Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Greg Coleman, on 21 December 2023, following his release from HMP Wealstun

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 020 7633 4100

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 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 Greg Coleman died of aspiration pneumonia caused by acute polydrug (opiates/opioids, cocaine) toxicity and substance misuse disorder, with hypertensive heart disease a contributory factor on 21 December 2023, following his release from HMP Wealstun on 8 December. He was 44 years old. We offer our condolences to those who knew him.

5. Mr Coleman was a frequent drug user in the community, before he was sent to prison in April 2022. While he initially completed a methadone (opiate substitute) treatment programme, Mr Coleman chose not to engage with substance misuse services in his last two prisons, from May 2023.

6. In October 2023, a pharmacist at Wealstun gave Mr Coleman methadone in error. Mr Coleman was admitted to hospital shortly afterwards, and experienced side effects for several days. The Head of Healthcare has since changed medication administration procedures at Wealstun.

7. Probation staff arranged release accommodation for Mr Coleman at an Approved Premises (AP). Mr Coleman did not attend the AP and did not engage with community drug and alcohol services following his release. Probation staff initiated his recall to prison, but he remained unlawfully at large until his death.

8. We make no recommendations.

The Investigation Process

9. We were notified of Mr Coleman's death on 30 April 2024. We do not know the reason for the delay.

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

11. We informed HM Coroner for Inner North London of the investigation. She gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

12. The Ombudsman's office wrote to Mr Coleman's father to explain the investigation and to ask if he had any matters he wanted us to consider. He asked one question, which is outside the remit of our investigation.

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

14. We also shared the initial report with Mr Coleman's family. They did not make any comments.

Background Information

HMP Wealstun

15. HMP Wealstun is a category C prison near Wetherby, West Yorkshire. There are ten residential units and a segregation unit. Practice Plus Group provides health care services.

Probation Service

16. 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

17. On 1 April 2022, Mr Greg Coleman was sent to HMP Pentonville for failing to comply with a court order and on remand for other offences. Mr Coleman had a history of substance misuse in the community, including crack cocaine and heroin. In prison, he was initially prescribed methadone (medication for opiate withdrawal).

18. On 17 October, Mr Coleman was sentenced to 40 months in prison for assault. He was transferred to HMP Belmarsh.

19. On 10 May 2023, Mr Coleman's prison offender manager (POM) referred him to community probation staff. They said that Mr Coleman had a long history of polysubstance misuse but had completed substance misuse courses while on remand. The POM said that Mr Coleman would maintain he no longer had issues with alcohol or drugs, but that his prison records indicated that he might currently be using illicit substances. Mr Coleman's community offender manager (COM) identified that he was due for release in December and would have licence conditions around his substance misuse.

20. On 12 May, Mr Coleman was transferred to HMP Wayland. He was referred to Phoenix Futures (substance misuse services) but chose not to engage with them.

21. During his time at Wayland, Mr Coleman missed appointments with the offender management unit (OMU) and his POM.

22. On 30 September, prison staff discovered Mr Coleman under the influence of illicit substances. They completed a Phoenix Futures referral. It does not appear that anyone from Phoenix Futures saw Mr Coleman before his transfer.

23. On 19 October, Mr Coleman was transferred to HMP Wealstun. He declined a referral to prison drug and alcohol recovery services (DARS), as he said he had no problems with drugs or alcohol.

24. At Wealstun, Mr Coleman completed an application for the mental health team, but they noted that there was not enough time for them to see him prior to his release. They asked Mr Coleman to contact them if he needed any specific materials and sent him an anxiety booklet.

25. On 28 October, Mr Coleman attended the medicine hatch in the morning to collect his medication. (Mr Coleman was prescribed medication for arthritis and long-standing leg pain.) A pharmacist gave him 40ml of methadone in error. Prison and healthcare staff monitored Mr Coleman afterwards.

26. Later that morning, prison staff called a medical emergency as Mr Coleman said that he had fallen and hit his head. A nurse reviewed him, during which Mr Coleman started to slur his words. He told the nurse that he had had two seizures. Mr Coleman was transferred to hospital, where he refused treatment and was returned to Wealstun.

27. Shortly after his return, Mr Coleman told a nurse that he had lost consciousness and had been sick. The nurse advised him that the nausea was a side effect and was one reason why he was sent to hospital.

28. On 29 October, a nurse reviewed Mr Coleman in his cell. Mr Coleman said he was generally unwell and still "groggy". He said that he had vomited more overnight. Mr Coleman also said that he had begun to refuse food. (It is unclear why Mr Coleman had stopped eating, although it is possible that this was in relation to the side effects he was experiencing from being given methadone.) Prison and healthcare staff kept him under observation over the following days. (Mr Coleman began to eat meals again soon afterwards.)

29. On 30 October, Mr Coleman complained to prison staff of chest pains and his arm being numb. Later, he stated that he felt slightly better. A nurse asked to complete clinical observations, but Mr Coleman refused. Prison staff monitored him overnight.

30. On 10 November, a nurse assessed Mr Coleman after he complained of chest pain. He told the nurse that he had a brief episode of intensive chest and shoulder pain. Mr Coleman said the pain had now gone and he therefore refused clinical observations. He asked to be seen in the healthcare clinic for a ‘heart test’ as the chest pains had been ongoing intermittently for some time. Healthcare staff booked an electrocardiogram (ECG) appointment for Mr Coleman on 13 November.

31. On 13 November, Mr Coleman declined his ECG appointment, because he felt it was not required.

32. Probation staff secured a place in an Approved Premises (AP) for Mr Coleman ahead of his release. The senior probation officer (SPO) told us an AP placement was in place for Mr Coleman so he could receive key worker support, and 1 to1 supervision sessions with the COM to address offending behaviour, as well as to identify support needs.

33. Probation staff also liaised with Change, Grow, Learn (CGL) community drug and alcohol services to assist Mr Coleman’s substance misuse issues, and arranged for him to attend weekly appointments following his release.

34. On 8 December, Mr Coleman was released from prison on licence. He was not offered naloxone because he had not engaged with substance misuse services at Wealstun. (Approved Premises now have naloxone on site, which Mr Coleman could have accessed had he attended the AP to which he was directed.)

Post-release management

35. At 1.30pm on 8 December, Mr Coleman called probation staff to say that he had not yet got on the train from Leeds and so would not be in time for his AP induction. He missed his initial appointment with probation staff, who asked AP staff to allow Mr Coleman time to attend at 8.00pm that day. Mr Coleman failed to attend, and, on 9 December, probation staff recalled him back to prison for breach of licence conditions.

36. There is no information on where Mr Coleman was living after his release. He never attended the AP to which he was directed and remained unlawfully at large. He did not attend any release appointments with CGL.

37. Mr Coleman also did not attend a benefits appointment that probation staff had arranged through commissioned rehabilitative services.

Circumstances of Mr Coleman's death

38. On 21 December, the London Ambulance Service (LAS) was called to a residential address in Islington to an unresponsive man who was later identified as Mr Coleman. He was pronounced dead by ambulance staff. Class 'A' drugs and paraphernalia were found near Mr Coleman's body.

Contact with Mr Coleman's family

39. On 30 April 2024, we were notified of Mr Coleman's death by the Coroner. We do not know when or by whom Mr Coleman's next of kin was notified of his death.

Post-mortem report

40. The post-mortem report concluded that Mr Coleman died of aspiration pneumonia caused by acute polydrug (opiates/opioids, cocaine) toxicity and substance misuse disorder, with hypertensive heart disease a contributory factor.

Findings

41. On 28 October, a pharmacist at HMP Wealstun gave Mr Coleman 40ml of methadone in error. Mr Coleman was admitted to hospital shortly afterwards and experienced side effects for several days. In other circumstances, the outcome could have been much worse.

42. Healthcare staff completed an investigation and have since changed medication administration processes at Wealstun. We do not therefore make a recommendation, but the Head of Healthcare will wish to review the effectiveness of the revised procedures to ensure that a similar incident does not happen in future.

43. This incident occurred several weeks before Mr Coleman was released from prison, and we found no evidence that it contributed to his death. While Mr Coleman had a history of substance misuse, he did not engage with substance misuse services in Wealstun or at his previous prison.

44. Probation staff secured appropriate release accommodation at an Approved Premises, but Mr Coleman did not attend the premises and was unlawfully at large following his release. This also meant that he did not engage with community drug and alcohol services, or other agencies that would help him settle into the community post-release. We are satisfied that prison and probation staff did all they could to assist Mr Coleman in the transition from prison to the community.

Inquest

45. The inquest into Mr Coleman's death concluded on the 22 November 2024. The coroner confirmed that Mr Coleman died of a drug related death.

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

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 020 7633 4100