Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Liam Darby, on 21 July 2023, following his release from HMP Erlestoke

A report by the Prisons and Probation Ombudsman

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OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO

WHAT WE VALUE

Summary

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

2. Since 6 September 2021, the PPO has investigated post-release deaths that occur within 14 days of the person's release from prison.

3. If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

4. Mr Liam Darby died from respiratory depression on 21 July 2023, following his release from HMP Erlestoke on 18 July 2023. This was caused by central nervous system depression, which was in turn caused by the combined use of heroin, codeine, methadone, pregabalin and alcohol. He was 31 years old. We offer our condolences to those who knew him.

5. Although Erlestoke told us that the substance misuse service at the prison saw Mr Darby frequently for clinical and psychosocial care in the two months he spent there, we found that record-keeping was poor and did not document the treatment he received. We make the following recommendation:

   The Head of Healthcare should ensure that all contact and interventions with prisoners under the care of the substance misuse service are properly recorded.

The Investigation Process

6. HMPPS notified us of Mr Darby's death on 26 June 2024.

7. The PPO investigator obtained copies of relevant extracts from Mr Darby's prison and probation records.

8. We informed HM Coroner for Winchester of the investigation. They gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

9. The Ombudsman's office contacted Mr Darby's mother to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond.

10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Erlestoke

11. HMP Erlestoke is a category C prison which holds men who have been convicted or remanded into custody. Oxleas NHS Foundation Trust provides healthcare, including mental health services, at the prison. Change Grow Live provides substance misuse services.

Probation Service

12. The Probation Service works with all individuals subject to custodial and community sentences. During a person's imprisonment, they oversee their sentence plan to assist in rehabilitation, prepare reports to advise the Parole Board and have links with local partnerships to which they refer people for resettlement services, where appropriate. Post-release, the Probation Service supervises people throughout their licence period and post-sentence supervision.

Key Events

Background

13. On 4 November 2022, Mr Liam Darby was convicted of robbery and sentenced to two years and ten months in prison. He was sent to HMP Winchester.

14. During his initial health screen, it was noted that he was withdrawing from drug use and had a stoma bag due to his intravenous drug use. Winchester's substance misuse service saw Mr Darby regularly, including for psychosocial intervention. He was given harm minimisation advice and therapy.

15. On 15 May 2023, Mr Darby was transferred to HMP Erlestoke, where he was referred to the mental health service and substance misuse service. Erlestoke told the investigator that Mr Darby had no direct contact with the mental health service as there were no indications it was needed.

16. On 16 May, the substance misuse service booked an initial appointment with Mr Darby for 25 May. Although Erlestoke told us that they saw him that day, there is no record of this interaction or any subsequent contact with him. He was prescribed methadone.

17. On 30 May, Mr Darby's community offender manager (COM) completed an Offender Assessment System (OASys) assessment which identifies a prisoner's risks and needs. This noted that Mr Darby's offending behaviour was significantly linked to his substance misuse, and he would benefit from addressing this.

Pre-release planning

18. On 7 June, Mr Darby's prison offender manager (POM) handed over Mr Darby's care to his COM in preparation for his release the following month. Mr Darby attended the handover. The probation records system noted that they were in the process of completing a referral to the Community Accommodation Service (CAS2, for people who do not have suitable accommodation for the term of their licence) for post-release accommodation and had discussed Mr Darby's mental health needs with him. He was advised to register with a GP immediately on release. It was agreed that he also needed to be referred to NHS Inclusion, a community service, for his prescriptions and support on release.

19. On 19 June, Mr Darby was trained on how to use naloxone (a medicine that reverses an opioid overdose) and was to be released with it.

20. On 14 July, the substance misuse service referred Mr Darby to NHS Inclusion.

21. Erlestoke's substance misuse service referred Mr Darby to NHS Inclusion for clinical treatment for his substance misuse, and he was given a bridging prescription of methadone. Mr Darby's COM told us that NHS Inclusion also provided psychosocial interventions for substance misuse.

Post-release management

22. On 18 July, Mr Darby was released from Erlestoke on a Home Detention Curfew. His licence conditions required him to be tested for Class A and B drugs and to address his substance misuse offending behaviour.

23. The prison told the investigator that Mr Darby was given harm minimisation advice on release but there is no record of this. Mr Darby was released with naloxone, quetiapine (an antipsychotic medication prescribed to Mr Darby for his personality disorder) and fluoxetine (an antidepressant).

24. Mr Darby reported to his CAS2 accommodation, a shared house in Hampshire, where his support worker saw him. She noted that he was "high in mood" and grateful to be out of prison. He talked about improving his life and focusing on himself. She saw Mr Darby twice that day. He did not raise any concerns and said he had no intention of harming himself.

25. That day, Mr Darby had his first appointment with Probation. His usual COM was on annual leave, so another COM saw him instead. They discussed some of his licence conditions. Mr Darby told her that he had difficulties with his mental health but that mental health services would not help him due to his substance misuse.

26. The COM noted that Mr Darby had been released from prison without his prescriptions. She contacted NHS Inclusion who gave them to Mr Darby. The substance misuse clinical lead at Erlestoke told the investigator that the substance misuse service had realised the day after Mr Darby's release that he had not been given his prescriptions and contacted NHS Inclusion about it.

Circumstances of Mr Darby's death

27. At approximately 9.00pm on 19 July, Mr Darby's housemate saw him going to the bathroom to change his stoma bag. This was the last time he saw him. It was noted in the police's sudden death report for the Coroner that Mr Darby had voiced no intentions of suicide or self-harm and had not raised any other concerns.

28. At approximately 8.44am on 21 July, a support worker knocked on Mr Darby's door, but he did not respond. She knocked a further two times before she went into his room and found him on the bedroom floor. She called the ambulance service immediately. Paramedics arrived at 8.47am and pronounced Mr Darby dead at 8.48am.

29. Drug paraphernalia was found in Mr Darby's room, including small cooking spoons and syringes, one of which appeared to be used.

Post-mortem report

30. The post-mortem report concluded that Mr Darby died of respiratory depression, caused by central nervous system depression. This was in turn caused by the combined use of heroin, codeine, methadone, pregabalin and alcohol.

31. Post-mortem toxicology results identified in Mr Darby's system morphine (at a level associated with fatalities), alcohol (at a level over the drink-drive limit), methadone

and pregabalin (which had been prescribed) and a number of other drugs at a therapeutic level.

Inquest

32. At an inquest held on 10 December 2024**,** the Coroner concluded that Mr Darby died of misadventure.

Support for staff

33. After Mr Darby's death, his COM felt that he was well supported by his then manager. During our investigation, his current manager also offered support, including signposting him to relevant support services.

Findings

Substance misuse services

Medications on release

34. Mr Darby was not released with his bridging medication prescriptions as he should have been. The substance misuse clinical lead told the investigator that this was an error, and the substance misuse service had since implemented a new process which requires a CGL staff member to check at reception if the prison leaver is being discharged with all their medication and prescriptions. As the service has identified the learning and addressed the issue, we do not make a recommendation.

Substance misuse support in prison and pre-release

35. Mr Darby had a significant history of substance misuse that was linked to his offending behaviour. While at Winchester, the substance misuse service saw him regularly and gave him psychosocial intervention, including therapy, weekly. This was good practice.

36. Mr Darby was also referred to Erlestoke's substance misuse service and was appropriately prescribed methadone. Erlestoke also trained him in the use of naloxone and appropriately gave it to him on release.

37. The Quality and Governance Lead at Erlestoke identified that the substance misuse service saw Mr Darby frequently but that not all their contact with him was documented. The CGL Team Lead at Erlestoke also told the investigator that they had seen Mr Darby but were concerned about their poor record-keeping. The investigator saw little evidence in either the prison or healthcare records to establish what substance misuse care Mr Darby received. Although the Lead told us that she expected that Mr Darby received psychosocial intervention at Erlestoke, we saw no records to confirm this. As a result, we are unable to comment on the appropriateness of the substance misuse support Mr Darby received at Erlestoke or how well it equipped him for his release. We make the following recommendation:

    The Head of Healthcare should ensure that all contact and interventions with prisoners under the care of the substance misuse service are properly recorded.

Adrian Usher
Prisons and Probation Ombudsman **February 2025**

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