Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Jason Patmore, a resident at Penrose Drive Approved Premises, on 9 August 2024

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. 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.

3. Mr Jason Patmore died from a multiple drug overdose on 9 August 2024, following his release from HMP Chelmsford on 5 August to Penrose Drive Approved Premises (AP). He was 31 years old. We offer our condolences to those who knew him.

4. Mr Patmore had a history of substance misuse and of complex, unpredictable behaviour. He was offered the opportunity to engage with the substance misuse service at Chelmsford but declined any help. He was released to Penrose Drive AP so probation staff could provide closer monitoring and support. However, he spent only one night at the AP before failing to return. Probation staff recalled Mr Patmore to prison and a warrant was issued for his arrest, however he was found dead two days later.

5. We make no recommendations.

The Investigation Process

6. HMPPS notified us of Mr Patmore's death on 9 August 2024.

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

8. We informed HM Coroner for Essex 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 Patmore's next of kin, his mother, to explain the investigation and to ask if she had any matters she wanted us to consider. She asked for the name of Mr Patmore's probation officer and where they worked. This has been answered in the report.

10. We shared our initial report with HMPPS. They asked if it could be made clearer that this case involved an emergency recall out of hours. The report has been amended accordingly.

11. We sent a copy of our initial report to Mr Patmore's mother. She did not notify us of any factual inaccuracies.

Background Information

Penrose Drive Approved Premises

12. Approved premises (APs) previously known as probation and bail hostels, accommodate offenders released from prison on licence and those directed there by the courts as a condition of bail. Their purpose is to provide an enhanced level of residential supervision in the community, as well as a supportive and structured environment.

13. Penrose Drive accommodates 25 residents in a Psychologically Informed Environment (PIE), providing tailored support and supervision. A key worker is allocated to each resident to oversee their progress and wellbeing and to help them adhere to licence conditions and the AP rules. Staff are on duty 24 hours a day to monitor residents' behaviour and report to their community offender manager.

HMP Chelmsford

14. HMP/YOI Chelmsford is a category B local reception prison which holds both convicted and remanded adult and young adult men. The Forward Trust provides substance misuse treatment services.

Key Events

Background

15. Mr Jason Patmore had an extensive history of criminal convictions which were predominantly of a violent nature. Probation records note that Mr Patmore had complex mental health difficulties which were exacerbated by his misuse of alcohol and drugs, and most of his offences were committed whilst under the influence of alcohol. Records note that previously, Mr Patmore had repeatedly declined to engage in any substance misuse treatment and was reluctant to discuss his substance misuse issues with those working with him. While in the community, Mr Patmore failed to attend multiple pre-arranged appointments with community substance misuse services.

16. Mr Patmore had a diagnosis of paranoid schizophrenia (symptoms of paranoid schizophrenia include hallucinations and delusions and an inability to distinguish thoughts and ideas from reality), dissocial personality disorder (characterised by behaviours such as impulsivity, recklessness, irresponsibility, and deceitfulness) and attention deficit hyperactivity disorder (ADHD).

17. Prison and probation records note that Mr Patmore showed no willingness or motivation to comply with prison rules, court orders and probation requirements and due to his complex, unpredictable and hostile behaviour, he spent most of his previous prison sentences segregated in the Care and Separate Unit (CSU). He also spent time under constant supervision due to his stated intent, and attempts, to take his own life.

18. Mr Patmore was released from HMP Chelmsford on 17 April 2024, where he had been residing in the CSU. Upon release, he was immediately detained under the Mental Health Act over concerns that he was experiencing a psychotic episode. (Psychosis is a mental illness, where an individual loses contact with reality and may see or hear things that are not there (hallucinations) or believe things that are not true (delusions).) Medical professionals concluded that, at that time, Mr Patmore was not presenting as experiencing psychosis and did not need hospital treatment. As a result, on 19 April, Mr Patmore was discharged into the community. However, he was immediately arrested by the police on outstanding assault charges and the following day, Mr Patmore was convicted of the assault of an emergency worker and was sentenced to 24 weeks in prison. He was sent back to Chelmsford.

Pre-release planning

19. When Mr Patmore arrived at Chelmsford, a nurse completed an initial health screening in which Mr Patmore declined to give his substance misuse history. Due to his behaviour, for his own safety and at his request, he was located in the CSU.

20. Over the next few months, Mr Patmore remained in the CSU where he was regularly monitored by prison staff. He also spent time under constant supervision and was managed under prison suicide and self-harm procedures (known as ACCT).

21. On 8 May, Mr Patmore was convicted of assault and was sentenced to 16 weeks in prison (to run concurrently with the sentence for his index offence).

22. During an ACCT review on 25 May, Mr Patmore said he did not have any issues with substance misuse.

23. On 31 May, during an ACCT review, Mr Patmore was reminded of the support services available to him at Chelmsford, including the substance misuse support available from the Forward Trust.

24. On 13 June, staff stopped ACCT monitoring, and moved Mr Patmore to the incentivised substance-free living unit (ISFL) on E Wing (the drug interventions unit).

25. Over the next few months, Mr Patmore appeared to settle into the prison regime and his behaviour improved. He told staff that he was enjoying the benefits of the ISFL unit, was not taking drugs, and provided multiple negative mandatory drug tests. He remained on the ISFL unit until his release from Chelmsford on 5 August.

Release from HMP Chelmsford

26. On 5 August, a nurse saw Mr Patmore prior to his release and gave him a seven-day supply of discharge medication. He was released from Chelmsford at around 10.00am, and attended Penrose Drive Approved Premises (AP) as instructed.

27. As part of the induction process, an AP worker warned Mr Patmore about the risks associated with taking drugs and alcohol. She explained that individuals released from prison may have a reduced tolerance for illicit substances, and therefore the risk of overdose is greater. She told Mr Patmore that he may be required to complete random alcohol and drugs tests whilst at Penrose Drive. Mr Patmore refused to sign to say he understood this information. The AP worker told Mr Patmore about the benefits of naloxone (a medication used to reverse the effects of opioid overdose) and asked if he would like a naloxone kit. Mr Patmore declined, would not give a reason, and refused to sign to confirm that it had been offered to him.

28. At approximately 12.00pm, Mr Patmore attended his probation induction by video link from the AP. His community offender manager (COM), based at Ilford Probation Office, completed his induction, went through his licence conditions, and encouraged Mr Patmore to comply with the AP rules. This included reiterating that Mr Patmore must be back at the AP for 5.00pm that day to have his electronic monitoring tag fitted and must abide by his 9.00pm curfew thereafter. Mr Patmore left the AP later that afternoon.

29. At around 5.00pm, Mr Patmore telephoned the AP to say that he could not find his way back to the premises. After multiple phone calls and staff attempts to locate Mr Patmore, a passer-by was able to give Mr Patmore details of his location which he relayed to AP staff. Staff escorted Mr Patmore back to the AP where he had his tag fitted and gave a sample for a random drugs test (results of this test were not received until 12 August, which showed the presence of multiple illicit drugs).

30. At 9.40pm, Mr Patmore was seen on CCTV opening the AP gate and talking to a woman on the street. He later admitted that he had been asking her to buy alcohol for him. After initially becoming aggressive, Mr Patmore was reminded of the consequences of breaking his curfew and agreed to go back inside the AP.

31. At 2.00pm the next day, Mr Patmore attended an appointment at the job centre where he received an advance payment of Universal Credit. He briefly returned to the AP with an unknown woman and told staff that they had drunk a bottle of vodka. At around 5.00pm, Mr Patmore left the AP and did not return for his 9.00pm curfew.

32. At 10.22pm, an AP worker tried to contact Mr Patmore however his mobile phone was switched off. He did not return to the AP that night.

33. As Mr Patmore had breached multiple licence conditions and his whereabouts were unknown, it was assessed that his risk could no longer be safely managed in the community. Staff initiated emergency recall procedures out of hours. The recall was subsequently endorsed the next day by Mr Patmore's probation officer and their senior probation officer, in accordance with standard procedures, and a warrant was issued for his arrest.

Circumstances of Mr Patmore's death

34. On 8 August, Mr Patmore travelled to Chelmsford where he met a woman who agreed to let him stay in her flat for the night. The next morning, the woman found Mr Patmore lying on the floor, unresponsive. She called the emergency services who attended and at 9.56am, and paramedics pronounced life extinct.

Post-mortem report

35. The post-mortem report concluded that Mr Patmore died from a multiple drug overdose (methadone, morphine and alcohol).

Findings

Substance misuse support

36. When Mr Patmore arrived at Chelmsford, he declined to give the reception nurse his history of substance misuse, and therefore was not referred to the prison's substance misuse service. Mr Patmore spent the next few months in the CSU or under constant supervision conditions. During this time, staff focused their efforts on stabilising his mental health presentation and reducing the risk of harm he posed to himself. He was reminded of the substance misuse support available from the Forward Trust during ACCT reviews on 31 May and on 13 June, however, did not accept these offers of support.

37. The Forward Trust Service Manager at Chelmsford told us that some staff (herself included) knew Mr Patmore from a previous sentence and had informal, brief conversations with him and asked if he wanted to engage with the service. On each occasion, he declined. The investigator was told that these conversations were not documented communications as they were informal and ad-hoc, and not in response to a referral. We recognise that engagement with substance misuse services is voluntary, and that Mr Patmore declined support while at Chelmsford. However, it would have been good practice to document these discussions in Mr Patmore's prison records to ensure continuity of care and to keep other staff members informed.

38. In June, Mr Patmore moved to the IFSL unit where he remained until his release. During this time, he appeared to settle into the prison regime and provided multiple negative drug tests. Overall, we found no evidence that Mr Patmore was using illicit substances in prison and, given his reluctance to engage, we are satisfied that Chelmsford did all they reasonably could to manage the risks associated with Mr Patmore's substance misuse.

39. When Mr Patmore arrived at Penrose Drive AP, he was encouraged to complete naloxone training and accept a kit, which he declined. He did not give a reason for this decision and refused to sign the associated paperwork. The investigator spoke to the AP manager who explained that reasons for refusal can be documented on the induction document however, residents do not have to provide a reason for refusal.

40. During Mr Patmore's induction, staff warned him about the risks and dangers associated with substance misuse, including the risk of overdose, however he refused to sign to say that he understood these risks. Mr Patmore was also told he would need to complete random drug tests whilst residing at the AP. He was tested on the evening he arrived, however the results of this test were not received until after his death. Additionally, the investigator was told that all staff at Penrose Drive are trained in naloxone use, carry a kit in their waist belts, and a surplus of kits are located in the first aid boxes and medication cabinets. It is promising to hear that there will always be trained staff on the premises to administer naloxone in the event of an opiate overdose, regardless of whether residents carry their own supply or not. We are satisfied that Penrose Drive did everything they reasonably could to manage the risks associated with Mr Patmore's substance misuse.

41. We are satisfied that Mr Patmore's COM took appropriate measures to address his substance misuse upon his release from prison. This included securing a space in an AP where Mr Patmore could be closely monitored, regularly drug tested and had access to additional support and guidance from AP staff. Additionally, Mr Patmore's COM added licence conditions to comply with any requirements relating to addressing his substance misuse issues.

42. We are satisfied that both the prison and probation services did all they could to manage the risks associated with his substance misuse.

43. We make no recommendations.

Good practice

44. We would like to highlight the good practice of the AP workers at Penrose Drive. When Mr Patmore failed to return to the AP on 5 August, staff at Penrose Drive took proactive steps to confirm his location before an AP worker went above and beyond their expected duties by personally going out to meet Mr Patmore, and escort him back to the premises. Their actions ensured his safe return to the AP and prevented him from being recalled that evening.

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

Inquest

At the inquest, held on 28 August 2025, the Coroner concluded that Mr Patmore's death was drug related.

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