Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Neil West, on 4 June 2024, following his release from HMP Nottingham

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

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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. On 4 June 2024, Mr Neil West died from a severe brain injury, caused by a cardiac arrest, which in turn was caused by suspected/unknown substance misuse. Mr West had been released from HMP Nottingham 12 days earlier. He was 51 years old. We offer our condolences to those who knew him.

5. Probation staff made efforts to address Mr West's substance misuse and put appropriate licence conditions in place. Despite the Probation Service's efforts, a video-link meeting between Mr West, his community offender manager and prison offender manager was not organised to plan for his release. Had a meeting been scheduled with Mr West, the COM would have known where Mr West wanted to be released to and he could have facilitated substance misuse referrals earlier. However, there is no evidence that Nottingham received the email requests for a meeting.

6. We make no recommendations.

The Investigation Process

7. HMPPS notified us of Mr West's death on 11 September 2024.

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

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

10. Mr West did not have a named next of kin and we were therefore not able to contact anyone about our investigation into his death.

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

Background Information

HMP Nottingham

12. HMP Nottingham is a category B reception prison which holds men who have been convicted or remanded into custody. Nottinghamshire Healthcare Foundation Trust provides healthcare, including mental health and substance misuse services, at the prison.

Probation Service

13. 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

14. On 28 March 2024, Mr Neil West was sentenced to 17 weeks in prison for breaching his sexual harm prevention order. He was sent to HMP Nottingham.

15. During his initial health screen, he told healthcare staff that he drank 10 units of alcohol a day, he had last used Mamba (a psychoactive substance) the previous day and had used crack cocaine a week earlier. He reported no thoughts of suicide and self-harm but had a history of depression, for which he was prescribed mirtazapine which he felt was working well. He refused mental health and substance misuse referrals and was 'adamant he would 'keep himself safe'. Healthcare staff discussed harm reduction strategies with him, and he was told how to refer himself for support, if needed.

16. That day, during a key work session with an officer from the safer custody team, Mr West again declined a referral to the substance misuse service and said he would manage without one. They discussed harm reduction and the risk of using substances in prison.

17. Also that day, the substance misuse team saw Mr West. He refused support for his alcohol consumption.

18. On 1 April, during a key work session with an officer who worked in the first night centre at the time, Mr West said that he used alcohol and drugs and was receiving specialist help in the community.

19. On 3 April, Mr West's community offender manager (COM) emailed the service manager of Hope House (a homelessness charity that provides accommodation in Worksop in Nottinghamshire), where Mr West had lived before going to prison. He told her that Mr West had been convicted. She agreed to keep his bedspace open for him.

20. On 11 April, Mr West saw a probation services officer for a resettlement interview. He told her that he would be homeless on release and gave consent for accommodation referrals to be made to HMPPS' Commissioned Rehabilitative Services (CRS, which provides support services to prison leavers) and the local authority under the statutory duty to refer those at risk of homelessness. That day, she emailed the COM to ask him to submit these referrals for Mr West. The COM told the investigator that he did not complete them, as he had arranged for Mr West's space at Hope House to remain available to him.

21. On 17 April, the COM's administrative assistant tried to arrange a video-link meeting so that Mr West, his COM and his prison offender manager (POM) could plan for his release. She sent a meeting request through a system called Jitbit (a ticketing software used in the East Midlands probation region which enables the user to send and receive emails).

22. The administrative assistant contacted the prison by phone on 23 April to check whether they had received the meeting request by email. The prison had not received an email request and therefore had not responded. They told us that if

they had received an email to request a meeting, they would have facilitated a video-link call.

23. On 20 April, the prison resettlement team booked an appointment for Mr West at the job centre for 24 May. Records indicate that Mr West was told about this appointment but we do not know whether he attended.

24. On 24 April, the COM emailed the POM to discuss Mr West's accommodation at Hope House and confirm whether Mr West wanted to return there. The COM told the investigator that he then spoke to her but could not recall their discussion.

25. On 2 May, the COM emailed the service manager to let her know that Mr West's scheduled release date was 23 May.

26. On 13 May, a member of staff at Nottingham's Careers, Information, Advice and Guidance Team conducted a pre-release interview with Mr West. He told Mr West that he had been referred to the local authority for the Chesterfield area (in case he did not want to remain at Hope House in Worksop) under the statutory duty to refer those at risk of homelessness.

Release from HMP Nottingham

27. On 23 May, Mr West was released from Nottingham. He declined to see healthcare staff before release which meant he was released without his mirtazapine prescription. The Head of Healthcare told the investigator that Mr West could have collected his mirtazapine from his GP post-release. He also told the investigator that Mr West was not offered naloxone (a medication that rapidly reverses an opioid overdose) because he had not disclosed a history of opiate use.

28. Mr West reported to his probation office for an initial appointment with his COM. Mr West signed his licence, which included a drug-testing and alcohol tag condition. The COM discussed referring Mr West to Change Grow Live (CGL, a substance misuse support service). The COM told the investigator that Mr West did not seem keen to be referred. The COM told him that he would need to present at Hope House daily from 5.00pm until he could have an alcohol monitoring tag fitted. They agreed to discuss and complete a substance misuse referral at his next appointment. Following the appointment, Mr West left for Hope House, where he lived until his death.

29. Neither Nottingham nor the COM referred Mr West to any community substance misuse or mental health services. Nottingham told the investigator that Mr West had declined to engage with services, and his depression was historic. The COM told the investigator that he had not completed a substance misuse referral as he was not sure whether Mr West planned to live in Chesterfield in Derbyshire or Worksop in Nottinghamshire which were covered by two different services.

30. On 31 May, Mr West failed to attend a probation appointment with his COM, who subsequently asked for an enforcement letter to be sent.

Circumstances of Mr West's death

31. At 1.20pm on 31 May, paramedics were called to a town centre in Nottinghamshire after Mr West went into cardiac arrest. When they arrived, Mr West's friends were trying to resuscitate him and had also administered naloxone. The paramedics took over resuscitation efforts. Mr West's friends told the paramedics that they had seen Mr West putting lighter gas fluid into a cloth and inhaling it. The paramedics noted that they smelt alcohol on Mr West. He was taken to hospital and placed on a ventilator.

32. The hospital stated that Mr West had a gastric bleed, commonly caused by stomach ulcers, which happen as a result of alcoholism. The hospital conducted a drug toxicology test, the result of which was clear.

33. On 4 June, it was suspected that Mr West had brain damage from the cardiac arrest. Hospital doctors decided to withdraw treatment, and the ventilators were switched off and Mr West died around 10 minutes later.

Cause of death

34. A hospital doctor established that Mr West died from severe brain injury. This was caused by a cardiac arrest which in turn was caused by suspected/unknown substance misuse. A post-mortem examination and toxicology tests were not carried out as the Coroner accepted the cause of death provided by the doctor.

Inquest

35. At an inquest held on 24 June 2024, the Coroner concluded that Mr West's death was drug related.

Findings

Mr West's cause of death

36. The hospital doctor identified suspected/unknown substance misuse as having ultimately caused Mr West's death. Mr West's friends had told paramedics that they had seen him sniffing lighter gas fluid before he was admitted to hospital. It is likely that he continued to take substances in the community post-release. Although Mr West declined substance misuse support in custody and in the community, prison staff appropriately signposted him to services and gave him harm reduction advice while in custody. Healthcare staff were not able to prescribe his mirtazapine or remind him of the risks of taking drugs on release as he declined to see them before he left prison.

Post-release management

37. The COM put in place reasonable measures to address Mr West's substance misuse issues on release. This included adding licence conditions for drug testing and an alcohol tag.

38. Although the COM included a licence condition for Mr West to comply with any requirements relating to addressing his substance misuse, his licence did not provide details of a drug testing and support service for him to access. The COM told the investigator that this was because he did not know which area Mr West planned to live in – Worksop or Chesterfield - which were in two separate catchment areas for substance misuse services: CGL in Worksop or Derbyshire Recovery Partnership in Chesterfield. If he had put one of the services in the licence condition, it would have required a formal licence variation to change the licence details. Mr West was already known to both substance misuse services, and was referred to CGL Worksop by a member of staff at Derbyshire Recovery Partnership before he went to prison.

39. The COM told the investigator that he planned to refer Mr West to community substance misuse services once he had been released and confirmed where he planned to live in the initial appointment. He told the investigator that their initial priority was to explain the licence conditions and discuss his accommodation (which he had in place). As Mr West had to attend Hope House by 5.00pm, they planned to complete a referral at his next appointment the following week but Mr West had not attended.

40. The COM had secured accommodation for Mr West at Hope House (where he lived before coming to prison) in the event that Mr West chose to remain in that area, and this was where Mr West lived after his release from prison.

Governor and Head of Probation Delivery Unit to note

Video-link appointments

41. Video-link calls are an important tool for pre-release planning. As community offender managers have little knowledge of a prison leaver's time in custody,

meetings by video-link can help to establish their wishes for post-release and provide an opportunity to discuss pre-release planning and post-release supervision with the prison offender manager.

42. The COM told the investigator that he spoke to the POM remotely on Microsoft Teams, but ultimately could not speak to Mr West while he was in custody. He told the investigator that because he could not speak to Mr West, he was not sure where he planned to live once he was released from prison. This made it difficult for him to arrange a substance misuse referral to the right service before Mr West's release.

43. The novel use of Jitbit for communication may have played a role in why Nottingham did not appear to have received the video-link request by email as although there is some evidence that an email request was sent, Nottingham had no evidence to suggest the email (sent through the Jitbit system) had been received. Had a meeting been scheduled with Mr West, the COM would have known where Mr West wanted to be released to and he could have facilitated substance misuse referrals for the appropriate area earlier.

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

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Canary Wharf, London E14 4PU

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