make it more difficult for the PPO to be notified. The time taken for the PPO to be notified was also not affected by the progression of the pilot or by the time between date of release from prison and death:



**Figure 5. Case-by-case timeline of notifications. Grey bars denote the time between release from prison and death, pink bars denote time between death and notification to the PPO. Each case that the PPO opened an investigation into is plotted in chronological order; case number 1 denotes the first case.**

Figure 5 illustrates two points; firstly, there is no effect of time on the notification process. As the evaluation progressed (starting with case number one on the y-axis), the pink bars, which denote the days taken for the PPO to be notified, do not decrease. This suggests the average time for the PPO to be notified of a post-release death will not change greatly after the pilot. Secondly, the time between the date of release to date of death did not in turn affect the time taken for the PPO to be notified of the death<sup>25</sup>. For instance, if an individual died at the maximum 14 days after their release, it would not mean a longer time was taken for the PPO to be notified of the death. The factors that affect the timeliness of notifications may become clearer in future, as more cases are analysed.

## Thematic insights into the notification process

### Notification delays and duplicates

<sup>25</sup> The time taken between release and death, and death and notification were transformed into z-scores as the former timescale had an artificial threshold of 14 days. Z-scores were then plotted in a scatter with a Pearson's correlation to assess any relationship.

PPO staff spoke about delays in receiving notifications. These delays can negatively impact on the investigation process as it becomes more challenging to piece together the events leading up to the death.

*“And sometimes it’s been really delayed. There’s been instances where we haven’t been notified for several weeks following a death.” – PPO staff member*

There have also been occasions when the PPO has received a duplicate notification from different organisations such as the NHS, police, and sometimes prisons<sup>26</sup>. Some PPO staff questioned whether the PPO was being notified of all deaths by probation.

*“I still don’t know if we’re getting all the notifications. We sometimes get informed by the coroner, and, in one recent case, by the police; and also, in one recent case, by the NHS, by the NHS commissioners, of deaths of people who’ve recently been released from prison under probation supervision, which haven’t been notified to us through the normal channels. So that’s a kind of flag for me that we’re not . . . would we ever have been notified of those deaths had either the coroner, the NHS or the police not told us?” – PPO staff member*

## **Notification information**

PPO staff said that at times the notification forms they receive can lack important information, particularly the details of the death. This leads to delays in the investigation process as investigators may need to wait for a post-mortem report to know the cause of death. Notification forms may also lack details around the location of the death, requiring PPO staff to establish where the death took place in order to inform the correct coroner.

*“I think sometimes the information can be too sketchy and not very detailed. And there’s been times where we’re not sure of the address that somebody has died at. And because of that, we then don’t know which coroner to approach – that can be a difficulty.” – PPO staff member*

External stakeholders also spoke of some of the difficulties with the notification process and being able to provide detailed notification forms. Some of the barriers they mentioned included probation themselves not receiving substantial enough information to decipher who has died and what the circumstances were.

*“Sometimes you just get a call from a family member that says, ‘Bob has died,’ and then the phone goes down. And then it takes weeks and weeks and weeks*

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<sup>26</sup> The usual route of notification would be through the National Incident Management Unit (NIMU), which is the same route followed for all fatal incident notifications to the PPO.

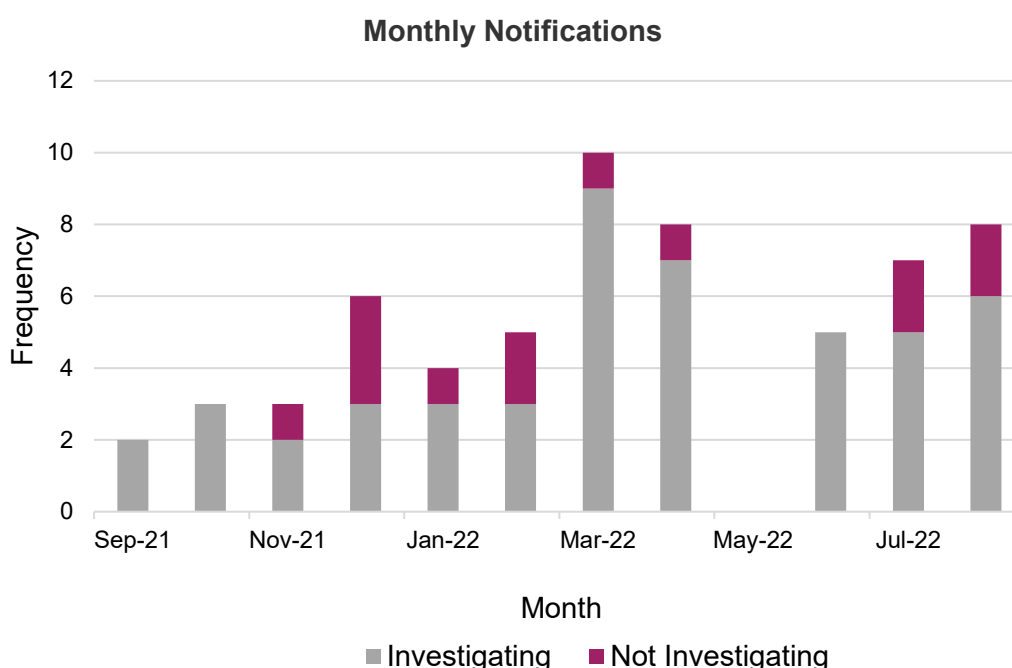
*and weeks to really piece together whether Bob did actually die.” – External stakeholder*

However, external stakeholders were engaged with the notification process and understood the importance of the quality of the information for PPO investigations.

### 3.1.2. Investigation decision

#### Number of investigations started

During the pilot, the PPO was notified of 61 post-release deaths, of which investigations were started in 48, representing a rate of 79%. All cases of which the PPO was notified and did not start investigations into were due to the individuals dying after 14 days of release from prison. The single case where the PPO started an investigation following the death of an individual who had died more than 14 days after their release, was investigated because in the early months of the pilot, the PPO had a slower intake of cases which fell within the 14-day criteria. This meant that there was greater capacity at that time, and the PPO was keen to explore whether additional learning could be identified in such cases<sup>27</sup>.



**Figure 6. Monthly breakdown of notifications split by investigation decision. While the data range does run into September 2022, no notifications were received from 1st September 2022 to 5th September 2022, and the five days are not represented.**

<sup>27</sup> This case resulted in two recommendations, one each for the Local Probation Delivery Unit and the Prison Governor.

## Thematic insights into information provided for decision to investigate

### Threshold of 14 days

The 14-day period for the remit of a post release death was considered to be about right by most PPO staff, with all stakeholders highlighting this as a critical time period of transition from custody to community.

*“But I think two weeks ensures that there’s not too many external factors that could have influenced death. We’re looking at a very short timescale.” – PPO staff member*

However, some external stakeholders suggested a need for clarity about when this period begins, i.e., the day of release or the day following release<sup>28</sup>.

*“So, the only thing that I would say is, for one particular case, it counted as the day after release, the 14-day counted it as a day after release. To me, when we were asked to look at this guy and provide information, it had gone beyond the 14 days, but apparently it starts the day after that person is released from custody. It was a little like a grey area and I know there has to be a cut-off, but it just seemed to be as if it was a little bit irrelevant in a way.” – External stakeholder*

### Value of learning from natural causes death investigations

External stakeholders said they thought the decision to investigate certain cases should be based on the circumstances of the death. Some questioned whether the learning from natural causes deaths would be valuable.

*“I don’t know the extent to which you would expect a probation officer to get highly involved in somebody’s natural cause treatment.” – External stakeholder*

*“I’m going to guess it’s an awful lot of work and it might well be that you change your parameters to the just self-inflicted, whatever it’s going to be. Natural cause deaths, I understand why you would investigate them, if it’s going to be a kind of a through-care from a healthcare point of view, but I’m not sure.” – External stakeholder*

### 3.1.3. Investigation process and reports

#### Reports issued and timeliness

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<sup>28</sup> The PPO counted the day of release as the beginning of the 14-day period for all cases.

The descriptive statistics concerning initial and draft stage reports are as follows:

	Initial stage reports	Final stage reports
Number Issued	11 reports	5 reports
Death Category	<ul style="list-style-type: none"> <li>- 7 other non-natural reports</li> <li>- 3 self-inflicted report</li> <li>- 1 natural causes report</li> </ul>	<ul style="list-style-type: none"> <li>- 3 other non-natural reports</li> <li>- 1 self-inflicted report</li> <li>- 1 natural causes report</li> </ul>
Timeliness	73%	100%
Average Mean Completion Times	<ul style="list-style-type: none"> <li>- 25 weeks for other non-natural and self-inflicted</li> <li>- 11 weeks for the natural causes report</li> </ul>	8 weeks

**Table 3. Descriptive statistics for initial and final stage reports.**

With timeliness of both initial and final stage reports exceeding the PPO's operational targets, the lower volume of reports completed can be considered to be due to the fewer notifications that were received at the beginning of the pilot<sup>29</sup>. Figure 6 in section 3.1.2. shows a gradual increase in notifications towards the end of the pilot, which would have consequently had implications for investigations that could be progressed to initial report stage.

## Thematic insights into the investigation process

### Clinical reviews

PPO staff spoke about the difficulty in identifying whether the investigation would require a clinical review<sup>30</sup>. If a notification form is lacking information about the death, it can cause delays to investigations as the PPO would need to wait for more information before deciding whether a clinical review is needed. PPO staff also spoke

<sup>29</sup> The effect of pilot progression was tested statistically through a Chi Square test with actual monthly values against expected values (mean average). Although a gradual increase can be seen in Figure 6, this was found to be not significant.

<sup>30</sup> Clinical reviews were initially requested for all post-release deaths from natural causes. This was a straightforward way for investigators to decide whether to commission a clinical review. As the PPO's learning from the pilot grew, this was changed mid-pilot so that the need for clinical reviews was considered for all post-release investigations, regardless of the cause of death. The PPO changed this because they recognised that it was important to have a clinical review for all cases where there was learning, or strong potential for learning about pre-release clinical planning and referrals. For example, clinical expertise might be needed for a self-inflicted death where the person had significant health issues. In such circumstances, the PPO may want to understand the pre-release planning in relation to mental health care.

about how clinical reviews can be helpful for cases where mental health is an issue as they provide an insight into the mental health care received.

*“– there’s a lot of stuff that needs to happen at the beginning, like asking for a clinical reviewer, for example. I can’t really do that until I know more circumstances around the death, kind of indicating what they might have died of. It can be quite difficult.” – PPO staff member*

*“...have been the format of clinical reviews. So, there might be cases where it’s really helpful to kind of get a reflection on mental health care, substance misuse provision. And there is an overlap with healthcare, but it doesn’t necessarily fit into the structure that we have now for clinical reviews<sup>31</sup>. So that has been a barrier, because it’s meant we’re making decisions about having a clinical review or not, rather than looking at tweaking it or having a method of consultation process with clinical reviewers, which would be super really.” – PPO staff member*

## **Flexibility in approach to investigations**

PPO staff also noted positives about the investigation process. These included maintaining a flexible approach to report structures, when to commission a clinical review and successfully using nDelius<sup>32</sup>. They also found that the investigations went smoothly and were completed in a short amount of time.

*“With regards to the template, I think that’s been overcome slightly by just managers being super flexible and understanding that it’s a work in progress, it’s not a final document. And, yes, and I think the barriers about not being able to approach key players, it’s been overcome in one sense in that I know that X is particularly eager to kind of reflect on that and look at how we can change it” – PPO staff member*

## **Probation liaison officers**

A barrier to the investigation process was the delay in identifying a probation liaison officer. PPO staff said the previous process of contacting the central hub<sup>33</sup> to be given a single point of contact (SPOC) or liaison officer was time consuming. Changes to the approach have resulted in the PPO contacting probation regions direct which PPO staff have said speeds up the process.

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<sup>31</sup> The PPO is currently working with the NHS to create a more tailored clinical review template for post-release death investigations.

<sup>32</sup> nDelius is the national probation service case management system.

<sup>33</sup> The central hub refers to HMPPS’ Safer Custody Casework Team.

*“when we were first allocated cases, was that we had to go through HMPPS to be allocated a probation contact. That took weeks, despite numerous chases to HMPPS. It just felt unnecessary and an introduced a step that we didn’t need. But now that that has changed, it’s ironed itself out quite quickly.” – PPO staff member*

## **Effective training and resources**

Some PPO staff praised the PPO investigators for their positivity and picking up a new area of work so quickly.

*“I think it was really helpful to have all the training materials at the outset. So, we did have quite comprehensive training materials and templates, report templates. I think it was good to have all that in place before we even started. So, investigators had that pretty much from day one. I think that worked well. What else worked well? I think, generally, the investigations have gone fairly smoothly. And I think the investigators have, for a new area of work, they’ve kind of got to grips with it fairly quickly.” – PPO staff member*

## **nDelius and information sharing**

One factor relevant to information sharing between the PPO and probation is training on nDelius. Once PPO staff were able to successfully navigate nDelius it was much quicker to find the necessary information themselves without having to go to probation staff.

*“But if you go through nDelius, you’ve got access to it there. So, I found that to be really useful. So, if every investigator used that system, then you would get access to the material from the Probation Service. Because they’re very good at . . . they seem to be very good at uploading all of their contacts onto the system...” – PPO staff member*

The external stakeholders also noted that at times they were put under time pressure to send over documentation to the PPO despite some investigators already having access to this on nDelius. They also said that PPO investigators would send out a template asking for information without editing it to take into consideration what they already had. However, sometimes there was inconsistency between PPO staff about what information was needed.

*“We do seem to get from different PPOs [investigators] different requests for information. I know beforehand I’ve sort of prepared what I’m expecting to be asked for and then I don’t always get asked for all that, or I might get asked for more.” – External stakeholder*

## Impact on probation staff<sup>34</sup>

Given that the pilot represented a new area of work for the PPO, there were some gaps in PPO staff knowledge. This led to some confusion around the contact levels probation staff had with prison leavers, with some PPO staff thinking probation staff have very little contact. There were also some concerns about the effect of the cases on probation staff. This included being aware of the potential to re-traumatise staff during the investigation process and ensuring that the PPO provide clarity of purpose. It was also noted that having introductory chats with probation staff about the PPO helped them to understand the investigation process.

*“I think what has [been] helpful as well is for me, when I have spoken to the probation manager, to just understand, well, just make sure that they feel comfortable that I approached the probation officer at the right time, that I’m not retraumatising them or anything. I have met with the manager and the probation officer jointly on Teams, just to speak about the process and what to expect before I’ve then gone on to interview, because I think it’s such a new process, I’ve felt really keen that they understand and don’t feel as anxious, because I think the PPO just sends alarm bells to people.” – PPO staff member*

External stakeholders highlighted how some probation staff have been working with prison leavers for many years and their deaths can be traumatic. This was also reflected by prison staff.

*“...sometimes these people have been working with them for years.” – External stakeholder*

*“I think it’s important that we find out at the earliest possible opportunity because certainly with one of them it was somebody who was case managed prior to release, somebody who’d built up a relationship with a lot of prison staff here” – External stakeholder*

This also extended to a concern around the lack of support for probation staff involved in the investigation process with the PPO:

*“...I’ve had to raise about the staff support – during interviews they haven’t said they’ve felt appropriately supported. And it might be that the line manager has spoken to them, but they’re just not aware of external services that they can access.” – PPO staff member*

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<sup>34</sup> This finding around staff support is also reflected in the additional findings section of 3 cases, where the PPO identified that practitioners were not offered follow-up support after the death and/or were not aware of follow-up care resources available to them.

This was also touched upon by external stakeholders who discussed wellbeing concerns they had around probation practitioners and their involvement in these cases and the resulting investigation pilot:

*“...So, I think that’s nice, that awareness of the impact on staff, and basically avoiding it where we can. You know or being really careful in how we manage it.” – External stakeholder*

### **External stakeholder expectations of communication**

External stakeholders spoke of the inconsistency of communication during the investigation process. This mostly involved issues with contact levels and communicated expectations of the external stakeholders’ role during the investigation process. For example, external stakeholders discussed being contacted multiple times for interviews or told they would be needed for an interview, but then received no contact from a PPO investigator.

This was also identified by an experienced external participant who noted that the contact levels between a death in custody and a post-release death were different:

*“Very limited contact. Very different to a natural cause death or more so a self-inflicted death, where daily contact probably with an investigator for the first week, and then intense contact by phone and e-mail. It’s basically, you collating information. Once you’ve got that information, which is provided, then you do your investigation, and it doesn’t require involvement from myself unless further things are sought. So, I don’t have a lot of contact with investigators.” – External stakeholder*

External stakeholders were engaged with the investigation process, but when they did not receive any learning or a conclusion to the investigation, they questioned the value of the investigation. These inconsistencies in communication impacted on what the external stakeholders were able to say about the learning from the pilot.

### **Language difference**

During the thematic analysis process, it was noted that the language and terminology used by probation is different to the PPO. During interviews, external stakeholders would often refer to death under probation supervision reviews<sup>35</sup>. These were

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<sup>35</sup> According to the reporting and reviewing deaths under probation supervision Policy Framework, a death under supervision review is completed by the allocated probation practitioner's line manager (or another line manager) in all cases except where the PPO has confirmed they will be completing an

considered comparable to a PPO investigation by external stakeholders. One participant noted how the language can come across as confusing.

*“to communicate with that staff member and explain what the PPO is, because not all members of staff know, and to understand why . . . to soften the language a bit in terms of ‘investigation’ and we’re ‘investigating the death’. Oh, that was my other point, I was never clear what we were investigating. Are we investigating the death, or are we investigating the members of staff practice? It was never clear to me. Or both, probably.” – External stakeholder*

## **Probation engagement**

External stakeholders noted the learning curve for PPO staff and probation staff when they were all grappling with a new process. Probation practitioners’ actions were also being reviewed by the Probation Service concurrently. External stakeholders spoke about how they dealt with deaths under supervision infrequently. They lacked experience of the PPO investigation process, unlike those who work in prisons who can rely on other staff who have experienced a PPO investigation.

*“...relationships between the Ombudsman and the prison estate are really well established. They’ve been going in and out of there for years. Whereas we’re new to the party, really. So, we have had a couple of tricky situations. Another time, you know, the Ombudsman has said they don’t need to interview staff, so we’ve relayed that message to staff. And then all of a sudden, the Ombudsman’s called that person out of the blue, which again is really stressful...” – External stakeholder*

Some external stakeholders found there was good practice of positive and constructive communication from the PPO during the investigation process. They found the PPO to be adaptable, and that conducting interviews via Microsoft Teams was convenient.

*“. . . not in particular. I think she was very flexible about when interviews and questions were going to be asked and allowed me to sort of pick that from . . . on my own time schedule.” – External stakeholder*

## **Sustainability of investigations**

The PPO investigation teams consist of investigators and senior investigators. The PPO carefully considered the allocation of investigator resource at the outset of the

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investigation, where the death relates to a resident of Approved Premises, where the death was expected or where the death resulted from an accident which did not involve drugs, alcohol or where there is no evidence of the presence of a known risk factor.

pilot and have kept this under review during the pilot, with the decision made that PPO investigators would be allocated all post-release death investigations. Although PPO senior investigators investigate self-inflicted deaths in custody, the PPO considers that the investigation of post-release self-inflicted deaths is more in line with other causes of post-release deaths. This is because the investigation of a post-release death is less focused on the circumstances of the death than it would be for a prison death. Post-release death investigations focus on pre-release planning and post-release supervision. Although all deaths are investigated on a case-by-case basis, the self-inflicted deaths that occur in custody and are investigated by senior investigators are notably more complex. They will involve more interviews and for example, the detailed consideration of the ACCT procedures in place. Whereas post-release self-inflicted death investigations would focus on factors such as identification of risk of suicide or self-harm in prison, appropriate continuity of care for medication, referrals to mental health and other appropriate services in the community, and the appropriate handover to probation concerning risks prior to release.

PPO staff highlighted the allocation of cases to investigators and how a potential expertise gap could influence the sustainability of conducting effective post-release death investigations. PPO staff highlighted that post-release death cases frequently present as complex, with external, 'out of remit' factors and multi-agency involvement. This resulted in concern around whether investigators of an appropriate grade are allocated these cases:

*“The sustainability, I think it comes down to staffing. I think there needs to be a discussion, a constructive discussion about whether people who . . . post-release cases who commit suicide, is it appropriate . . . to be dealing with those cases? Because if it wasn't a post-release case, it would be dealt with at a higher grade, . . . So, it is sustainable, but you've got to have the staff in place. It's down to staffing. And it has to be allocated to the appropriate grade as well.”*  
– PPO staff member

This contributed to pressure experienced by PPO staff who felt an apprehension around investigating post-release cases at this stage, as they had less experience with these types of investigations, but highlighted the benefit of support in the department:

*“But, yes, I think I still feel sort of a little bit apprehensive. I think when I get a natural [causes case] – when I get a prison death, it's like, yes, I know what I'm doing, 100% confident in going into it. Whereas with the probation deaths, I'm a bit like oh, OK, let's see, you know, probably spend a bit more time on it, like sort of really trawling through all of the details. So, yes, I would say apprehensive, maybe not super confident, but getting there, with the help of my colleagues.”* – PPO staff member

PPO staff also emphasised the positives of utilising experience of their colleagues<sup>36</sup>, particularly those who had a background in probation:

*“And the implications on a post-release death of that process happening, I didn’t understand. But somebody [who formerly worked] in probation sat down and explained it to me, what probation should have done, which they didn’t do. So, it’s really . . . it’s invaluable having the [former] probation staff in our office, for me.” – PPO staff member*

## **Family liaison and next of kin**

The PPO issued 2 next of kin surveys and received a single completed response<sup>37</sup>. Additionally, PPO staff said that the level of contact between themselves and next of kin had been minimal. PPO staff suggested the reason for this may be due to the difficulty with finding the contact details for next of kin. PPO staff noted that next of kin details were often missing or out of date when a prisoner is released. It was also noted that probation staff do not collect next of kin details.

## **3.2. Lessons learnt from post-release death investigations**

### **3.2.1. Learning generated from investigations**

#### **Recommendations issued**

In the 11 investigations that reached initial report stage<sup>38</sup>, the PPO issued a total of 13 recommendations<sup>39</sup> in 7 investigations<sup>40</sup>. The PPO did not issue recommendations in 4 investigations. The 11 investigations consisted of:

- 7 other non-natural reports where the PPO issued a total of 6 recommendations in 4 reports.
- 3 self-inflicted reports where the PPO issued a total of 7 recommendations.
- 1 natural causes report where the PPO did not issue any recommendations.

The category breakdowns for the recommendations issued are given in Figure 7:

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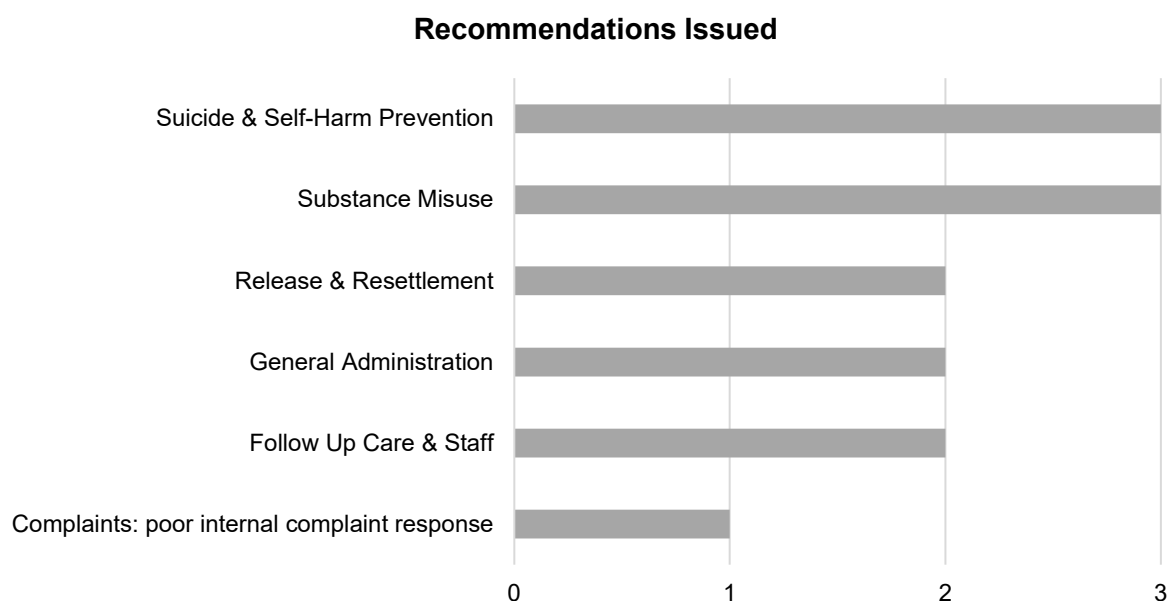
<sup>36</sup> PPO investigators were able to access the expertise of managers and senior investigators whenever it would assist investigations, whether the death occurred in custody or post-release.

<sup>37</sup> Results have not been presented due to an ungeneralisable sample.

<sup>38</sup> Out of these 11, five had reached final report stage.

<sup>39</sup> These recommendations are from initial report stage and are therefore subject to change, please see the About the Data section for more information.

<sup>40</sup> Comparisons to recommendations that are made from prison or approved premises death investigations cannot be made due to the differences in sample sizes. See section 4.4. Further Research for comparisons that are planned.



**Figure 7. Number of recommendations issued by the PPO in initial stage reports, separated by category.**

### Recommendation recipients

Recipients of the recommendations issued by the PPO are as follows:

Recipient	Quantity
Regional Probation Director	6
Prison Governor/Director	2
Head of Healthcare in prisons	2
Prison Governor/Director and Head of Healthcare in prisons <sup>41</sup>	1
HMPPS	1
Local Probation Delivery Unit	1

**Table 4. Breakdown of recipients of recommendations issued by the PPO in initial stage reports.**

<sup>41</sup> This recommendation was made jointly to the Director and Head of Healthcare, hence why it is separated from other categories.

## Thematic insights from learning within the PPO's remit

### Handovers from prison to probation<sup>42</sup>

PPO staff frequently referred to ACCT and mental health support and issues with this being successfully handed over to probation at point of release:

*“A specific example is a case where the person was on an ACCT when they were in prison, right up to the time of their release, they were being managed under ACCT – which is the Prison Service suicide and self-harm prevention measures – and there was no handover to the community probation officer.” - PPO staff member*

### Naloxone provision and uptake<sup>43,44</sup>

PPO staff also touched upon the provision of naloxone (medication used to reverse an overdose of opioids) and the lack of consistency in this being provided to prison leavers at risk of substance misuse at point of release<sup>45</sup>:

*“...anyone who's under the care of substance misuse in prison – well, specifically, I suppose, for opioid drugs – they should be offered naloxone before they're released. So, in this particular case, we found it wasn't done. So, I think, hopefully, our recommendation to that prison will mean that it is done routinely in future.” – PPO staff member*

An additional issue that emerged was the lack of uptake of naloxone by prison leavers. PPO staff speculated that this may be related to prison leavers' perceived stigma of agreeing to take possession of naloxone.

*“...remove the stigma from taking the naloxone from the prison, because it's a really useful tool and saves lives. So, yes, that theme definitely could be used to create some impact.” – PPO staff member*

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<sup>42</sup> This finding is also reflected in the additional findings section of 6 cases, where investigators identified a lack of communication between establishment and prison leaver regarding accommodation provision or the substance misuse service they were required to engage with at point of release, as well as a lack of information sharing regarding the prison leaver's ACCT history or previous incidents, to manage risk.

<sup>43</sup> The finding relating to naloxone provision was reflected in the additional findings section of 1 case, where the investigator identified that the establishment failed to provide the prison leaver with a naloxone kit.

<sup>44</sup> Findings relating to naloxone uptake were reflected in the additional findings section of 3 cases, where investigators identified that although the establishment offered naloxone and training on using it, the prison leaver declined to take up the offer at point of release.

<sup>45</sup> Naloxone provision and uptake is considered as good practice, see ACMD review of the UK naloxone implementation, Advisory Council on the Misuse of Drugs (2022). Available at: <https://www.gov.uk/government/publications/acmd-naloxone-review/acmd-review-of-the-uk-naloxone-implementation-accessible#conclusions>

As this related to prison leavers' own refusal to take up the offer of naloxone, it limited the recommendations that PPO staff felt the PPO was able to make. However, they suggested that it was a recurring theme in investigations of drug-related deaths.

*“And then there’s also another...things that I guess I hadn’t expected was things like no naloxone being offered” - PPO staff member*

### **Substance misuse and ‘through the gate’ support**

As well as the provision of naloxone, we found PPO staff expressed a concern based on findings from investigations that there was a lack of ‘through the gate’ support for individuals at risk of substance misuse more generally. In addition to handover to external agencies, this included communication around release plans and support in place for the prison leaver themselves.

*“...in terms of, say, you’ve secured accommodation the day before release – ensuring that gets passed to the prisoner that’s being released. ... in this case that they weren’t aware that they had accommodation to go to, which may have influenced their decision to stay at a friend’s that night and sadly overdosed. So just communication of plans and ensuring plans get to a prisoner, essentially, if they are being arranged very last minute within, I don’t know, 12 to 24 hours of release.” – PPO staff member*

### **Impact of investigations and recommendations<sup>46</sup>**

Despite learning on handover from prison to probation, an emerging finding based on interviews with PPO staff was the limited learning they felt the investigations had provided.

They appeared to feel challenged by the limitations of the PPO’s remit and the new issues that emerged during the investigations, and therefore the recommendations they were able to add to the report.

*“When we were writing the reports in the first instance, it’s quite difficult to know what is reasonable and what isn’t, when we should be making recommendations.” - PPO staff member*

This included finding the right audience for those recommendations.

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<sup>46</sup> At this stage the PPO had completed 11 initial stage reports and 5 final stage reports, please see section 2.3.3. for implications of a small sample size.

*“And then the difficulty of pinpointing who that learning should go to, that’s been a bit of a process. But quite a positive one...It’s more, kind of, like, oh yes, we need to make sure that that’s going to the right people.” – PPO staff member*

Additionally, external stakeholders spoke about uncertainty in how HMPPS were expected to implement any findings that had come out of the investigation pilot<sup>47</sup>.

*“But I don’t know how that learning is then shared with both the Prison and Probation Service and then how that’s expected to be implemented in their delivery plans – that I’m not clear of.” – External stakeholder*

This related to the challenges experienced by external stakeholders regarding multi-agency involvement. They referred to the range of agencies (including charities and NGOs) that would be involved in prison leavers’ care and the resulting difficulties in communicating any learning that did come from the investigations.

*“Now, I know that in the community there are lots of changes on a regular basis, from various agencies and no one really is a hundred percent confident on a process at any given time.” - External stakeholder*

External stakeholders also touched upon the limitations of added learning from the PPO’s investigation process, particularly in the case of natural cause deaths. This referred to examples where it would be difficult to identify anything that could have been done to foresee the death in the community.

*“We’ve had a couple back where we’ve not had any learning identified by the PPO. They’ve basically said that there was nothing that we could have done to foresee or prevent the death. So, in that instance, I suppose the learning is that we’ve done what we should be doing, and that’s helpful.” - External stakeholder*

However, the majority of external stakeholders were positive about engaging with the learning produced from the pilot. They were also able to identify examples of good practice from investigations and spoke positively of how this could inform practice going forward.

*“Equally, are there areas of good practice around other regions that we should be sharing? You know, are there places who are doing something particularly well, and we need to make sure we replicate that in other regions? So, I think it works both ways.” - External stakeholder*

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<sup>47</sup> The PPO has existing procedures for both making recommendations to HMPPS, and HMPPS responding to the PPO.

*“...but being able to reflect on that practice was a good learning point for me, because this was maybe one of those cases where I’d worked quite closely with the prison prior to release, namely just because there was a good prison offender manager, and that working relationship was really good. So, it’s being reinforced that, actually, that was effective practice that I’d then been more motivated to make more of an effort to do that in other cases. Whereas sometimes you think, ‘Does this really make a difference?’ And that reinforcement, that actually it does make a difference and it is quite . . . it is positive that that working relationship has worked, I’ve made more of an effort to make sure that things have happened.” - External stakeholder*

For example, regarding timely drug referrals.

*“So I know that there was a lot of reference to the work that had been done in custody around drug misuse and how that had then been transferred into the community, through referrals being put in early and appointments being made and that kind of thing. So, I think that was really positive that that was outlined and that those pathways were discussed and made explicit how important they were. Because I think quite often that that might be the process, but it’s not actually how it works in practice, nine times out of ten.” - External stakeholder*

### **3.2.2. Learning outside of PPO’s remit**

#### **Accommodation<sup>48</sup>**

A theme identified throughout interviews with PPO staff was that of accommodation and homelessness. This related to the challenges of multi-agency involvement. While it is within the PPO’s remit to investigate whether the prison leaver left prison with accommodation arranged or with No Fixed Abode (NFA), the handover often involves agencies which are external to HMPPS. As these agencies fall outside the PPO’s remit, PPO staff identified a key issue being the lack of communication between these agencies and probation.

*“So, yes, that’s the main thing that’s come out of one of the investigations. And that’s something that we are taking forward, is how we can work with partnership agencies to have really structured review periods and, and communication lines between the two. But also ensure they understand why it’s important that we know this when it’s happening, not three weeks later.” – External stakeholder*

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<sup>48</sup> Investigators have also reflected issues regarding accommodation in the additional findings section of 6 cases, where they have identified that there was insufficient handover between the establishment and the housing provider at point of release and insufficient availability of suitable accommodation, including being placed in accommodation too far away from family and support network.

## Day of release

Another issue relating to prison leavers at risk of substance misuse identified by PPO staff was the potential impact of the day they were released from custody. 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.

*“I think...being released on a Friday and then dying over the weekend, we haven’t really been able to make any recommendations about that, I don’t think, because it’s sort of out of our remit to suggest that they get released earlier, but obviously, it’s a theme that has been happening.” - PPO staff member*

This is an issue that has been identified in the Prison Strategy White Paper<sup>49</sup>, 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.

Although PPO staff recognised that they were not able to make recommendations on these aspects of learning as they were outside of the PPO’s remit, they perceived it to be positive that they were able to identify some of these issues in the findings section of the investigation report. This allowed them to draw attention to key events that provided context to the investigation and the death.

*“And perhaps we can make comments on it that it’s not within our remit to make recommendations to said charity, however, we are concerned about the events that took place, you know, just so it’s highlighted that we acknowledge that. But I definitely think it should still form part of key events, so we can ensure the reader fully understands the circumstances. Because in that case, actually, it did cause a lot of difficulties.” - PPO staff member*

## Recommendations and learning in the Probation Service

Additionally, PPO staff highlighted that there were differences in how probation policy is applied in comparison with prison policy. This was perceived to be a barrier to identifying learning applicable to probation staff, whose policy tends to be guided by professional judgement rather than mandated actions.

*“...and a lot of the policy and practice guidance are not mandated actions, they are called ‘good practice’ or ‘professional judgement issues.’ So, in that, it’s a barrier that we can’t often find very clear things to say to probation, ‘You need*

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<sup>49</sup> Prisons Strategy White Paper. Ministry of Justice (2021). Available at: [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/1038765/prisons-strategy-white-paper.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1038765/prisons-strategy-white-paper.pdf)

*to improve on this,' or, 'You haven't done that,' because it's so dynamic, how they work and it's very based on, yes, professional judgement. So, I think that's been a barrier. And that's been something that is also one of the lessons learned."* – PPO staff member

However, as previously discussed, PPO staff and external stakeholders were able to identify good practice from their experiences of the investigation process.

### **Handover and release into the community**

Although both PPO staff and external stakeholders identified examples of good practice, a recurring theme which emerged from the interviews with external stakeholders was the concern around handover from custody to community. External stakeholders identified this specifically in the case of at-risk individuals and the responsibility of the Prison Service in the handover of their care to the community:

*"There are risks that we become aware of in custody that should be handed over appropriately. There's always been – we've always sought to hand over risky individuals to the community."* – External stakeholder

This also extended to their understanding of the learning that was coming out of the pilot investigation process and the focus it provided on release arrangements and information sharing, in comparison to the learning which had previously focused on custody.

*"I think it is, from our perspective, that looking at this through the gate picture is and will shine a light on different aspects of what is part of HMPPS processes. And, you know, the work we've done today has been very prison focused and about an individual's time in custody. And I think those issues that I talked right at the beginning about, release arrangements, about information sharing, I think is one of the key things we can see immediately is coming out of the reports about that management of the offender from custody into the community." -*  
External stakeholder

A barrier to identifying learning from the investigation pilot emerged from external stakeholders, who suggested it was often difficult to establish who exactly was responsible in the process of handover from custody to community. This was identified as a result of the number of external agencies who would potentially be involved in the prison leaver's release process. This often led to a lack of understanding of where to target the learning for continued improvement at the conclusion of investigations.

*"So, it's always been a grey area in the fact that who's responsible and actually, sometimes, who do you handover to. If somebody's first time in custody, they*

*won't have outside probation [contacts in place]. They might not be under the care of mental health or their GP. At that point it's always difficult to find somebody responsible." – External stakeholder*

This was an issue identified particularly in relation to local prisons that received a high turnover of individuals who may not have had previous contact with these agencies in the community.

## 4. Conclusion and recommendations

This chapter reports the evaluative findings for both the process and impact areas of the evaluation. The findings follow the order of the evaluation: notification process, investigation decision, investigation process and report, learning generated from investigations, and learning outside the PPO's remit. Highlighted in bold are findings of importance, areas for the PPO to consider, or direct actions for the PPO.

### 4.1. Post-release death investigations and effectiveness

#### Notification process:

1. **Notifications from the pilot skewed heavily towards other non-natural deaths, specifically drug-related deaths.** This largely matches previous MoJ data on deaths of offenders in the community<sup>50</sup>, **so can be expected to continue.**
2. Notification timeliness averaged a mean of 10 days between date of death and notification to the PPO. **The majority of notifications fell under the 10-day mark, reflecting a robust output for a new notification system.** PPO staff voiced concerns over notification delays, with these **relative delays making it difficult for investigators to collate information for the investigation.** Given that there was no effect of pilot progression on notification timeliness, **the PPO should be aware that post-release death notifications will be relatively more delayed compared to prison death notifications and consider the impact of this.**
3. Late notifications could not be predicted by death category due to variance; **the death category did not determine when the PPO would be notified.** The time taken to notify the PPO of a death was also not affected by pilot progression, **suggesting that current notification timeliness is stable.** No association was found between the date of release to date of death and when the PPO was notified of the death, **when an individual died did not affect the time taken for the PPO to be notified.**
4. Notification effectiveness was a concern highlighted by PPO staff, where in some cases the PPO received multiple notifications for the same death or through parties outside of the normal channel. **It was therefore queried whether the PPO was being notified of all deaths within the criteria.** PPO

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<sup>50</sup> Deaths of offenders supervised in the community, England and Wales, 2021/22. Ministry of Justice (2022). Available at: [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/1113566/deaths-of-offenders-in-the-community-2021-22-bulletin.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1113566/deaths-of-offenders-in-the-community-2021-22-bulletin.pdf)

notifications are similar to expected levels from MoJ data on deaths of offenders in the community<sup>51</sup>.

5. Information on location and the circumstances around the death were sometimes scarce when the PPO received the notification, potentially leading to delays in the investigation process. However, external stakeholders shared difficulties in obtaining substantial information prior to notifying the PPO. **The PPO should engage with probation to identify whether information gathering is the only barrier to substantial information being provided with the notification form.**

#### Decision to investigate:

6. The decision to investigate was dictated by the 14-day threshold between date of release and date of death. The PPO opened investigations into 79% of deaths it was notified of, all cases that the PPO did not start investigations into were due to the individual dying more than 14 days after release. **A single case where the individual died after 14 days was accepted for investigation by the PPO, to identify whether additional learning could take place, at a time of high capacity.**
7. Some external stakeholders felt that the decision to investigate should be based on circumstances within the 14-day period, as it was questioned how much learning could be gained from natural causes deaths. **The PPO should assess, when greater data is available, whether post-release natural causes deaths provide substantial learning.**

#### Investigation process and reports:

8. In the small report sample, **timeliness of 73% was reported for the 11 initial stage reports and 100% for the five final stage reports.** While comparisons cannot be made to prison death report timeliness due to the small sample size, **timeliness statistics from post-release reports exceed operational timeliness targets of 70% for the PPO<sup>52</sup>.**
9. The PPO has effectively made changes to approaches around requesting clinical reviews and obtaining a probation liaison officer during the pilot. **These changes have resulted in more efficient investigations.**

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<sup>51</sup> Deaths of offenders supervised in the community, England and Wales, 2021/22. Ministry of Justice (2022). Available at:

[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/1113566/deaths-of-offenders-in-the-community-2021-22-bulletin.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1113566/deaths-of-offenders-in-the-community-2021-22-bulletin.pdf)

<sup>52</sup> Prisons and Probation Ombudsman Business Plan 2022/23. Prisons and Probation Ombudsman (2022). Available at: <https://s3-eu-west-2.amazonaws.com/ppo-prod-storage-1g9rkjhkjmkgw/uploads/2022/04/PPO-Business-Plan-22-23.pdf>

10. Initial training materials allowed investigators to quickly familiarise themselves with a new area of work, as did having colleagues who had worked in probation and had background knowledge. **The PPO should continue to identify internal and external sources of knowledge and experience to aid the transition to investigating post-release deaths for new investigators.**
11. Information gathering was quicker and easier once investigators had access to nDelius. External stakeholders also voiced concerns that information requests from the PPO could be easily met by accessing nDelius reducing delays. **The PPO should ensure all post-release investigators have access to nDelius with a refresher training session.**
12. Concerns were voiced over how the PPO can support external stakeholders during the investigation process. **The PPO should consider whether external sources of support for probation staff could be more effectively signposted by Probation Service managers.**
13. External stakeholders in probation highlighted how terminology differences can cause difficulties, and PPO staff voiced how introductory conversations around the investigative process and what is expected from probation helped to ease concerns. **The PPO should continue to consider that external stakeholders in probation may have dealt with few, if any, supervision deaths and that an investigative process may seem daunting. Contact to specifically ease initial concerns and explain expectations of the investigative process through mediums such as the telephone should be considered where possible.**
14. Concerns were voiced by external stakeholders around engagement, communication, and not having internal resources to familiarise themselves with the PPO investigative process. **The PPO should consider if outreach such as a communications campaign will aid stakeholder support, strengthen working relationships, reduce terminology differences, and increase awareness about the PPO.**
15. PPO staff highlighted that post-release deaths are often complex, with external out of remit factors, and multi-agency involvement. PPO staff questioned whether the current process for allocating investigations was sustainable, including how to ensure staff continued to develop the knowledge required to investigate deaths which present more complex, interacting factors. **The PPO should consider staffing allocation plans after the pilot.**

## 4.2. Lessons learnt from post-release death investigations

### Learning generated from investigations:

16. In the 11 investigations that reached initial report stage, **the PPO issued a total of 13 recommendations in 7 investigations.** Inferences from

recommendation type, recipients, and comparisons to the number of recommendations in prison death investigations cannot be made due to a small sample size.

17. PPO staff frequently highlighted issues with **handover of information that related to ACCT and mental health support**. The PPO made 4 recommendations that concerned information sharing with probation, with 3 of these mentioning risks around suicide, management of ACCT, and substance misuse respectively.
18. Recommendations around the **lack of naloxone provision at point of release and lack of through the gate support for individuals at risk of substance misuse more generally** were also raised as points for concern by PPO staff. The PPO made 2 recommendations on the provision of naloxone.
19. In addition to naloxone provision, PPO staff highlighted an issue around the lack of naloxone uptake by prison leavers. It was voiced that **findings around uptake could have an impact through reducing the stigma associated with naloxone provision**.
20. PPO staff also raised an important finding that **effective communication with the released individual could aid resettlement**.
21. The PPO also made **recommendations on provision of support for staff, effective exploration of incidents of concern with service users, clear record keeping, and appropriate offender management referrals** (a single recommendation each respectively).
22. Investigations also contributed to highlighting **good practice in probation, which allowed external stakeholders to then inform their approach in other cases**.

#### **Learning outside of PPO's remit:**

23. PPO staff and external stakeholders identified key factors of accommodation and homelessness, a **lack of communication between external agencies and probation was identified as a key issue**. External stakeholders voiced how this finding has **changed practice in probation, with emphasis on how probation can implement structured review periods and communication lines with partnership agencies**.
24. The factor of **day of release was also highlighted as an impactful finding**, albeit outside of the PPO's remit, as identified in the Prison Strategy White Paper.
25. PPO staff highlighted that probation policy is guided by professional judgement rather than mandated actions. **The PPO should consider how its reliance on policy in investigations can be better tailored for probation practices where the policy works alongside professional judgement**.
26. External stakeholders highlighted the **benefit of the PPO's investigations encompassing the handover from custody to the community**, especially

for those prison leavers considered at risk. However, this handover was highlighted as a **potential barrier effecting the impact of the PPO's investigations, as it was difficult to establish who was responsible for continuity of care when external agencies were involved.**

### **4.3. Methodological appraisal**

Semi-structured interviews were the most appropriate method to explore and understand the experiences of stakeholders. Topic guides for the interviewing process aided the exploration of all explicit research aims, whilst allowing flexibility for respondents to share insights and varying standpoints. Interviewers followed scripts to ensure ethical standards of informed consent and confidentiality were maintained. Aside from a single interview conducted by a trained PPO fatal incidents investigator, all other interviews were conducted by trained PPO research analysts. Every eligible internal and external stakeholder that was able and willing to participate during the evaluation window was included. The main constraints were resourcing and deadlines, however 20 transcripts from a variety of stakeholders can be considered substantial.

The main methodological area of concern was response bias as interviewers, especially internal interviewees, who may have felt less able to express themselves honestly to colleagues and work-partners. However, this risk was mitigated by ensuring that participants were aware their transcripts would be anonymised by blinded transcribers, and that interview data would not be held after publication of the report. For analytical rigour, the thematic analysis was conducted by two researchers independently and the findings were assimilated with any discrepancies discussed critically until consensus was reached.

### **4.4. Further research**

Points to consider for further research are listed below, first touching on areas that can be addressed in a potential follow up report, followed by areas that can be addressed in the longer term.

#### **Immediate term:**

1. Revisiting notification data with a greater sample size will allow more robust analysis into:
  - a. Whether initial trends around notifications continue
  - b. The proportion of notifications the PPO receives that consist of the prison leaver being released on a Friday
2. Revisiting recommendations data with a larger sample will allow for analysis that was not conducted in the current report:

- a. Whether certain death categories are more likely to produce recommendations
- b. Rates of which recommendations are accepted or rejected
- c. The most likely recipients for the PPO's recommendations broken down by death category
- d. Comparison of number and type of recommendations in post-release deaths to prison deaths
- e. Thematic analysis on recommendations data to assess prevailing themes
- f. Interviews with prison governors and heads of healthcare to assess whether recommendations have resulted in changes to policy or practice

### **Longer term:**

3. Numbers in the current sample were not large enough to analyse any differences in investigations and recommendations across men and women. However, given that the PPO has previously emphasised the importance of acknowledging the diverse, complex needs of women in prisons<sup>53</sup>, it is important to investigate to what degree this proliferates into post-release deaths.
4. Probability analysis to identify what kind of notifications the PPO is most likely to receive, relating to death type and complexity. This analysis can help to inform what kind of demand is to be expected from post-release deaths in the future, and potentially what staff resourcing can help accommodate this.
5. Investigating the influence on post-release deaths of factors such as sentence length, the categorisation of prison that the individual is released from, and where individuals are released to, when data is available.

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<sup>53</sup> Annual Report 2021/22. Prisons and Probation Ombudsman (2022). Available at: [https://s3-eu-west-2.amazonaws.com/ppo-prod-storage-1g9rkjhkjmkgw/uploads/2022/10/15.32\\_PPO\\_ARA\\_2021-22\\_FINAL\\_WEB.pdf](https://s3-eu-west-2.amazonaws.com/ppo-prod-storage-1g9rkjhkjmkgw/uploads/2022/10/15.32_PPO_ARA_2021-22_FINAL_WEB.pdf)

## 5. Appendix

### 5.1. Methodological aims and objectives

Overall Aim	Area	Method
Post-release death investigations and effectiveness	Notification process	Number of post-release notifications
		Timeliness of post-release notifications
		Reasons for late notifications
		Thematic insights into the notification process
	Investigation decision	Number of investigations started
		Information provided for decision
	Investigation process and reports	Reports issued and timeliness
		Thematic insights into the investigation process for the PPO
		Thematic insights into the investigation process for prison and probation
Lessons learnt from post-release death investigations	Learning generated from investigations	Recommendations issued
		Recommendation recipients
		Thematic insights into recommendations
	Learning outside of the PPO's scope	Thematic insights into learning outside of recommendations

## 5.2. Prison release establishment list

Prison establishment	Number of post-release death notifications
HMP Altcourse	3
HMP Cardiff	3
HMP Durham	3
HMP Humber	3
HMP/YOI Exeter	3
HMP High Down	2
HMP Leeds	2
HMP Peterborough	2
HMP/YOI Eastwood Park	2
HMP Bullingdon	1
HMP Channings Wood	1
HMP Elmley	1
HMP Foston Hall	1
HMP Highpoint	1
HMP Leicester	1
HMP Lincoln	1
HMP Lindholme	1
HMP Northumberland	1
HMP Preston	1
HMP Risley	1
HMP Swansea	1
HMP The Mount	1
HMP Wealstun	1
HMP Winchester	1
HMP/YOI Doncaster	1
HMP/YOI Hindley	1
HMP/YOI Lancaster Farms	1
HMP/YOI Moorland Closed	1
HMP/YOI New Hall	1
HMP/YOI Norwich	1
HMP/YOI Stoke Heath	1
HMP/YOI Styal	1
HMYOI Low Newton	1
HMYOI Portland	1