Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Dylan Davies, on 28 December 2021, following his release from HMP Cardiff

A report by the Prisons and Probation Ombudsman

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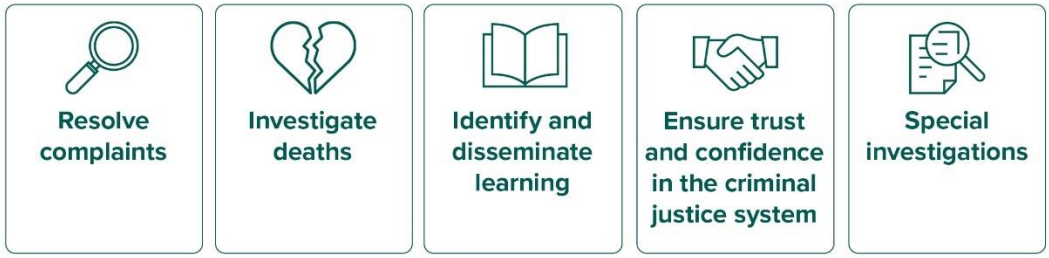
OUR VISION

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

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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 a prisoner's release.

3. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

4. Mr Dylan Davies died of combined drug toxicity and features consistent with drowning on 28 December 2021, following his release from HMP Cardiff on 17 December. He was 28 years old. I offer my condolences to his friends and family.

5. When Mr Davies met with the prison resettlement team to discuss his re-release; he said he had no support needs. This contradicted what was recorded in his probation assessments, which noted his lack of accommodation and substance misuse issues, and the associated risks. We are concerned that the resettlement team did not use other available information and relied on what Mr Davies told them when concluding that no referrals were required. Fortunately, Mr Davies was already known to services and was given relevant appointments as a result. Had this not been the case, no support would have been in place and the risks would have increased significantly.

6. Mr Davies was released from prison on a Friday. At his first probation supervision appointment he reported that he could not stay at his planned release address. He then missed a meeting arranged with the local housing provider, a substance misuse appointment and, several days later, his second probation supervision appointment. His failure to attend these meetings meant he had breached his licence conditions. The risks were increased by the fact that community services are not accessible at weekends. We are concerned, therefore, that there is no evidence of any contingency planning for Mr Davies, or follow up action regarding breaches, by the Probation Service.

Recommendations

- The Local Delivery Unit manager of Swansea Neath Port Talbot Probation Service should ensure that offender managers clearly record decisions relating to risk and licence conditions in NDelius.

The Investigation Process

7. The PPO investigator obtained copies of relevant extracts from HMP Cardiff and probation records.

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

9. The Ombudsman's family liaison officer contacted Mr Davies' mother, to explain the investigation and to ask if she had any matters for the investigation to consider. We did not receive a response.

10. We shared the initial report with HM Prison and Probation Service. They highlighted some factual inaccuracies, which we have amended accordingly.

Background Information

HMP Cardiff

11. HMP Cardiff is a medium secure local prison. It holds approximately 800 male prisoners who have either been convicted or are on remand. Substance misuse services are provided by the Cardiff and Vale University Health Board and psychosocial support by the Welsh Centre for Action on Dependency and Addiction (WCADA), as part of the Dyfodol consortium, which also delivers drug and alcohol services in the local community.

HM Inspectorate of Prisons

12. The most recent inspection of HMP Cardiff was in November 2019. Inspectors reported that the prison was reasonably good at supporting prisoners with rehabilitation and release plans. They found that the prison exchanged some information with community offender managers prior to a prisoner's' release. However, there was not enough evidence that community offender managers undertook a high standard of release planning to ensure that the risk of serious harm on release would be managed effectively.

The Probation Service

13. The Probation Service supervises individuals serving community orders, provides offenders with resettlement services while they are in prison (in preparation for their release) and supervises all individuals for a minimum of 12 months when they are released from prison on licence. Supervision in the community is carried out by a community offender manager.

HM Inspectorate of Probation

14. The most recent inspection of Swansea Neath Port Talbot Probation Service was in January 2022. Inspectors highlighted that casework relating to high-risk individuals on post-release licences was satisfactory. However, those on licence assessed as medium risk were not managed as well.

Offender Management in Custody (OMiC)

15. The OMiC model is a case management system for offenders. The model aims to ensure better co-ordination and sequencing for individuals as they transition from prison into the community. Individuals have both community and prison offender managers who contribute to release planning. They also have a key worker - a dedicated prison officer that they meet with regularly, for the purpose of developing a constructive and motivational relationship that helps with choices they need to make during their time in custody. The level of support provided by these roles is determined by the length of sentence and level of risk highlighted in probation assessments.

Integrated Offender Management (IOM)

16. The IOM system is designed to reduce the risk of reoffending presented by prolific offenders, through multi-agency collaboration. It involves an increased level of monitoring and risk reduction support in the community, for those identified locally as a priority. Agencies meet regularly to share information and ensure joined up decision making processes.

Key Events

Background

17. On 11 February 2019, Mr Dylan Davies was convicted of burglary and was given a 36-month prison sentence. It was not his first time in prison.

18. Mr Davies was released on 29 April 2021. He was recalled to HMP Cardiff on 23 November for not complying with his licence conditions. He was returned on a fixed term recall for a set period of 28 days.

19. Mr Davies had a history of depression and a diagnosed personality disorder. He had been admitted to hospital for a psychotic episode in 2017. He was prescribed antidepressants and antipsychotic medication, which he took as directed while in prison and in the community following release. He also had a history of using both non-prescribed medication and illicit drugs in the community.

20. Mr Davies had a long history of offending and was identified as a prolific offender. He was allocated to the Integrated Offender management (IOM) Team at Swansea Neath Port Talbot Probation to manage the associated risks.

21. On 21 November Mr Davies' community offender manager (COM) updated Mr Davies' probation assessment of risk and need (OASys assessment). The assessment outlined risk factors associated with him living at his mother's address on release and suggested that the long-term plan was for him to seek independent housing with his local authority. It also noted Mr Davies' history of substance misuse and recreational drug use.

22. When Mr Davies arrived at Cardiff on 23 November, a nurse undertook an initial healthcare screening. Mr Davies told her that he had used drugs in the past and she referred him for an assessment with the prison drug team. She also arranged for his prescription antidepressant and antipsychotic medication to continue. Dyfodol staff assessed Mr Davies the following day.

Pre-release planning

23. The same day, the COM made a housing referral to the Forward Trust, a Commissioned Rehabilitative Service providing accommodation support and interventions both pre and post-release.

24. On 30 November, the COM was notified that someone had been identified as Mr Davies' prison offender manager (POM) contact. (Mr Davies was not allocated a prison offender manager because he was only in prison for 28 days and was medium risk.) She was able to help him with any questions he had before his release, and she would act as the liaison with the COM.

25. There is no record in the prison or probation case management systems that any further contact was made between the POM and the COM prior to Mr Davies' release.

26. On 30 November Mr Davies was seen by a prison resettlement officer in preparation for his release on 17 December. She reviewed his plans for release and noted that Mr Davies had settled in well at Cardiff and did not have any concerns that required her support. Mr Davies said that he had lived with his mother before prison and could return there on release. He also spoke about his mental health diagnosis and medication. Mr Davies said that he had no substance misuse issues and had not been seen by Dyfodol in prison.

27. While Mr Davies' substance misuse issues were not captured by the resettlement team, they were picked up by Dyfodol due to Mr Davies' previous use of the service and his comments in Reception.

28. On 14 December Mr Davies was reviewed by a keyworker from the prison substance misuse team, Neath Dyfodol. (Neath Dyfodol is also the community drug team.) He was given information on the risks of using substances at the same time as his prescribed medication, and strategies for harm minimisation when in the community. The keyworker referred Mr Davies for an appointment with the community Neath Dyfodol on the day of his release.

29. On Friday 17 December, the day of Mr Davies' release, an officer issued Mr Davies with a copy of his licence conditions. Mr Davies had standard licence conditions that required him to attend probation appointments and stay at his mother's address unless otherwise authorised by Probation. The COM had noted that the risk of him relapsing if homeless during the COVID pandemic outweighed the risks associated with him returning to live with his mother. He was also required to address his use of controlled drugs and alcohol and offending behaviour problems with support from the Swansea Probation Office and/or Neath Dyfodol Office (community drug team). The licence conditions included a requirement to comply with regular drug testing.

30. Later that day Mr Davies was released with a travel warrant to attend his first probation appointment in Swansea at 1.00pm. He was also asked to attend an appointment with Neath Dyfodol Office in the afternoon.

Post-release

31. The COM was not in the office on the day of Mr Davies' first supervision appointment. A duty Probation Service Officer carried out the appointment on her behalf. Mr Davies told him that he could not stay at his mother's address. He confirmed that he would engage in his scheduled telephone appointment with Neath Port Talbot Housing Options later that afternoon. The duty Probation Service Officer gave Mr Davies a travel warrant to get to his substance misuse appointment with Neath Dyfodol in Port Talbot. There is no record of steps taken to resolve the lack of housing that night or over the following days before longer term accommodation was secured.

32. Mr Davies did not attend his planned appointment with Neath Dyfodol later that day. Records from the community drug team indicate that a member of staff notified probation.

33. There is no evidence that Mr Davies attended the telephone appointment with Neath Port Talbot Housing Options that afternoon as planned and no evidence of any follow up action regarding this.

34. During the evening of 17 December, a member of the public found Mr Davies unconscious. He was admitted to Morriston Hospital's accident and emergency department at approximately 9.00pm on the basis of a suspected drug overdose. He remained in hospital overnight. At 8.30am the following morning, he was seen by a mental health nurse for a mental health assessment. He told her that he had been celebrating with non-prescription drugs, following his release from custody. He was assessed as posing a low risk of harm of suicide via substance use or overdose and discharged. The hospital ordered a taxi and support from the Red Cross to take Mr Davies to his mother's house.

35. At 10.40pm on 20 December, as a follow up to a referral from the hospital, the police conducted a welfare check on Mr Davies. He was not present at his address. The next day, the police notified the COM, via email, but she was not in the office. There are no further probation records regarding Mr Davies between 21 December and 24 December when he was due for his next probation appointment.

36. Mr Davies did not attend his second probation appointment on 24 December. There is no record of the action taken by probation staff in response to this.

37. On the evening of 24 December, Mr Davies was reported missing to the police by his mother. He had failed to return home having been out with friends the previous day. Mr Davies' friend contacted Mr Davies' mother to ask if he had made it home, as he had been under the influence of drugs. The friend said Mr Davies had fallen down a hill into water.

38. On 28 December, a PC at South Wales Police informed the COM that a body, believed to be that of Mr Davies, had been recovered in a waterway in Port Talbot. On 29 December, the PC confirmed with Probation that the body had been formally identified as Mr Davies.

Post-mortem report

39. The Coroner concluded that Mr Davies died of combined drug toxicity (damage to organs from a high level of drugs in the body) and features consistent with drowning. At the Inquest, on 30 June 2022, the Coroner concluded that Mr Davies' death was due to misadventure.

Support for staff

40. An internal paper review of Mr Davies death was initiated on 31 December 2021 in line with Probation Instruction 2014-01 (PI 2014-01 - Reviewing and Reporting Deaths of Offenders Under Probation Supervision in the Community). Support was offered to the COM by email and included a list of support networks for her to access.

Findings

Release planning

41. When the resettlement team met with Mr Davies on 30 November, he said he required no particular support. The resettlement team recorded that no further action was required and referred him to probation staff for any further support. They did not consult any other information sources, such as offender managers or case management systems, before arriving at their conclusion. Mr Davies was referred on to substance misuse and housing support providers because he was already known to them. For individuals not known to services, this would not have been the case and would have significantly increased the risks.

Licence conditions

42. Mr Davies was released on a Friday and disclosed that he could not stay at his approved address as planned. He was required to seek authorisation for any alternative addresses but there is no record of any discussions about this. Mr Davies confirmed that he would engage with his scheduled telephone appointment with housing providers later that afternoon, but there is no record of a contingency plan in place if he did not attend the meeting. Community services are generally not accessible over the weekend, which may have caused him to be made homeless.

43. Mr Davies' prison and probation records document that his regular use of non-prescribed drugs and alcohol increased his risk of self-harm and suicide (through accidental or intentional overdose). His licence included a condition to address his drug use by attending appointments with Neath Dyfodol (community drug team) to reduce the risk of relapse. He was given an appointment with them on the day of his release and failed to attend. The Neath Dyfodol office recorded that they were unable to contact him despite several attempts between Friday 17 and Monday 20 December.

44. There is no record of any action taken by probation as a result of the breaches that took place following Mr Davies' release. It is unclear why breach action was not considered. IOM teams are required to meet every day with the police and substance use services to discuss updates, decisions and actions regarding all supervised individuals. This joint work is not recorded on individual case records, and we make the following recommendation:

    The Local Delivery Unit manager of Swansea Neath Port Talbot should ensure that offender managers clearly record decisions relating to risk and licence conditions in NDelius.

Friday release

45. Friday release was noted by Mr Davies' prison offender manager as a factor that would increase the risk of relapse. We note that in June 2022, the Ministry of Justice Prisons Strategy White Paper announced plans to end Friday releases for those vulnerable to addiction, mental health issues and homelessness, in recognition of the challenges this creates for accessing support services at

weekends. We are pleased that the Ministry of Justice is taking action to address these issues.

Inquest

46. The inquest into Mr Davies' death concluded on 30 June 2022, and returned a verdict of misadventure.

Kimberley Bingham
Acting Prisons and Probation Ombudsman **January 2025**

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