Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Craig Topham on 28 June 2024 following his release from HMP Nottingham

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. 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.

3. Since 6 September 2021, the PPO has investigated post-release deaths that occur within 14 days of the person's release from prison.

4. Mr Craig Topham died from mixed drug toxicity on 28 June 2024 following his release from HMP Nottingham on 25 June 2024. He was 54 years old. We offer our condolences to those who knew him.

5. We found that despite being aware of Mr Topham's substance misuse and mental health issues, his Community Offender Manager did not refer him for services in the community for support. We also found that because Mr Topham had not engaged with the substance misuse team at Nottingham, he was released without a naloxone kit on 25 June.

Recommendations

- The Head of Service at East Midlands Probation Delivery Unit should ensure that Community Offender Managers complete appropriate referrals to community services in preparation for a prisoner's release, including when there are licence conditions in place, to allow for continuation of support.

The Investigation Process

6. HMPPS notified us of Mr Topham's death on 3 July 2024.

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

8. The investigator interviewed Mr Topham's Community Offender Manager.

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

10. The Ombudsman's office contacted Mr Topham's next of kin to explain the investigation and to ask if she had any matters she wanted us to consider. She did not have any questions but asked for a copy of our report.

11. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

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

Background Information

HMP Nottingham

13. HMP Nottingham is a category B prison which holds convicted and remanded male prisoners. It is managed by HMPPS.

Probation Service

14. 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 appropriates. Post-release, the Probation Service supervises people throughout their licence period and post-sentence supervision.

Key Events

Background

15. On 7 February 2024, Mr Topham was sentenced to 24 weeks imprisonment for public order offences. He was sent to HMP Nottingham.

16. During his reception health screen, a nurse noted that Mr Topham had a recent history of drug and alcohol misuse. She noted that Mr Topham was prescribed medication for anxiety and methadone (medication used to treat opioid use disorder). The nurse referred Mr Topham to the prison's mental health team and the substance misuse service.

17. Mr Topham engaged with the substance misuse service. He was allocated a recovery worker, who discussed harm reduction, tolerance levels, signs of an overdose and what to do in an overdose situation. The recovery worker delivered naloxone (medication that can reverse the effects of an opioid overdose) training to Mr Topham, and he agreed to take a naloxone kit upon release.

18. Mr Topham also engaged with the mental health services at Nottingham. On 14 March, a psychiatrist assessed Mr Topham after staff shared concerns about his recent behaviour, which included emotional and aggressive outbursts, and paranoia. The psychiatrist concluded that Mr Topham was experiencing drug induced psychosis. He prescribed him olanzapine (antipsychotic medication) and planned to review him again in three weeks' time. A nurse completed a psychosis care plan for Mr Topham and the mental health team continued to monitor him.

19. On 30 April, Mr Topham was released from Nottingham on licence and was to reside at an approved premises. On 1 May, he breached his licence conditions - for being under the influence of alcohol and breaching his curfew and was sent back to prison for a 14 day fixed-term recall (a recall to prison for a set period before being re-released). Between May and June, Mr Topham was re-released and recalled to prison for a 14 day fixed-term recall on two further occasions for alcohol misuse and breaching his curfew. While in prison, he continued to engage with the substance misuse and mental health teams. Mr Topham was last recalled to prison on 12 June and was sent back to Nottingham.

20. At Mr Topham's first reception health screen, the nurse noted that Mr Topham was on medication for his mental health. The nurse referred him to the substance misuse team, as Mr Topham reported a history of substance misuse. However, he declined support from the substance misuse team because he said that he would be released in two weeks. He was advised to self-refer if he changed his mind. Mr Topham was not prescribed methadone during this period in prison.

21. A nurse completed a mental health assessment with Mr Topham. He noted that Mr Topham was on olanzapine and appeared stable.

Pre-release planning

22. On 17 June, Mr Topham's Community Offender Manager (COM) referred Mr Topham for approved premises accommodation. This was rejected.

23. The COM completed a Duty to Refer (a referral to the local authority if someone is homeless or threatened with homelessness) and liaised with the local homelessness prevention team, as Mr Topham would be homeless upon his release. She was told that the team would prioritise Mr Topham for Milestone House (supported accommodation) on the day of his release.

24. The COM completed Mr Topham's licence and, considering his substance misuse and mental health issues, added several additional conditions. These included attending all appointments with mental health professionals, attending all appointments to address his substance misuse, and to comply with drug testing.

25. The COM did not have contact with Mr Topham during his most recent period in prison and she did not refer him to any support services in the community. At interview she said that she did not receive a handover from Mr Topham's Prison Offender Manager (POM). Mr Topham's POM told us that she did not contact the COM as the recall period was so short (14 days). She said she that she checked Mr Topham's records and noted that the COM was sourcing accommodation.

Post-release management

26. On 25 June, Mr Topham was released from Nottingham on licence. He was released with a supply of olanzapine. However, as he did not engage with the substance misuse team in prison, and he was not currently prescribed medication for his drug addiction, he was not released with a naloxone kit.

27. At 3.00pm, Mr Topham attended an induction appointment at Derby probation office. He was seen by a duty COM. Mr Topham was released with no accommodation. The duty COM and Mr Topham discussed his accommodation needs, mental health, and substance misuse. She instructed Mr Topham to report to the local council office as homeless. She also instructed him to attend an appointment with his COM the following day.

28. The local council offered Mr Topham accommodation at Milestone House. He accepted the offer and moved into the property that day.

29. On 26 June, Mr Topham attended an appointment with his COM. They discussed his drug and alcohol misuse and she offered to complete a referral to the community substance misuse service. Mr Topham said that he was not prescribed methadone and that he was drug free. He declined to be referred to the community substance misuse service but said that he knew where to get support if he needed it. She did not ask Mr Topham to take a drug test. They also discussed his engagement issues which had led to his previous recalls, mental health, and finances. She gave Mr Topham his next appointment for 1 July.

Circumstances of Mr Topham's death

30. On 28 June, a member of the public found Mr Topham dead outside in a residential area in Derby. They notified police, who found various items in Mr Topham's possession, including several bags of cannabis. Paramedics attended and pronounced life extinct at 8.01pm. The COM was notified of Mr Topham's death on 1 July.

Post-mortem report

31. The post-mortem report concluded that Mr Topham died from mixed drug toxicity. Chronic obstructive pulmonary disease also contributed to, but did not cause his death.

Findings

Pre-release planning

32. Mr Topham had a history of substance misuse and poor mental health. In the year before his death, Mr Topham was released and recalled to prison several times, serving short periods of imprisonment. Generally, he fully engaged with the substance misuse and mental health services while in prison. The COM regularly liaised with Mr Topham's POM's, at various establishments, during his previous sentences to share information. At interview, she said that she had not received any communication from Mr Topham's POM at Nottingham during his last recall (from 12 June to 25 June). When asked why she had not initiated contacted, she told us that at that time her priority was securing accommodation for Mr Topham. Mr Topham's POM told us that she did not contact the COM as the recall was so short. She said that she checked Mr Topham's records and noted that the COM was sourcing accommodation.

33. During Mr Topham's last sentence, the COM did not have contact with him to discuss his release planning. She told us that this was because each of Mr Topham's recalls was a 14-day fixed recall, and she did not have sufficient time to plan contact with him. Clearly, the best release planning is achieved from good communication and collaborative working between POMs and COMs, and involving the prisoner. We did not find evidence that this is a systemic issue and so make no recommendation on this occasion.

Naloxone provision

34. With the exception of his most recent period in prison, Mr Topham engaged with the prison substance misuse teams regularly throughout his sentence. He had several discussions with substance misuse recovery workers, from various prisons, about the risks of continued drug use. Mr Topham was also prescribed methadone for much of his sentence (he was not prescribed methadone on his last recall to prison). He received naloxone training prior to his releases and received a naloxone kit on each occasion.

35. During his most recent period in prison at HMP Nottingham, from 12 June to his release on 25 June, Mr Topham did not engage with the substance misuse team. Healthcare staff offered to complete a referral, but he declined support, saying that he would only be in prison for two weeks.

36. The local naloxone policy at Nottingham says that naloxone can be supplied to anyone in the course of lawful drug treatment services. Despite having a history of substance misuse, as Mr Topham declined to engage with the service, he was not referred to the community substance misuse team upon his release and he was not released with a naloxone kit.

37. The investigator spoke with the substance misuse service manager, who confirmed that there is currently no system in place at Nottingham to identify prisoners who have a history of substance misuse, previous engagement, and have returned to the establishment and declined to engage with the service. He thought a system

that captured these prisoners would be beneficial so naloxone could be offered to them.

38. We recognise that there are regional differences across the Prison Service in the approach to distributing naloxone on release. We cannot know whether it would have changed the outcome for Mr Topham, but he could have benefited from being offered naloxone on release.

39. In a previous post-release death investigation at Nottingham, we recommended that the Head of Healthcare work in partnership with agencies to satisfy themselves that the local policy on the offer and issue of naloxone on release captures prison leavers with previous opiate use and other relevant risk factors. At the time of drafting this report, we are waiting for HMPPS and the healthcare providers to respond to the recommendation. Therefore, we do not make a further recommendation at this time.

40. At Mr Topham's appointment on 26 June with his COM, he said he was not prescribed methadone and that he was drug free. She had added a drug testing condition to Mr Topham's licence. As per Probation Instruction 30/2014 'Drug appointments and testing for licence conditions and post-sentence supervision', when this additional condition is added, testing is not voluntary and does not require consent, although the individual can refuse to provide a sample, and the probation provider will administer the test. She confirmed that she had received training to administer these tests. In this instance, we consider that she could have administered the drug test to confirm that Mr Topham was drug free, as he had reported.

41. At interview, the COM told the investigator that she had planned to refer Mr Topham to the community substance misuse team and mental health team but did not get a chance to before he died. She said that she was aware of Mr Topham's mental health conditions and that he had been prescribed antipsychotic medication. We consider that she should have referred Mr Topham to these services in preparation for his release, particularly because he had an additional licence condition requiring him to engage with the substance misuse service. Mr Topham would have also benefited from support from the mental health team following his release to allow for continuity of care. We recommend:

The Head of Service at East Midlands Probation Delivery Unit should ensure that Community Offender Managers complete appropriate referrals to community services in preparation for a prisoners release, including when there are licence conditions in place, to allow for continuation of support.

Inquest

42. At the inquest held on 15 January 2025, the Coroner concluded that Mr Topham died of drug-related causes.

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

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