

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr Neil McCarthy, on 20 March 2024 following his release from HMP Hollesley Bay**

**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. 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 Neil McCarthy died from the respiratory depressive effects of methadone on 20 March 2024 following his release from HMP Hollesley Bay on 7 March 2024. He was 57 years old. We offer our condolences to those who knew him.
5. Mr McCarthy had a history of substance misuse. He was appropriately supported for this in prison and on release. We did not identify any significant learning relating to the pre or post-release planning. We make no recommendations.

## The Investigation Process

6. HMPPS notified us of Mr McCarthy's death on 6 June 2024.
7. The PPO investigator obtained copies of relevant extracts from Mr McCarthy's prison and probation records.
8. We informed HM Coroner for Hammersmith and Fulham of the investigation. She gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
9. The Ombudsman's office contacted Mr McCarthy's family to explain the investigation and to ask if they had any matters they wanted us to consider. Mr McCarthy's family had questions about Mr McCarthy's medication and his release from prison. These questions have been addressed in this report and in separate correspondence.
10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.
11. Mr McCarthy's family received a copy of the initial report. They did not make any comments.

## Background Information

### HMP Hollesley Bay

12. HMP Hollesley Bay is a category D, open, resettlement prison, which holds male prisoners coming to the end of their sentences. It is managed by HMPPS.

### 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.

### HM Inspectorate of Prisons

14. HMP Hollesley Bay was inspected in 2018, and again, in April 2024, after Mr McCarthy's death. Inspectors reported that the substance misuse teams were well led and enthusiastic, providing an effective service to maintain recovery. They had good working relationships with the prison and a strong joint commitment to its drug strategy and action plan. They also reported effective post-release support and community engagement which was developed 12 weeks before release.

### HM Inspectorate of Probation

15. The most recent inspection of NPS Hammersmith, Fulham, Kensington, Chelsea, and Westminster Division was in October 2022. Inspectors found very poor quality of work and gave the rate of 'Inadequate'. They found ineffective monitoring arrangements to keep the public safe which was a serious concern. They found there were clear delivery plans and improved relationships with key partner agencies but the impact of these were yet to be seen in effective delivery of services. Only 20% of the people on probation that were surveyed said they had access to the services they needed through the Probation Service.

## Key Events

### Background

16. On 19 March 2022, Mr Neil McCarthy was remanded to HMP Wandsworth charged with burglary.
17. On 10 May, Mr McCarthy was sentenced to 50 months in prison. He was due to be released on 7 March 2024.
18. On 30 May, Mr McCarthy was transferred to HMP Wayland.
19. On 10 January 2024, Mr McCarthy was transferred to HMP Hollesley Bay.
20. A nurse completed Mr McCarthy's initial health screen and noted that he had a history of heroin use and that he was prescribed 50ml of methadone (used to treat opioid dependence). This prescription was continued at Hollesley Bay, and Mr McCarthy felt that the prescribed amount was helping him. Mr McCarthy said that he suffered with depression but felt stable with his mental health at that time because he was taking mirtazapine (antidepressant).
21. On 25 January, a GP at the prison and a substance misuse recovery worker saw Mr McCarthy for a review. Mr McCarthy had been on 50ml methadone for two years and told the GP that he would reduce the dose in the community. Mr McCarthy was offered naloxone training (a medication that can reverse the effects of an opiate overdose) but he declined.
22. On 26 January, a nurse saw Mr McCarthy as part of his drug addiction therapy. Mr McCarthy said that he did not want to reduce his methadone prescription while in prison. The nurse explained the discharge process and informed him that an appointment would be arranged for him with the local community drug and alcohol service on release.
23. On 23 February, a nurse saw Mr McCarthy again as part of his drug addiction therapy, and he reported he was still happy on his current dose of methadone and felt stable. Mr McCarthy told the nurse that he would arrange his own GP appointment on release because he was going to be living in the same area he had been living before. During this meeting, they discussed risk factors around his reduced tolerance to illicit drugs and Mr McCarthy said that he understood.

### Pre-release planning

24. The pre-release team at Hollesley Bay completed a duty to refer (DTR) form (the Homelessness Reduction Act 2017 requires prisons and probation services to refer anyone who is homeless or at risk of becoming homeless within 56 days to a local housing authority) and sent it to Hammersmith and Fulham council, the area where Mr McCarthy would be returning to on release, on 9 January.
25. A housing advisor at Hollesley Bay continued to chase the outcome of the DTR, and, on 2 February, he was informed that Mr McCarthy would be discussed at the Hammersmith and Fulham council housing panel the following day, and that the

housing options team at the council would be liaising with other agencies and completing an assessment with Mr McCarthy.

26. On 13 February, the housing advisor chased the outcome of the housing panel meeting because no one from the housing options team had been in touch to complete an assessment with Mr McCarthy. He did not receive a response.
27. On 27 February, Mr McCarthy's Community Offender Manager (COM) completed a CAS3 accommodation referral (temporary accommodation for those leaving prison homeless). The referral was accepted on 29 February, and Mr McCarthy was offered an 84-night placement with Housing Action Management (HAM) within a shared unit.
28. On 5 March, the housing advisor informed the COM that the homeless application to Hammersmith and Fulham council was still outstanding, because alternative accommodation had been found for him. However, when Mr McCarthy attended the CAS3 accommodation, HAM would be able to pass his application to the Single Homeless Project (SHP) team, who would then support him with move on accommodation.
29. Turning Point (a service supporting individuals with complex needs) provided Mr McCarthy with two post-release appointments, the first on 8 March to complete a medication review, take observations and arrange prescriptions, and the second appointment was arranged for 13 March to discuss the different treatment options available to Mr McCarthy.

### **Release from HMP Hollesley Bay**

30. On 7 March, Mr McCarthy was released from Hollesley Bay on his conditional release date. He was released with a 2-week supply of his current medication (including his antidepressant) until he was able to see his community GP.
31. Mr McCarthy did not attend his initial appointment with probation on the day of his release, due to the time it took him to travel from Hollesley Bay, but he was given another appointment to attend the following day. A duty probation officer emailed the CAS3 accommodation to let them know that Mr McCarthy was unlikely to attend his induction because he had not yet arrived at the probation office to receive his accommodation address. (Mr McCarthy did not have a phone. It appears that he stayed with a friend on release from Hollesley Bay.)
32. On Friday 8 March, Mr McCarthy attended his initial appointment with Turning Point. He was given a six-day prescription of methadone and a follow up appointment for 14 March to collect his next prescription. However, the Deputy Operations Manager confirmed that Mr McCarthy did not attend any further appointments after his initial appointment on 8 March.
33. That day, Mr McCarthy attended the probation office for his initial appointment, and he was seen by the duty probation officer. She noted that Mr McCarthy looked unkempt and was very frustrated that he had missed his induction at the CAS3 accommodation. She gave Mr McCarthy his next probation appointment for 11 March (which he did not attend).

34. Following the initial appointment, the duty officer completed another DTR to Hammersmith and Fulham Council.
35. Mr McCarthy was told to attend his CAS3 accommodation induction on 8 March, but he did not attend. As a result, HAM withdrew the offer of accommodation and informed his COM.
36. Mr McCarthy was homeless, but he was staying with his friend until he could find alternative accommodation. Because he did not engage with the CAS3 accommodation provider, they did not refer him to the SHP for ongoing accommodation support.
37. The COM told the investigator Mr McCarthy attended the probation office on 12 March, wanting to know what was happening about his accommodation. As he did not have an appointment booked, she was only able to speak to him briefly, but she told him another DTR had been submitted for him. She also advised him to present as homeless to the council. There is no evidence to suggest Mr McCarthy presented himself as homeless to the council.
38. Mr McCarthy was given another appointment to attend the probation office on 18 March, but he did not attend.

#### **Circumstances of Mr McCarthy's death**

39. At 2.00pm on 20 March, Mr McCarthy's friend called the emergency services when he found him unresponsive on the floor. Mr McCarthy had been sleeping on an airbed in his friend's flat. Rigor mortis (recognisable signs of death characterised by stiffening of the body) had set in and Mr McCarthy was cold to the touch.
40. The paramedics found drug paraphernalia in the flat. Mr McCarthy's friend told the paramedics that Mr McCarthy had been using heroin and crack cocaine.

#### **Post-mortem report**

41. The post-mortem report concluded that Mr McCarthy died from the respiratory depressive effect of methadone, exacerbated by the use of pregabalin and bromazepam (a synthetic benzodiazepine).



## Findings

### Substance misuse

42. Mr McCarthy had a history of substance misuse. While he was in prison, he was seen regularly by the Substance Misuse Service and warned about the risks and dangers of taking drugs. He was also offered training in the use of naloxone, but he declined. He was offered a naloxone kit on release, but again declined.
43. Mr McCarthy was promptly referred to the community drug and alcohol service to ensure he was provided with the support he needed on release, and he continued his methadone prescription in the community.
44. We are satisfied that both the prison and probation services did all they could to manage the risks associated with his substance misuse.

### Accommodation

45. We consider that the COM appropriately prepared for Mr McCarthy's release. She secured CAS3 accommodation on release, however he did not attend his induction, and the bedspace was withdrawn.
46. A DTR was completed, and Mr McCarthy was advised to present as homeless to the local council as they also have a duty of care to support those without accommodation, however there is no evidence to suggest Mr McCarthy presented himself as homeless. We consider that prison and probation staff took the appropriate steps to find suitable accommodation for Mr McCarthy on release. It seems that initially missing the induction at the CAS3 accommodation on his day of release was sufficient to discourage him from attending the necessary appointments to secure accommodation.

**Adrian Usher**  
**Prisons and Probation Ombudsman**

**January 2025**

At the inquest held on 9 June 2025, the coroner concluded Mr Neil McCarthy died from a drug related death.

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