Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Thomas Griffiths, following his release from HMP Portland, on 7 September 2023

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. From 6 September 2021, the PPO investigates post-release deaths that occur within 14 days of the prisoner's release.

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.

1. Mr Thomas Griffiths died from the toxic effects of cocaine on myocardium (heart muscle) complications on 7 September 2023, following his release from HMP Portland on 1 September. He was 34 years old. We offer our condolences to his family and friends.

2. Mr Griffiths had a history of poor mental health, drug and alcohol dependency and a history of attempted suicide and accidental overdose.

3. The clinical reviewer concluded that the mental health care Mr Griffiths received at Portland was not equivalent to that which he could have expected to receive in the community. She found that there was a lack of clinical curiosity and action taken to understand Mr Griffiths' mental health history and to formulate his risks which ultimately led to poor pre-release planning from a mental health perspective.

4. Mr Griffiths' community offender manager's efforts to find him suitable accommodation and to be added to the Community Mental Health Team's caseload is an example of good practice.

5. The clinical reviewer in response to the issues identified with multiagency working outside of the prison setting has made a Safeguarding Adult Review (SAR) referral to Somerset Council with a request that they consider commissioning a SAR.

Recommendations

- The Head of Healthcare should ensure that prisoners nearing release are referred to community mental health services when their presentation and history warrants it.

- The Head of Healthcare should review the 'to take out' protocol and ensure that guidance is included to encourage prescribers to review and understand a prisoner's level of risk with medication they are prescribing on release.

The Investigation Process

6. HMPPS notified us of Mr Griffiths' death on 17 October 2023.

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

8. NHS England commissioned a clinical reviewer to review Mr Griffiths' clinical care at the prison.

9. On 19 and 29 February 2024, the investigator and clinical reviewer jointly interviewed two members of staff at Portland by video link and a probation officer by video link.

10. We informed HM Coroner for Somerset of the investigation. She gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

11. The Ombudsman's office contacted Mr Griffiths' mother to explain the investigation and to ask if she had any matters she wanted us to consider. She had no specific questions.

12. We shared the initial report with HM Prison and Probation Service (HMPPS). They did not identify any factual inaccuracies.

13. We also shared the initial report with Mr Griffiths' mother. She did not make any comments.

Background Information

HMP Portland

14. HMP Portland is a Category C training and resettlement prison. Oxleas NHS Foundation Trust provides healthcare services.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Portland was in August 2022. Inspectors reported that since their last inspection in 2019, the Governor had begun an impressive transformation with a concerted effort to improve recruitment, defying the national trend with almost all officer posts filled. However, inspectors reported that there had been a problem with recruiting sufficient mental health staff and that support was largely confined to providing acute and urgent care, with no specialist psychological interventions.

16. Inspectors reported that sentence planning and offending behaviour work did not sufficiently support prisoners to make progress through their sentence. Resettlement planning arrangements were inconsistent and too many prisoners did not receive suitable support before their release.

Probation Service

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

HM Inspectorate of Probation

18. The most recent inspection of probation services in Somerset was in July 2023. Inspectors reported that there were several positive aspects, including impressive practice relating to engagement and supporting people on probation in their desistance from offending. Inspectors found that the staff vacancy rate was only 4%. However, the workloads of probation officers remained unacceptably high, and there were almost as many trainee probation officers as there were qualified members of staff. This meant that while the region had staff in post, they were not yet operating at full capacity. Work focusing on risk of harm was disappointing and improvement was needed in the quality of work to assess, plan, manage and review the risks posed by people on probation.

Key Events

19. On 2 September 2020, Mr Thomas Griffiths was remanded to HMP Bristol for robbery. On 30 October, he was convicted and sentenced to three years in prison. On 8 December, he was transferred to HMP Guys Marsh. On 20 October 2021, Mr Griffiths was released on licence.

20. On 20 July 2023, Mr Griffiths' licence was revoked, and he was sent to HMP Exeter.

21. Mr Griffiths had a history of poor mental health including autism, attention deficit hyperactivity disorder (ADHD), post-traumatic stress disorder (PTSD), emotionally unstable personality disorder (EUPD), depression, a history of drug induced psychosis, schizophrenia with paranoia (a type of delusion that usually involves thoughts of persecution) and drug and alcohol dependency. Mr Griffiths had a history of attempted suicide and accidental overdose.

22. At his initial health screen, Mr Griffiths told a nurse that he had previously been in a mental health hospital and had PTSD, EUPD and anxiety and depression. Mr Griffiths said that he had been assessed in hospital the day before after taking a deliberate overdose of medication, and that he had current thoughts of self-harm. The nurse referred Mr Griffiths to the mental health team. Mr Griffiths tested positive for cocaine, cannabis and benzodiazepine and told the nurse he had a history of heroin use. He also reported moderate to severe alcohol use.

23. Prison staff started HMPPS suicide and self-harm prevention procedures (known as ACCT).

24. Mr Griffiths was allocated a community offender manager (COM).

25. On 23 July, a recovery worker saw Mr Griffiths for a substance misuse review. Mr Griffiths told her that diazepam and opioids were the drugs he mostly used. He said that in the community he was under the care of the Somerset Drug and Alcohol Service. Mr Griffiths told the recovery worker that he had been sleeping in his car and needed help to find accommodation.

26. On 24 July, healthcare staff discussed Mr Griffiths at the mental health allocations meeting and agreed that he would be placed onto a caseload for regular review.

27. On 25 July, a resettlement officer completed Mr Griffiths' Basic Custody Screen (to identify the key issues to prioritise in Mr Griffiths' resettlement plan). She noted that Mr Griffiths had lived in a 'dry house' in Somerset for six weeks but was evicted and was therefore homeless. She noted that his local council had made him higher priority for housing. She asked that the COM complete a duty to refer (DTR – the Homelessness Reduction Act 2017 requires prisons and probation services to refer anyone who is homeless or at risk of becoming homeless within 56 days to a local housing authority), a Commissioned Rehabilitative Services referral (CRS – who support prisoners with accommodation) and to contact Mr Griffiths' community accommodation support worker.

28. Mr Griffiths told the resettlement worker that he was registered with a community GP. He said that he had complex mental health problems and had made many suicide attempts. Mr Griffiths asked to be referred to the Proactive Care Team

(PACT- a specialist team of health professionals who help adults who have complex health problems).

29. The COM completed Mr Griffiths' Offender Assessment System (OASys) risk and needs report. She noted that three months before the offences for which he was convicted, Mr Griffiths was attacked which resulted in a significant deterioration in his mental health and had led him to relapse into illicit substance use. Mr Griffiths said that before his recall he had moved back in with his mother. She noted that Mr Griffiths' mother's accommodation was not suitable for Mr Griffiths on release.

30. The COM noted that Mr Griffiths would be released at the end of his sentence with no probation supervision. (His sentence expiry date and licence expiry date were 2 September 2023.) She noted that she would arrange a meeting with prison staff, healthcare and accommodation professionals to plan for his release.

31. On 27 July, Mr Griffiths was transferred to HMP Portland.

32. On 28 July, at his initial health screen, Mr Griffiths told a nurse that he had a history of attempted suicide but did not have any current thoughts of suicide or self-harm. He told her that he would like to work with the Integrated Substance Misuse Service (ISMS). She referred him to the service. Mr Griffiths was not referred to the mental health team.

33. Mr Griffiths was allocated a prison offender manager (POM).

34. That day, a probation service officer completed a DTR to Somerset Council.

35. On 31 July, Mr Griffiths saw a recovery worker from the ISMS and told her that he had used Subutex (buprenorphine, used to treat opioid dependence) illicitly at Exeter. Mr Griffiths said that he did not want to leave Portland with a 'habit' and would like ongoing support from Change Grow Live (CGL - provide psychosocial services).

36. On 1 August, a recovery worker from CGL saw Mr Griffiths. Mr Griffiths asked to receive counselling in the community to address his previous trauma. She discussed with him the dangers of using Subutex illicitly.

37. On 2 August, a senior probation officer noted that Mr Griffiths would be released on 1 September, on a one-day licence, and that his sentence expired the following day. She noted that his DTR and CRS referrals had both been completed. She noted that the COM was holding a meeting on 3 August, to discuss Mr Griffiths. She noted that Mr Griffiths had health issues, a history of self-harm, poor mental health and multiple needs and that these issues could be progressed after the meeting.

38. On 3 August, the COM had a meeting with a worker from the Link (South Somerset's health and wellbeing community hub), a worker from CRS, a worker from 2nd Step (a mental health charity), a social worker from the Mental Health Social Care Team, an accommodation support worker, and a probation service officer. The COM said that she invited staff from Mr Griffiths' community mental health team (CMHT) and community GP surgery, but they did not attend. The social worker said that the CMHT could be involved with Mr Griffiths through a referral from his community GP. She noted that 2nd Step had two psychologists who could offer additional support. The COM noted that following the meeting she would ask

the Dairy House (a Church-based community centre in Wells who had previously provided accommodation for Mr Griffiths) if they would consider accepting Mr Griffiths back and that she would arrange a further meeting for 17 August. (This meeting went ahead as planned, but a representative from Dairy House did not attend.)

39. On 4 August, prison staff closed the ACCT procedures.

40. On 13 August, a custodial discharge coordinator saw Mr Griffiths for pre-release planning. Mr Griffiths told her that he would be released homeless. He said that in the community he would seek support for his mental health. She offered Mr Griffiths naloxone (used to reverse the effects of opiate overdose), which he declined. She gave Mr Griffiths a pre-release information booklet including information regarding mental health support charities in the community.

41. On 21 August, the COM emailed a service manager at Rethink and asked her to reconsider Mr Griffiths' referral for accommodation. The service manager told her that they did not have capacity to assess Mr Griffiths' application before his release.

42. That same day, the COM received an email from Mr Griffiths' community accommodation worker who said that he had sent a referral to Home Group (a housing association and social enterprise charity) for their consideration.

43. That day, the social worker told the COM that she had contacted the community mental health team who had confirmed Mr Griffiths would need to be re-referred to them on release.

44. On 23 August, prison staff restarted the ACCT procedures, because Mr Griffiths was low in mood and anxious about his impending release.

45. On 24 August, healthcare and prison staff discussed Mr Griffiths at a Safety Intervention Meeting (a prison and healthcare meeting to discuss complex prisoners). A nurse from the ISMS saw Mr Griffiths who denied any thoughts of suicide and self-harm.

46. On 1 September, the day of Mr Griffiths' release, the custodial discharge co-ordinator saw Mr Griffiths and gave him one month's supply of his medications including mirtazapine and propranolol. She also gave Mr Griffiths a paper prescription for pregabalin because this could not be dispensed due to it being a controlled drug.

47. Mr Griffiths was released homeless, but he told the COM that he was going to live with his mother until he could find more suitable accommodation.

Post-release planning

48. Mr Griffiths' licence conditions required him to report at 1.00pm on 1 September, to the duty officer at the Yeovil probation office. His licence conditions also required him to attend the Somerset Drug and Alcohol Service, Turning Point, to address his drug problems and to be drug tested as required by his community offender manager.

49. Mr Griffiths reported to the Yeovil probation office. The COM explained the terms of his licence and confirmed that they ended the following day and that he would no longer be subject to probation supervision. She told Mr Griffiths that the Probation Service would continue to support him if needed.

50. On 5 September, the COM emailed a support coordinator at Home Group who had received an accommodation referral for Mr Griffiths. She told the coordinator that Mr Griffiths was temporarily living with his mother but that the accommodation was not suitable for him. She said that Mr Griffiths' mother could help arrange an assessment with him and gave the coordinator a brief summary of his offence history.

Circumstances of Mr Griffiths' death

51. On 6 September, Mr Griffiths' mother went to work and was not due to return home until the following afternoon. At 10.21am on 7 September, because she had not heard from Mr Griffiths overnight, she returned home to check on his welfare, and found Mr Griffiths unresponsive on the kitchen floor. At 10.45am, ambulance paramedics confirmed that he had died. There were multiple blister packs of used and unused medication nearby.

52. There was no evidence that Mr Griffiths had intentionally overdosed on substances in an attempt to end his life.

Post-mortem report

53. The post-mortem concluded that Mr Griffiths died from the toxic effects of cocaine on various heart complications, including myocardial infarction (heart attack), arrhythmias (abnormal heart rhythms), and myocarditis (inflammation of the heart muscle).

54. Toxicology test showed that Mr Griffiths had recently taken cocaine at a recreational level and had also taken tramadol, diazepam, mirtazapine, pregabalin, benzodiazepines and cannabis.

Support for staff

55. After Mr Griffiths died, a senior probation officer offered the COM support and explained the support services available to her.

Findings

Clinical care

56. The clinical reviewer concluded that the mental health care Mr Griffiths received at Portland was not equivalent to that which he could expect to receive in the community.

57. The clinical reviewer said that there was a lack of clinical curiosity and action taken to understand Mr Griffiths' mental health history and to formulate his risks and ultimately this oversight led to poor pre-release planning from a mental health perspective.

Substance misuse

58. The clinical reviewer concluded that Mr Griffiths was appropriately referred and had regular contact with substance misuse services at Portland. After Mr Griffiths told a recovery worker that he had used Subutex at Exeter she noted that she would inform a non-medical prescriber. However, there is no evidence that this happened. The clinical reviewer also noted that there is no evidence that Mr Griffiths was monitored to determine whether he continued to use Subutex. The recovery worker advised Mr Griffiths of the dangers of using Subutex on top of his prescribed medication.

Mental health care

59. When Mr Griffiths arrived at Exeter he was referred to the PCMHT and supported under ACCT. The clinical reviewer found no evidence that mental health services at Exeter or Portland tried to obtain Mr Griffiths' community mental health team records or to make contact with his community care coordinator. When Mr Griffiths transferred to Portland there was no handover of care from Exeter.

60. When he arrived at Portland, Mr Griffiths was not referred to the mental health team despite being identified as being appropriate for support on a secondary caseload at Exeter. The clinical reviewer noted that the mental health team at Portland saw Mr Griffiths because he was being supported by the ACCT process rather than being considered for longer-term monitoring and assessment based on his history from the community and at Exeter.

61. The clinical reviewer concluded that the extent and complexity of Mr Griffiths' mental health was not fully known or understood by the healthcare team at Portland. When Mr Griffiths was at Portland, mental health services were entirely reliant on bank and agency staff. The Head of Healthcare said that he had difficulty in recruiting a mental health clinical lead resulting in a lack of clinical leadership.

Pre-release planning

62. The COM told the investigator that Mr Griffiths was discharged from the community mental health team (CMHT) when they became aware that he was being returned to custody. She said that she asked for them to keep his registration open so that they could be involved in his release planning. On 3 August, she invited the CMHT

to a pre-release planning meeting, but they did not attend. At the meeting the mental health social worker told her that a referral to the CMHT would have to be made by Mr Griffiths through his community GP. The clinical reviewer said that this relied on Mr Griffiths having a place to live and being registered with a community GP and was not a proactive and holistic way to ensure his access to mental health care. The COM also invited the GP surgery where Mr Griffiths was registered before he went to prison to the meeting, but they also did not attend. The actions and decisions of community health providers is outside our remit. However, the clinical reviewer concluded that more could have been done by the healthcare team at Portland to ensure that he had sufficient mental health support in the community on his release. The clinical reviewer concluded that the prison mental health team could have referred Mr Griffiths to the CMHT pre-release. We make the following recommendation:

The Head of Healthcare should ensure that prisoners nearing release are referred to community mental health services when their presentation and history warrants it.

Medication management

63. The custodial discharge coordinator said that Mr Griffiths would be given one week's supply of prescribed medication when he left Portland, but, for reasons unknown, a prescriber gave him a month's supply. The clinical reviewer was concerned that this happened, given Mr Griffiths' high-risks in the community around medication and the fact that he was not able to keep his medication in-possession at Portland and had a recorded history of taking too much prescribed medication to alleviate his psychological distress. The clinical reviewer identified that the 'to take out' medication protocol at Portland did not include guidelines on reviewing a prisoner's risk around medication. We make the following recommendations:

The Head of Healthcare should review the 'to take out' protocol and ensure that guidance is included to encourage prescribers to review and understand a prisoner's level of risk with medication they are prescribing on release.

64. The clinical reviewer made a number of other recommendations that the Heads of Healthcare at Exeter and Portland will wish to address:

65. The clinical reviewer in response to the issues identified with multiagency working outside of the prison setting has made a Safeguarding Adult Review (SAR) referral to Somerset Council with a request that they consider commissioning a SAR. Somerset Safeguarding Adults Board subsequently confirmed that they had accepted the SAR.

Accommodation

66. Homelessness on release from prison is a significant and complex challenge. This was the case for Mr Griffiths. When Mr Griffiths was recalled, his supported accommodation at the Dairy House was withdrawn. On release Mr Griffiths' stayed with his mother an address which was not suitable for him. He was appropriately referred to Somerset Council under the conditions of the Homelessness Reduction Act. The COM engaged with many charities in an attempt to find him suitable

accommodation. Sadly, despite his clear needs, no accommodation had yet been secured for him.

Good practice

67. The COM should be commended for her efforts to support Mr Griffiths, including trying to find suitable accommodation and for her concerns regarding his mental health. In particular, she arranged a multi-agency meeting on 3 August, to discuss his release planning which included accommodation options and invited staff from the CMHT and his community GP surgery. We consider that she went above and beyond what might reasonably have been expected of her role.

Inquest

68. The inquest into Mr Griffths' death concluded on 4 June 2024, and concluded that his death was related to substance use.

Adrian Usher
Prisons and Probation Ombudsman **September 2024**

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