Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Ms Lisa Docherty, on 21 February 2024, following her release from HMP Peterborough

A report by the Prisons and Probation Ombudsman

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

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100

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. Ms Lisa Docherty died from mixed drug toxicity on 21 February 2024 following her release from HMP Peterborough on 12 February 2024. Bronchopneumonia (inflammation of the lungs) and ischaemic heart disease (caused by narrowed heart arteries) were listed as contributory factors. She was 49 years old. We offer our condolences to those who knew her.

5. Healthcare and substance misuse staff at Peterborough supported Ms Docherty with alcohol detoxification and prescribed her medication to manage her substance misuse issues. Staff made appropriate referrals to community substance misuse services to prepare for her release. Ms Docherty was released to private rented accommodation and issued with a naloxone kit. We did not identify any significant learning relating to the pre-release planning or post-release supervision of Ms Docherty. We make no recommendations. We do, however, recognise the efforts that Ms Docherty's community offender manager went to, when she missed her appointment, which sadly led to her discovering Ms Docherty deceased in her flat.

The Investigation Process

6. HMPPS notified us of Ms Lisa Docherty's death on 29 February 2024.

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

8. The investigator interviewed Ms Docherty's community offender manager on 8 April 2024.

9. We informed HM Coroner for Essex of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

10. The Ombudsman's office contacted Ms Docherty's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They had no questions but asked for a copy of our report.

11. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out a factual inaccuracy, and this report has been amended accordingly.

12. Ms Docherty's family received a copy of the draft report. They did not make any comments.

Background Information

HMP Peterborough

13. HMP Peterborough is a category B prison which holds convicted and remanded male and female prisoners in separate sides of the prison. It is managed by Sodexo. Northamptonshire NHS Foundation Trust provides all healthcare.

Probation Service

14. 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 appropriates. Post-release, the Probation Service supervises people throughout their licence period and post-sentence supervision.

Key Events

Background

15. On 20 January 2023, Ms Docherty was sentenced to a two-year suspended sentence order (SSO) for drug offences. On 4 October 2023, she appeared in court for breaching the SSO. Ms Docherty was remanded to prison and taken to HMP Peterborough.

16. At her initial health screening on 4 October, Ms Docherty told a nurse that she had a history of substance misuse. She tested positive for cocaine, opiates and cannabinoids. Ms Docherty did not report any physical health issues. A GP prescribed medication to lessen her withdrawal symptoms from alcohol and a gradually increasing dose of methadone. Additionally, the GP prescribed pain relief, anti-sickness medication, thiamine (vitamin B), and trazodone (used to treat depression and anxiety). Healthcare staff monitored her for signs of alcohol withdrawal over the next few days. Ms Docherty was also later prescribed medication to help her sleep.

17. During her initial substance misuse assessment on the same day, Ms Docherty told a nurse that she lost her methadone prescription and had started taking drugs straight away when she was last released from Peterborough in January.

18. On 6 October, an officer referred Ms Docherty to the mental health team following her induction. She told the officer she had depression, anxiety and paranoia, and used drugs to manage her mental health. On 8 October, the mental health team placed Ms Docherty on a waiting list after her triage appointment. Staff noted that she was not a risk to herself and took medication to support her mental health needs.

19. On 10 October, a nurse assessed Ms Docherty to check for withdrawal symptoms and recorded that she appeared stressed and was crying all the time. Staff checked on her that evening and found her asleep. The following day, a healthcare support worker completed Ms Docherty's seven-day substance misuse review with her. The healthcare support worker noted that she was stable on 30ml of methadone. They took her blood pressure, which was within normal range.

20. On 12 October, a substance misuse recovery worker saw Ms Docherty. She declined completing a full substance misuse assessment and recovery work. Ms Docherty said she wanted to engage with a drug and alcohol service in the community and he referred her. He noted that he discussed harm reduction with Ms Docherty and gave her naloxone training (used to reverse the effects of an opioid overdose).

21. On 7 November, Ms Docherty appeared in court and her SSO was activated due to missed probation and substance misuse appointments. (If a person does not comply with the requirements of their suspended sentence, the court will usually activate the original custodial sentence and send the person to prison.)

22. Ms Docherty did not attend her appointments with a nurse on 18 October and 11 November. She also did not attend a substance misuse review on 13 November.

23. On 25 November, Ms Docherty made a formal complaint stating that she had missed a healthcare appointment that morning because her wing was on lockdown (when prisoners need to remain in their cells). She stated that someone should have taken her to healthcare despite the lockdown. She also wrote that she had missed five appointments due to lockdown, double-booked appointments, or not being informed about appointments. Ms Docherty stated that she needed a GP appointment and that the appointment issues were worsening her mental health.

24. On 27 November, prison staff responded to her complaint and agreed that she should have been collected for her appointment. However, they also wrote that staff were not responsible for informing her about appointments and she needed to check the kiosk for appointment reminders and to apply for further appointments.

25. On 15 December, Ms Docherty saw her key worker. (Key workers provide prisoners with an allocated officer that they can meet regularly to discuss how they are and any day-to-day issues they would like to address.) Ms Docherty told her that she enjoyed working at a restaurant within the prison. She did not raise any significant issues.

26. On 2 January 2024, Ms Docherty told a GP that she was experiencing anxiety and panic attacks. The GP prescribed propranolol (used to treat high blood pressure, which also helps with physical symptoms of anxiety).

27. On 11 January, Ms Docherty had a substance misuse review with a nurse. She said she wanted to detox as she did not want to take methadone once released. Healthcare staff agreed to reduce her methadone dose by 2ml each week, which meant that she would be prescribed 20ml of methadone by her release date. Ms Docherty said she wanted to engage in recovery work. (There is no evidence that this took place although there was only a month until her release and Ms Docherty did subsequently see a substance misuse worker for harm minimisation advice.)

28. During the same appointment, Ms Docherty discussed her mental health with the nurse, stating she had anxiety, depression, heard voices, and had taken trazodone for years. She wanted a review of her diagnoses. The nurse rereferred her to the mental health team.

29. On 16 January, Ms Docherty saw her key worker. Ms Docherty told her that she was concerned about her mental health and had not received any updates on her mental health referral. The key worker agreed to chase this up for her. She remained on the waiting list at the time of her release. On 24 January, she told the key worker that she was having issues sharing her cell with another prisoner and subsequently moved to an enhanced and open conditions unit.

30. On 9 February, Ms Docherty saw a substance misuse worker and confirmed that she was aware of her community drug and alcohol service appointment. He gave Ms Docherty harm minimisation advice and discussed her reduced tolerance levels to drugs.

31. On 12 February, Ms Docherty was released from Peterborough. A nurse recorded that Ms Docherty declined to have her clinical observations taken prior to release (which involves checking body temperature, blood pressure, pulse rate, and breathing rate).

32. Ms Docherty was released from prison with a naloxone kit.

Pre-release planning for Ms Docherty

33. On 21 November 2023, Ms Docherty attended a video link meeting with her community offender manager (COM) who had just been allocated. Ms Docherty said that before going to prison she had lived on her own in private rented accommodation and was not sure whether she could return to the property when released.

34. On 27 November, a resettlement probation practitioner emailed the COM to confirm that the Department for Work and Pension (DWP) would continue to pay Ms Doherty's benefits to cover her rent payments while she was in prison. Ms Docherty planned to return to her property following her release.

35. On 1 December, Ms Docherty was allocated a new community offender manager (COM). On 11 December, the COM confirmed with Ms Docherty's landlord that she could return to her address once released from prison. On 18 December, the COM emailed the POM for an update on how Ms Docherty had been in prison to help her complete a Home Detention Curfew application (HDC- a scheme which allows eligible prisoners to be released early from custody if they have a suitable address to go to). The COM authorised Ms Docherty's release under HDC, following a home visit on 3 January 2024.

36. On 22 January, a GP prescribed a month’s worth of trazodone to Ms Docherty to be given to her on 26 January. They also prescribed two months’ worth of propranolol to be given to her on 30 January to prepare for her release. She was prescribed 20ml of methadone from 8 February, reducing by a further 2ml from 16 February. Healthcare staff sent her methadone prescription to the community substance misuse service.

37. On 9 February, a substance misuse worker gave Ms Docherty an appointment to attend a community drug and alcohol service on 13 February at 2pm.

38. Ms Docherty’s COM instructed Ms Docherty to report to Colchester probation office on 13 February at 1.30pm. The COM did not know that Ms Docherty's substance misuse appointment was scheduled around the same time that day.

Post-release release from HMP Peterborough

39. On 12 February 2024, Ms Docherty was released from HMP Peterborough.

40. Ms Docherty attended the probation office on 12 February due to confusion about her appointment, which was scheduled for the following day. The COM was not present at the office at that time but told Ms Docherty that she would go into the office to see her. Ms Docherty said she was unable to wait for her as she had another appointment. She agreed to attend the probation office the next day, on 13 February at 9.00am.

41. Ms Docherty did not attend her probation appointment on 13 February and her COM sent her a warning letter and travel warrant (to cover the cost of her travel to the office). The following day, Ms Docherty attended the probation office.

42. Ms Docherty had an electronic monitoring tag fitted and was required to stay at her address from 7.00pm to 7.00am each day as part of her HDC conditions. During the appointment, she told her COM that she was struggling to get everything sorted, including attending the job centre and registering with a GP. She explained that she missed her probation appointment on 13 February because she was locked in a train toilet. The COM told the investigator that Ms Docherty engaged well but seemed keen to leave the appointment.

43. During the appointment, Ms Docherty told her COM that she did not want to use drugs in the community, and she did not need to collect her methadone prescription. The COM reminded Ms Docherty that she could attend the community drug and alcohol service if she changed her mind.

44. On 19 February, Ms Docherty did not attend her probation appointment. The COM was unable to get hold of her by phone. She sent Ms Docherty a compliance letter and text message confirming she had rescheduled her appointment for 21 February.

Circumstances of Ms Docherty's death

45. On 21 February, the COM conducted an unannounced home visit after Ms Docherty missed her probation appointment. Concerned that Ms Docherty was not answering the door, she called the police for a welfare check. She then contacted Ms Docherty's landlord, who arrived promptly and helped gain access to the property through the rear window. Upon entering, the COM found Ms Docherty unresponsive on a makeshift bed on the floor. There were no signs of life, and paramedics confirmed that Ms Docherty had died.

Post-mortem report

46. The post-mortem report concluded that Ms Docherty died from mixed drug toxicity of morphine and pregabalin (used to treat epilepsy, anxiety and nerve pain) which she had not been prescribed. Bronchopneumonia and ischaemic heart disease were listed as contributory factors.

47. Toxicology tests also identified the presence of cocaine, methadone, trazadone (her prescribed antidepressant) and propranolol. According to the post-mortem report, Oramorph (liquid morphine) and drug paraphernalia were found in her property.

Inquest

48. At the inquest held on 9 January 2025, the Coroner concluded that Ms Docherty's death was drug-related.

Support for staff

49. The COM was offered support and referred to appropriate services following Ms Docherty's death.

Findings

Accommodation

50. We consider that the COM appropriately prepared for Ms Docherty's release by liaising with Ms Docherty's resettlement worker, POM, and landlord before her release to confirm that she could return to her property. Ms Docherty was released with accommodation in place.

Substance misuse

51. Ms Docherty had a history of substance misuse. At her appointment with substance misuse services in October 2023, she said that she did not want to have a full assessment or engage with recovery work. The recovery worker gave her harm minimisation advice. On 11 January, Ms Docherty changed her mind and said she wanted to engage with recovery work. This did not occur before she was released but she was subsequently given harm minimisation advice and told about the dangers of overdose.

52. At the same appointment, Ms Docherty said that she did not want to take methadone following her release, so she was prescribed a reducing dose of methadone. This gradual reduction was necessary to lessen Ms Docherty's withdrawal symptoms.

53. Before Ms Docherty was released from Peterborough, staff gave her a naloxone kit. She was also given an appointment to attend community drug services and a prescription provided for methadone. Post-release, the COM put appropriate measures in place to address Ms Docherty's substance misuse issues. This included adding licence conditions to comply with any requirements relating to addressing substance misuse issues and engaging with a community substance misuse service.

Good Practice

54. The considerate efforts made by the COM to conduct a welfare check on Ms Docherty on 21 February, following her missed appointments were commendable. She demonstrated efforts that went above and beyond what could be expected and led to her finding that Ms Docherty had died.

Adrian Usher **March 2025**
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