



Independent investigation into the death of Mr Neil Yates on 25 April 2023, following his release from HMP Altcourse

A report by the Prisons and Probation Ombudsman

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



OGL

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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 been investigating 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 Neil Yates died of mixed drug (including opioids) toxicity and bronchopneumonia (infection of the lungs) on 25 April 2023, following his release from HMP Altcourse on 21 April. He was 53 years old. We offer our condolences to those who knew him.
5. Mr Yates had a history of opioid misuse. We found that although the substance misuse services at Altcourse trained Mr Yates in the use of naloxone (a medication that rapidly reverses the effects of opioid overdose), they did not offer Mr Yates a take home naloxone kit when he was released. We are satisfied that Altcourse has a local operating policy for take home naloxone and that the failure to offer Mr Yates a naloxone kit appears to have been an error. We bring this to the attention of the Head of Healthcare.
6. We make no recommendations.

The Investigation Process

7. HMPPS notified us of Mr Yates' death on 4 May 2023.
8. The PPO investigator obtained copies of relevant extracts from Mr Yates' prison and probation records.
9. We informed HM Coroner for Sefton of the investigation. They gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
10. The Ombudsman's family liaison officer contacted Mr Yates' sister to explain the investigation and to ask if she had any matters she wanted us to consider. She had questions about Mr Yates' prescription medication and whether this had any impact on his death. These questions have been addressed in the report.
11. Mr Yates' sister received a copy of the initial report. She did not make any comments.
12. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out one factual inaccuracy, and this report has been amended accordingly.

Background Information

HMP Altcourse

13. HMP Altcourse is a category B local prison which holds up to 1,164 male prisoners who have either been convicted or are on remand. Up to June 2023, it was managed by G4S, and G4S was the substance misuse treatment provider. It is currently run by Sodexo, who took over management of the prison in June 2023.

HM Inspectorate of Prisons

14. The most recent inspection of HMP Altcourse was in November 2021. Inspectors reported that all new arrivals were screened for alcohol and drug issues and if necessary, referred to the GP. Clinical assessments took place promptly and opiate substitution treatment was prescribed. Prisoners with drug or alcohol issues were placed on a detoxification wing. Inspectors reported that there were staff shortages within the substance misuse team, which meant there was limited access for prisoners who needed psychosocial support. The substance misuse team were unable to provide a holistic recovery service and the restricted regime limited the opportunities for group work. Prisoners received naloxone and training in how to use it, and information was shared with community services to support them on release.

Probation Service

15. 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.

Key Events

16. On 20 February 2023, Mr Neil Yates was remanded to HMP Altcourse, charged with driving offences. He was convicted and sentenced to 20 weeks in prison on 6 March.

Substance misuse services

17. When Mr Yates arrived at Altcourse on 20 February, a GP saw him to discuss his medication. Mr Yates told the GP that in the community, he was taking 600mg of MST (an opiate medication used to treat pain) each day. (He had initially been prescribed opiate medication for pain relief but then began to use it illicitly too, and also had a long history of heroin use.) The GP was unable to continue prescribing MST as it is a controlled drug that must be administered a few times a day, which is difficult to do within a prison setting. Instead, the GP prescribed him methadone (medication used to treat the symptoms of opiate withdrawal), as this has a long half-life and only needs to be administered once a day.

18. On 21 February, a substance misuse service (SMS) worker at Altcourse saw Mr Yates for an assessment. She gave Mr Yates training on naloxone (a medication that can rapidly reverse the effects of an overdose of heroin or other opioids).

19. On 25 February, a SMS worker saw Mr Yates for a review. Mr Yates told the SMS worker that he felt stable on his methadone. Mr Yates said that as he was on remand, he did not have a release date but that he was under the care of the local community drug team, and that he had an allocated keyworker.

20. On 1 March, a nurse at Altcourse saw Mr Yates to discuss his methadone prescription. Mr Yates said that he was having withdrawal symptoms and would like to have his methadone dose increased. The nurse sent this request to the GP to review.

21. On 3 March, a GP at Altcourse increased Mr Yates' methadone dose by 10mls.

22. On 17 April, a GP at Altcourse saw Mr Yates to discuss his medication. Mr Yates said that he would like to be prescribed zopiclone to help him sleep. However, the GP said that as he was already on five other sedative drugs, this would not be safe. The GP advised Mr Yates that he should consider weaning off some of the sedative drugs, however Mr Yates said that as he was being released soon, he would prefer to explore this with his GP in the community.

23. On 21 April, Mr Yates was released from Altcourse with a two-week supply of his medication.

Release from Altcourse

24. On 21 April, Mr Yates was released from Altcourse on Home Detention Curfew (HDC, where an individual is released early from prison and is monitored through curfew conditions) to his own rental property.

25. The same day, Mr Yates attended St Helens Probation office as instructed. Mr Yates' community offender manager (COM) completed his induction and issued Mr Yates with his next appointment.
26. The same day, the COM made a referral to Change Grow Live (CGL- the local community substance misuse service) and an assessment appointment was arranged for Mr Yates for 24 April.
27. On 24 April, Mr Yates attended his assessment appointment at CGL. The recovery worker noted that Mr Yates engaged well and did not appear under the influence of any illicit substances. The recovery worker gave him his next appointment for 5 May.

Circumstances of Mr Yates' death

28. In the early hours of 25 April, Mr Yates returned to his home address with a friend after going out to get some food. The friend said that he left Mr Yates sitting in a chair at approximately 2.00am while he went to a bedroom to go to sleep. At around 6.00pm, the friend woke up and found Mr Yates unresponsive in his chair. He called the emergency services and when paramedics arrived at approximately 7.00pm, they declared that Mr Yates was dead.
29. On 26 April, Merseyside Police informed HMPPS that Mr Yates had died.

Post-mortem report

30. The post-mortem report concluded that Mr Yates died of mixed drug toxicity and bronchopneumonia. Chronic obstructive pulmonary disease (COPD, chronic lung disease) and cirrhosis (scarring of the liver caused by long term liver damage) were contributing factors.
31. The pathologist found a medium level of methadone in Mr Yates' blood. The pathologist was unable to determine whether this level was consistent with prescribed or illicit usage.
32. The pathologist found a high level of morphine in Mr Yates' blood. The pathologist acknowledged that Mr Yates was prescribed morphine, however he said that the presence of a heroin metabolite suggested recent illicit heroin use and that this was highly likely to have contributed to Mr Yates' death.
33. Mr Yates was prescribed pregabalin. The pathologist found a high concentration of pregabalin in Mr Yates' blood which was consistent with excessive consumption and was highly likely to have contributed to Mr Yates' death. The pathologist noted that the combined use of opiates with pregabalin would have enhanced the toxicity of both drugs and increased the likelihood of respiratory depression and death.
34. The pathologist noted that the effects of respiratory depression would have been more severe due to Mr Yates' COPD. He also noted that Mr Yates cirrhosis would have increased the likelihood of developing infections.

Findings

Naloxone

35. Mr Yates had a history of opiate misuse and was prescribed methadone. Altcourse's local operating policy for take home naloxone acknowledges that for prisoners with a history of opioid use, the risks related to overdose and death are extremely high in the immediate period after release due to high rates of relapse and lower opioid tolerance. It states that a take home naloxone kit should be considered for all patients with a history of opiate misuse, and that they should be trained in its use.
36. We found that although SMS staff at Altcourse trained Mr Yates in the use of naloxone, they did not offer Mr Yates a naloxone kit when he was released from prison. We asked the Deputy Head of Healthcare at Altcourse why this was, but she was unable to provide an explanation as it was standard practice to issue naloxone to prisoners with a history of opiate use.
37. As Altcourse has a policy in place, we do not make a recommendation but bring this to the attention of the Head of Healthcare.

Substance misuse services

38. We found that SMS staff at Altcourse did not make a referral to the community drug and alcohol services. However, Mr Yates told the substance misuse service at Altcourse that he was already under the care of the local community drug and alcohol service with an allocated keyworker.
39. We are satisfied that Mr Yates' probation practitioner put appropriate measures in place to address his substance misuse issues when he was released from prison. This included arranging a release appointment with the local substance misuse agency and adding licence conditions for Mr Yates to comply with any requirements relating to addressing his substance misuse issues.

**Adrian Usher
Prisons and Probation Ombudsman**

March 2024

Inquest

The inquest, held on 1 November 2024, concluded that Mr Yates' death was drug related.



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