Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Myles Filose, following his release from HMP Winchester, on 7 April 2025

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 investigated 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 Myles Filose died of peritonitis caused by a small bowel perforation on 7 April 2025, following his release from HMP Winchester on 2 April. He was 43 years old. We offer our condolences to those who knew him.

5. The clinical reviewer concluded that the care Mr Filose received in the lead up to his release from Winchester was not of the required standard and therefore not equivalent to that which would have been received in the wider community.

6. The clinical reviewer had concerns regarding Mr Filose's mental capacity and ability to reasonably decline support. Mr Filose was presumed to have capacity when he declined a referral to NHS Reconnect (a care after custody service that seeks to improve the continuity of care of people leaving prison with an identified health need) and there is no evidence that he received a formal mental capacity assessment at Winchester.

Recommendations

The Head of Healthcare at Winchester should ensure that when an individual exhibits impaired cognition, mental distress, confusion or unusual behaviour, a formal Mental Capacity Act assessment is completed and documented, with evidence of best-interest decision-making if capacity is lacking.

The Investigation Process

7. HMPPS notified us of Mr Filose's death on 9 April 2025.

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

9. NHS England commissioned an independent clinical reviewer to review Mr Filose's clinical care at the prison.

10. We informed HM Coroner for Hampshire of the investigation. She gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report. The Coroner informed us that there would be no inquest held for Mr Filose's death.

11. The Ombudsman's office contacted Mr Filose's uncle to explain the investigation and to ask if he had any matters he wanted us to consider. He asked what provision was in place for Mr Filose's release and whether he was offered accommodation. He also wanted to know whether Mr Filose's health was assessed prior to his release and whether he was displaying any symptoms. His concerns have been addressed in our report and the clinical review.

12. 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.

13. Mr Filose's family received a copy of the draft report. They did not make any comments.

Background Information

HMP Winchester

14. HMP Winchester is a category B prison, with a small separate category C facility. It holds convicted and remanded male prisoners. Practice Plus Group is the healthcare and substance misuse provider.

Probation Service

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

Key Events

Background

16. On 14 February 2025, Mr Myles Filose was convicted of malicious wounding and was sentenced to 4 months in prison. He was sent to HMP Winchester. It was not his first time in prison.

Pre-release planning

17. On 14 February, Mr Filose attended his reception screening with a nurse. He reported that he had been homeless in the past year. The nurse recorded in the medical records that Mr Filose did not raise any concerns and he engaged well.

18. On 15 February, a healthcare assistant completed Mr Filose's second reception screening. She reviewed his family medical history and recorded that there were no concerns.

19. On 17 February, Mr Filose declined assistance with GP practice registration on release. It is recorded in his medical records that there was no requirement for him to have regular appointments with primary care staff while in prison.

20. On 19 February, Mr Filose's Prison Offender Manager (POM) introduced himself to Mr Filose and told him how to contact him.

21. On 20 February, Mr Filose had a blood test to check his blood sugar levels as he reported that he used to have glucose tablets for low sugar levels. The results came back as normal with no further action required.

22. On 4 March, prisoners raised concerns to staff regarding unusual behaviour from Mr Filose. They reported that he was making strange noises at night and talking to himself. Staff referred him to the mental health team.

23. On 20 March, a nurse saw Mr Filose for a mental health assessment. He said he did not want to engage, and the nurse recorded that she had no reason to doubt his capacity. Mr Filose reported that he was going to be homeless on release and did not want any support or involvement from support services. The nurse offered information around local support services for homeless people, a referral to NHS Reconnect (a care after custody service that seeks to improve the continuity of care of people leaving prison with an identified health need) and community mental health services, but Mr Filose declined.

24. On 27 March, following a multi-disciplinary team meeting, Mr Filose was discharged from the mental health team's caseload. There were no identified needs for secondary mental health services, and he did not want to engage.

25. A resettlement officer facilitated a video link meeting with Mr Filose and his Community Offender Manager (COM). He told them that he did not consent to housing referrals. The COM tried to explain that they needed his consent to share information with the local authority, but he was adamant that he would not engage. It is recorded that Mr Filose became verbally abusive to the COM and was spitting

on the floor as he left the room. The COM told us that she did not consequently complete any accommodation referrals for Mr Filose.

26. On 31 March, the COM completed an Offender Assessment System (OASys) risk and needs report for Mr Filose. She noted that a Duty to Refer (a referral to the local authority under the legal duty to refer those at risk of homelessness) and Commissioned Rehabilitative Services (CRS) referral for housing were completed prior to Mr Filose's last release. The COM assessed that Mr Filose's refusal to accept the support on offer during this sentence had made him wilfully homeless.

Release from HMP Winchester

27. On 2 April, Mr Filose was released from HMP Winchester. A nurse saw him prior to release. She recorded that he was fit and well and did not raise any concerns regarding his health.

28. Mr Filose attended his induction meeting with the COM. She went through his licence conditions with him. Mr Filose signed the induction paperwork, where he ticked his accommodation status as 'friends/family (transient) / rough sleeping'. His next appointment for assessment and planning was scheduled for 16 April.

29. On 7 April, Mr Filose's cousin contacted the COM, wanting to get an important message to Mr Filose about his mother. The COM texted Mr Filose and asked him to call her.

30. On 8 April, the COM texted Mr Filose again and gave him his cousin's phone number.

Circumstances of Mr Filose's death

31. On 10 April, the COM was informed by the police that Mr Filose had been found dead in an abandoned car that he had been living in on 7 April.

Post-mortem report

32. The post-mortem report concluded that Mr Filose died of peritonitis, caused by small bowel perforation. Bronchopneumonia contributed to, but did not cause, his death.

Support for staff

33. When we contacted the POM as part of this investigation, he told us that he had not been informed of Mr Filose's death and so had not received any support.

Findings

Clinical findings

34. The clinical reviewer concluded that the care Mr Filose received in the lead up to his release from Winchester was not of the required standard. It was therefore not equivalent to that which would have been received in the wider community.

35. The clinical reviewer found that there was an expectation amongst healthcare staff that Mr Filose would self-refer to social support services such as NHS Reconnect. Due to the concerns raised about Mr Filose's mental health and behaviour, the clinical reviewer questioned whether it was reasonable to expect Mr Filose to engage with these services without support from healthcare staff.

36. The clinical reviewer found that there was no documented evidence that a Mental Capacity Act assessment took place and Mr Filose was presumed to have had full mental capacity. However, he found that the medical records documented subtle features of deteriorating mental health and as such it would have been reasonable to escalate these concerns for an in-depth assessment. This may have allowed a more reliable judgment to have been made regarding Mr Filose's ability to make informed decisions about his health and welfare, including his ability to decline a referral to social support services on release. We therefore make the following recommendation:

    The Head of Healthcare at Winchester should ensure that when an individual exhibits impaired cognition, mental distress, confusion or unusual behaviour, a formal Mental Capacity Act assessment is completed and documented, with evidence of best-interest decision-making if capacity is lacking.

37. The clinical reviewer also made a further three recommendations. As they were not directly relevant to Mr Filose's death we do not repeat them here, but the Head of Healthcare at Winchester will wish to address them.

Accommodation

38. The COM told us that she made a referral to Commissioned Rehabilitative Services (CRS) and completed a Duty to Refer referral when Mr Filose was previously in prison, but he would not engage with the local authority or sign to give consent to share his details. She said he attended one appointment with CRS and then refused to engage. The COM discussed housing referrals with Mr Filose during this prison sentence, but he remained adamant that he would not consent to them and did not want any support with housing. The COM therefore did not submit further referrals, and Mr Filose was released homeless.

39. The Head of Southampton, Eastleigh and New Forest Probation Delivery Unit (PDU) told us that if probation practitioners have concerns regarding someone's mental capacity, they can escalate it to Adult Safeguarding in the local authority and ask for a capacity assessment. However, the COM did not have access to Mr Filose's medical records and there was no indication that she was aware of his behaviour in prison. Therefore, she did not have reason to doubt his capacity to decline accommodation support and did not request an assessment.

Governor to note

40. When we contacted the POM on 24 April, he was unaware that Mr Filose had died. He had not been offered any support following Mr Filose's death. We bring this to the Governor at Winchester's attention as it is important that all staff are informed and offered support in advance of an investigation.

Adrian Usher
Prisons and Probation Ombudsman **April 2026**

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