

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Leon Hughes, a resident at Deer Park Approved Premises, on 9 August 2024

A report by the Prisons and Probation Ombudsman

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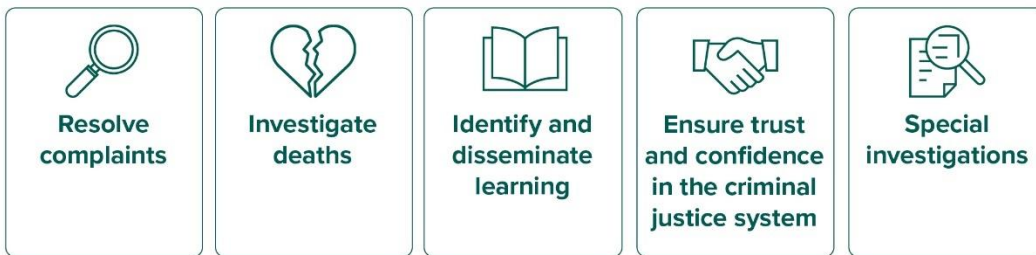
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OUR VISION

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



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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.

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.

Mr Leon Hughes died of multiple drug toxicity on 9 August 2024, while a resident at Deer Park Approved Premises. He was 35 years old. I offer my condolences to Mr Hughes' family and friends.

Mr Hughes was the first resident to die at Deer Park in three years.

Mr Hughes had been released from HMP Doncaster the day before his death. He had a history of substance misuse and mental health issues. Because Mr Hughes refused to engage with the substance misuse team at Doncaster, he was not referred to the community substance misuse service or offered a naloxone kit upon his release on 8 August.

The investigation found that there was a lack of communication between Doncaster and the Probation Service. Mr Hughes' prison offender manager and community offender manager had little contact regarding his release planning and engagement with services in prison.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Adrian Usher
Prisons and Probation Ombudsman

September 2025

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Summary

Events

1. On 18 September 2023, Mr Leon Hughes was remanded to HMP Nottingham. On 8 April 2024, Mr Hughes was sentenced to 18 months in prison for intentional strangulation.
2. On 10 June, Mr Hughes' Community Offender Manager (COM) referred him to Deer Park Approved Premises (AP) for post-release accommodation. On 24 June, He was offered a bedspace at the AP.
3. On 23 July, Mr Hughes was transferred HMP Doncaster.
4. On 8 August, Mr Hughes was released from Doncaster. He attended Doncaster probation office for his induction appointment. Mr Hughes did not attend the Deer Park AP on time so probation staff initiated his recall to prison.
5. At 7.10pm, a keyworker at the AP received a telephone call from Mr Hughes. She noted that he sounded under the influence of alcohol or drugs. She told Mr Hughes that he should have returned to the AP by 7.00pm to make it back for his curfew. Mr Hughes arrived at the AP at 10.17pm.
6. At 9.43am on 9 August, Mr Hughes left the AP. Shortly before 5.00pm, a member of the public found Mr Hughes dead on Pye Bank Road, in Sheffield. An ambulance was called and at 5.16pm, paramedics pronounced life extinct.
7. Police officers found drug paraphernalia (including needles and unknown drugs) in Mr Hughes' bag.

Findings

8. We found that there was a lack of communication between prison and probation staff. Mr Hughes' prison offender manager (POM) and community offender manager (COM) had little contact regarding his release planning and engagement with services in prison. We also found that Mr Hughes' licence conditions and reporting instructions were not communicated to him clearly, leading to possible confusion.
9. We found that despite having a history of substance misuse, as Mr Hughes was not engaging with the substance misuse team at Doncaster he was not offered a naloxone kit upon release on 8 August and was not referred to the community substance misuse service. We also found that Mr Hughes' COM did not know he was not engaging with the substance misuse team, and did not refer him to the community substance misuse team as she assumed the prison had referred him.

Recommendation

- The Governor and the Head of Service at Doncaster Probation Delivery Unit should review working relationships between staff and assure themselves that staff work collaboratively, share information appropriately and are clear about the responsibility to make referrals as part of pre-release planning.

The Investigation Process

10. HMPPS notified us of Mr Hughes' death on 13 August 2024.
11. The investigator obtained copies of relevant extracts from Mr Hughes' prison and probation records.
12. The investigator interviewed, Deer Park Approved Premises manager, and Community Offender Manager.
13. We informed HM Coroner for Sheffield of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
14. The Ombudsman's office wrote to Mr Hughes' next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. Mr Hughes' next of kin asked about his medication, the prison discharge grant and asked for a copy of our report. We have answered these questions in our report.
15. Mr Hughes' next of kin received a copy of the draft report. They raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.
16. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Background Information

Deer Park Approved Premises

17. Approved Premises accommodate individuals released from prison on licence and those on bail or community sentences. Their purpose is to provide an enhanced level of residential supervision in the community, as well as a supportive and structured environment. Residents are responsible for their own healthcare and are expected to register with a GP.
18. Deer Park is an approved premises in Sheffield, managed by HMPPS. It holds up to 34 men in single rooms. Each resident is allocated a key worker to oversee their progress and wellbeing. Key workers help to make sure residents comply with the rules of the approved premises and their licence conditions.
19. Residents are subject to approved premises rules in addition to any licence conditions they have been given. They are not allowed to leave the building between 11.00pm and 6.00am. Approved premises staff are on duty at Deer Park 24 hours a day.

Previous deaths Deer Park Approved Premises

20. There have been no deaths recorded at Deer Park Approved Premises in the last three years.

Key Events

21. On 18 September 2023, Mr Leon Hughes was remanded to HMP Nottingham charged with intentional strangulation of his ex-partner. On 8 April 2024, he was sentenced to 18 months in prison.
22. Mr Hughes had a history of substance misuse, mental health issues, and some physical health issues. He was prescribed medications to manage his mental and physical health conditions.
23. On 3 June, Mr Hughes transferred to HMP Humber.
24. On 10 June, the Community Offender Manager (COM) referred Mr Hughes to Deer Park Approved Premises (AP) for accommodation on his release from prison. On 24 June, Deer Park AP offered Mr Hughes a bedspace.
25. On 23 July, Mr Hughes transferred to HMP Doncaster. When he arrived, he refused to go on to the induction wing, so he was sent to the segregation unit. He remained there until his release.
26. At Mr Hughes' reception health screen, the nurse noted that he was on medication for his mental health conditions and she referred him to the mental health team. She noted that Mr Hughes had a history of substance misuse, however he said he was currently drug-free. The nurse attempted to drug test Mr Hughes, but he declined. The nurse referred him to the substance misuse team. She also noted that Mr Hughes did not engage during the screening as he said he did not want to be at Doncaster.
27. On 26 July, Mr Hughes was sentenced to 24 weeks in prison for possession of a bladed article (committed before he was remanded to prison).
28. On 30 July, a mental health nurse met with Mr Hughes to review his mental health. He noted that he knew Mr Hughes well from previous sentences. Mr Hughes said that he did not have any concerns about his mental health. The nurse discharged him from their service.
29. On 31 July, the COM emailed Deer Park and confirmed that Mr Hughes would have a 1.00pm sign in and a 7.00pm to 6.00am curfew on his licence, which the AP would enforce. During interview, the COM told us that she added the curfew condition to Mr Hughes' licence, but there is no evidence of this on his licence.
30. On 31 July, a substance misuse recovery worker assessed Mr Hughes. The recovery worker noted that Mr Hughes had a history of substance misuse but was not currently on medication to treat drug dependency. Mr Hughes said that while at Humber, he was using synthetic cannabinoids (spice) regularly. Mr Hughes said he enjoyed using spice and declined to engage in a discussion about harm reduction and naloxone (medication that can reverse the effects of an opioid overdose) training. As Mr Hughes declined support, the recovery worker discharged him.
31. On 8 August, Mr Hughes was released from Doncaster. Healthcare staff assessed that he was fit to be released and confirmed that he was released with a seven-day

supply of prescribed medication. Mr Hughes was also released with a discharge grant of £89.52. He was not provided with a naloxone kit.

Deer Park Approved Premises

32. At 11.00am, Mr Hughes attended his induction appointment at Doncaster probation office. A duty COM completed the induction paperwork with Mr Hughes. She told him to go Deer Park AP before his 1.00pm sign in. Mr Hughes said he had a taxi waiting outside the office, ready to take him straight there. Mr Hughes did not attend the AP in time for his 1.00pm sign in.
33. Probation staff considered that Mr Hughes' failure to attend the AP as instructed increased the risk he posed to the public and initiated his recall to prison.
34. At 7.10pm, a keyworker at Deer Park received a telephone call from Mr Hughes. She noted that he sounded under the influence of alcohol or drugs. Mr Hughes said that he could not walk as he was 'in a state' and was using a broken stick as a walking aid. He said he had borrowed someone's phone to make the call. The keyworker told Mr Hughes that he should have returned to Deer Park by 7.00pm to make it back for his curfew. Mr Hughes said he did not have a curfew. Mr Hughes arrived at the AP at 10.17pm. Staff did not drug-test Mr Hughes.
35. At approximately 9.30am on 9 August, a keyworker at the AP completed the first stage induction with Mr Hughes and explained the AP rules. She noted that he had a history of substance misuse and spoke to him about his tolerance levels, overdose risks and naloxone kits.
36. The AP manager, also spoke to Mr Hughes. He told her that he had smoked spice the day before following his release from prison. He said he had vomited as a result, and that his vomit and urine were black. She encouraged him to seek medical attention and offered to arrange a taxi to take him to the hospital, but Mr Hughes said he would make an appointment with his own GP.
37. At 9.43am after the induction, Mr Hughes left the AP and walked into Sheffield town centre with two other residents.
38. At 11.30am, The Public Protection Casework Section (PPCS) sent probation staff a decision to recall letter and revoked Mr Hughes' licence. During interview, the AP manager, told us that as Mr Hughes was not at the AP at the time, they did not notify police of his whereabouts to arrest him for the recall.
39. Staff at Deer Park did not see Mr Hughes for the rest of the day as he missed his 1.00pm sign in.

Circumstances of Mr Hughes' death

40. At 7.53pm on 9 August, police officers attended Deer Park to notify staff that shortly before 5.00pm, a member of the public had found Mr Hughes dead on Pye Bank Road, Sheffield. An ambulance was called and at 5.16pm, paramedics pronounced life extinct. The police officers said they found the AP telephone number in Mr

Hughes' bag, along with clothing and drug paraphernalia (including needles and unknown drugs).

Contact with Mr Hughes' family

41. The police were responsible for breaking the news of Mr Hughes' death to his family. The AP manager was appointed as the single point of contact for Mr Hughes' next of kin. On 13 August, she sent a letter of condolence to Mr Hughes' next of kin, offering support and, in line with national instructions, offered to contribute to the costs of the funeral. She had two further telephone calls with Mr Hughes' next of kin on 23 August and 11 November.

Support for residents and staff

42. After Mr Hughes' death, the AP manager debriefed the staff at Deer Park to ensure that they had the opportunity to discuss any issues arising, and to offer support. She also offered support to the residents of Deer Park. The COM was also offered support.

Post-mortem report

43. The post-mortem concluded that Mr Hughes died of multiple drug (morphine and cocaine) toxicity.

Findings

Release planning

Information sharing

44. While at Doncaster from 23 July to his release on 8 August, Mr Hughes was located in the segregation unit. During interview, the COM and AP manager told the investigator that they were not aware of this, but both said it would not have changed the way Mr Hughes' release was managed.
45. We found that there was little communication between prison and probation staff in preparation for Mr Hughes' release, with the majority of contact being between the COM and the pre-release team at Humber. Both the COM and Mr Hughes' Prison Offender Manager (POM) told us that due to the short period of time Mr Hughes was in Doncaster, their priority was ensuring that he had suitable accommodation upon release.

Reporting instructions and licence conditions

46. Prior to Mr Hughes' release, the COM did not have any direct contact with him. During interview, she told the investigator that she had been allocated his case on 18 June 2024. She attempted to arrange a pre-release meeting with Mr Hughes on 22 July, while he was at Humber, however he did not attend. During the meeting, she asked the pre-release team to pass release information, including the details of the approved premises placement and additional licence conditions, on to Mr Hughes. It is unclear if this information was passed on to Mr Hughes as he was sent to Doncaster the following day.
47. On 7 August, the day before Mr Hughes' release, the COM said she contacted the prison to ask them to let Mr Hughes know that he must report to Deer Park AP straight after his release, instead of reporting to Doncaster probation office as instructed on his licence. We think it unlikely that this message was communicated to Mr Hughes, as he attended the probation office first.
48. The COM told the investigator that when completing Mr Hughes' licence, she added a 7.00pm to 6.00am curfew condition. The investigator found that this condition was not included on Mr Hughes' licence. Unfortunately, the record of the licence conditions submitted to the prison is no longer available. We consider that this may have been an administration error but could have caused Mr Hughes some confusion, particularly if he was not informed about or reminded of this when he reported to the probation office on the day of his release.
49. We consider the best release planning is achieved from good communication and collaborative working, which involves the prisoner.

Substance misuse service

50. Mr Hughes had a history of substance misuse. During his sentence, he initially engaged with the substance misuse service. However, when he was sent to Doncaster on 23 July, he declined support from the service. Mr Hughes said he had

been regularly using synthetic cannabinoids (spice) at his previous establishment, and he enjoyed using it. He declined to engage in a discussion regarding harm reduction and naloxone training, overdose and low tolerance risks. As Mr Hughes declined support from the service, the recovery worker discharged him.

51. The local naloxone policy at Doncaster says the need for prescribing naloxone and training to use it is identified through assessment and one to one care management.
52. As Mr Hughes had declined support from the substance misuse team, and did not engage in a discussion regarding naloxone, training was not delivered and he was released without a naloxone kit. Additionally, as he declined to engage with the service, they did not refer him to the community substance misuse service.
53. The substance misuse lead at Doncaster, told us the local naloxone policy is currently under review, with one of the considerations being how prisoners who are not engaging with the substance misuse service can be identified and trained to use naloxone. She also told us that the prison now informs all prisoners who have been referred into their service of how to access community substance misuse services, even if they decline support in custody.
54. On this occasion, we make no formal recommendation as we are satisfied the prison have taken appropriate and responsive steps to address the identified issue.
55. However, we consider that there was a missed opportunity to refer Mr Hughes to the community substance misuse service for support. During interview, the COM told the investigator that she did not refer Mr Hughes to the community substance misuse service as she did not know he had declined support in at Doncaster and she assumed that the prison had referred him to the community service. We recommend:

The Governor and the Head of Service at Doncaster Probation Delivery Unit should review working relationships between staff and assure themselves that staff work collaboratively, share information appropriately and are clear about the responsibility to make referrals as part of pre-release planning.

Inquest

56. At the inquest held on 11 November 2025, the coroner concluded that Mr Hughes' death was drug related.

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