Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Renny Edwards, on 25 April 2024, following his release from HMP Swansea

A report by the Prisons and Probation Ombudsman

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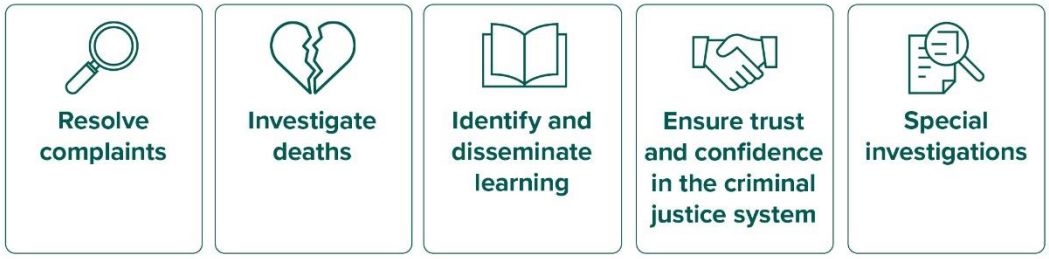
OUR VISION

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 Renny Edwards died from chronic alcohol misuse with epilepsy on 25 April 2024 following his release from HMP Swansea ten days earlier. He was 56 years old. We offer our condolences to those who knew him.

5. Mr Edwards had a licence condition in place to address his alcohol misuse. He twice attended the probation office while intoxicated, and he agreed to work with the community service. Despite this, probation staff did not refer him to the community drug and alcohol team and missed multiple opportunities to do so.

Recommendations

- **The Head of Probation Delivery Unit for Dyfed-Powys should ensure that when a risk is identified, appropriate referrals are promptly completed to the relevant community services.**

The Investigation Process

6. HMPPS notified us of Mr Edward's death on 26 July 2024.

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

8. The investigator interviewed one member of probation staff on 19 August 2024.

9. We informed HM Coroner for Pembrokeshire of the investigation. She gave us the results of the post-mortem examination and informed us that they were not holding an inquest. We have sent her a copy of this report.

10. The Ombudsman's office contacted Mr Edwards next of kin, his mother, to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond to our letter.

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

Background Information

HMP Swansea

12. HMP Swansea is a category B reception prison which holds men who have been convicted or remanded into custody. Healthcare services are provided by Swansea Bay University Health Board.

Probation Service

13. 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

14. On 30 December 2023, Mr Renny Edwards was remanded into custody at HMP Swansea and on 21 January 2024, was convicted of common assault and battery. He was sentenced to 24 weeks in prison. He had a history of alcohol misuse and had been diagnosed with epilepsy.

Pre-release planning

15. On 30 December 2023, a nurse saw Mr Edwards for his initial health screen. He told her that he was a heavy alcohol user but had recently reduced his intake. His epilepsy diagnosis was noted, for which he was prescribed medication throughout his time in prison.

16. On 2 January 2024, the substance misuse team saw Mr Edwards, but he declined their support. He told them he knew how to access support if he needed it.

17. On 1 February, Mr Edwards' Prison Offender Manager (POM) introduced himself to Mr Edwards. He noted that Mr Edwards was well known in the prison and had served a number of sentences there.

18. On 14 February, Mr Edwards' Community Offender Manager (COM) had a video call with Mr Edwards. He told her that he would work with the community drug and alcohol service on release.

19. On 22 February, the resettlement team saw Mr Edwards. He told them that he would return to his own accommodation on release.

20. On 4 March, Mr Edwards was released on licence from Swansea under the End of Custody Supervised Licence (ECSL) scheme which, at the time, allowed eligible prisoners to be released up to 18 days early to help reduce overcrowding.

21. On 12 March, Mr Edwards was recalled to Swansea for breaching his licence conditions. A nurse saw Mr Edwards for an initial health screen and noted that he had epilepsy.

22. On 13 March, the substance misuse team saw Mr Edwards, but he declined their support. They signposted him to local community services in preparation for his forthcoming release in April.

23. On 21 March, Mr Edwards' COM changed.

24. On 28 March, the new COM had a video call with Mr Edwards who confirmed that he would return to his own accommodation. They discussed post-release support and Mr Edwards agreed that he should be referred to the community drug and alcohol service to address his alcohol misuse.

25. On 2 April, Mr Edwards was released from Swansea. The next day, he was recalled to Swansea for failing to attend his probation appointment on the day of his release.

A nurse saw Mr Edwards for his initial health screen. He declined intervention for his alcohol consumption.

26. On 4 April, the substance misuse team saw Mr Edwards. He reported that he had an alcohol problem but declined any support. He confirmed that he knew how to contact them if he changed his mind.

27. On 10 April, Mr Edwards declined to engage with the resettlement team. He told them that he did not need their support.

28. On 12 April, a GP operating at Swansea prescribed Mr Edwards his medication for release. This included his epilepsy medication.

Post-release management/release from HMP Swansea

29. On 15 April, Mr Edwards was released from Swansea. A Senior Probation Officer (SPO) told us that he was released to his home address. He attended his initial appointment with the COM, who noted that Mr Edwards seemed "somewhat uncoordinated", but he maintained that he had not drunk alcohol (and probation staff would not have had the facilities to test him for alcohol at this appointment). The COM went through Mr Edwards' licence conditions with him, including a condition to address his alcohol problems. He noted that Mr Edwards understood the need to work towards his sentence plan objective on substance misuse.

30. On 16 April, Mr Edwards attended the probation office as he thought he had an appointment, even though he did not. Probation staff noted that he appeared drunk and had wet himself, so the receptionist had not let him in. The receptionist sent the COM a message to let him know.

31. On 22 April, Mr Edwards failed to attend a planned probation appointment. The COM issued a formal warning letter due to his failure to attend the appointment.

Circumstances of Mr Edwards death

32. On 25 April, the COM received a phone call from Mr Edwards' mother to say that Mr Edwards had been reported missing.

33. At 4.12pm that day, the Independent Domestic Violence Advocates (IDVAs) phoned the Probation Service and told them that Mr Edwards had died.

Post-mortem report

34. The post-mortem report concluded that Mr Edwards had died from chronic alcohol misuse with epilepsy.

Findings

Substance misuse

35. Mr Edwards had a history of alcohol misuse, and he had a licence condition in place to address his alcohol problems. During appointments with probation staff before his release, Mr Edwards agreed to work with the community drug and alcohol service on release. However, probation staff failed to refer him to the community alcohol team.

36. A SPO told us that, ideally, Mr Edwards should have been referred to the community alcohol service before his original release date of 4 March. However, he was released 18 days early and then was in the community for a short time before he was recalled. She said this meant that the plans to complete the referral were put on hold.

37. When Mr Edwards attended his induction with probation staff on 15 April, he was intoxicated. The SPO told us Mr Edwards should have been referred to the community alcohol team after his induction appointment, but it was not completed. She said that the COM may have been waiting for the next appointment to do this, but she could not confirm this as he was on long-term sick leave from work.

38. When Mr Edwards turned up to the probation office unannounced on 16 April, apparently intoxicated, the receptionist told us that he passed this information to the COM by sending a message through Microsoft Teams. The SPO was unable to confirm whether the COM received this message but said that if he did, she would have expected him to contact Mr Edwards or arrange an unannounced home visit. There is no evidence that this was followed up or that Mr Edwards was referred to the community alcohol service at this point.

39. Although it is not possible to know whether Mr Edwards would have received an appointment before his death, there were multiple opportunities to refer Mr Edwards to the community alcohol service, which were missed by probation. We therefore make the following recommendation:

    The Head of Probation Delivery Unit for Dyfed-Powys should ensure that when a risk is identified, appropriate referrals are promptly completed to the relevant community services.

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

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