Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Stephen King-Hall, a resident at McIntyre House Approved Premises, on 8 July 2025

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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

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.

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.

Mr Stephen King-Hall died of combined drug toxicity (morphine, heroin and cocaine) on 8 July 2025, while a resident at McIntyre House Approved Premises (AP). He was 51 years old. I offer my condolences to Mr King-Hall's family and friends.

Mr King-Hall had been released from prison on 26 June. Although he had a history of substance use, he denied using drugs at the AP and staff did not suspect him to be under the influence during his time there. The investigation found that prison and probation staff adequately supported Mr King-Hall. I make no recommendations.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

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

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Summary

Events

1. On 5 April 2024, Mr Stephen King-Hall was sentenced to 198 weeks' (approximately three years and 9 months) imprisonment for coercive behaviour. He transferred to HMP Featherstone in May 2024. Mr King-Hall moved to the Drug Recovery Wing in November and engaged well with the treatment programme there.

2. Mr King-Hall was released on 26 June 2025 and given naloxone (used to reverse the effects of opioid overdose) and his prescribed medication to take with him. He lived at McIntyre House Approved Premises (AP) after his release.

3. During his stay, Mr King-Hall was tested for drugs once, when he arrived, which was negative. He denied taking or considering taking drugs before and after his release. AP staff never suspected him to be under the influence.

4. On 7 July, Mr King-Hall returned to the AP and presented as usual. He spoke to staff and other residents and went to his room where staff last spoke to him at 11.00pm. When staff checked him at 1.00am on 8 July, they saw him slumped on his chair. They requested an ambulance immediately and started CPR. Paramedics arrived at 1.07am and took over life support. They pronounced life extinct at 1.39am.

5. The post-mortem report concluded that Mr King-Hall died of combined drug toxicity (morphine, heroin and cocaine) and that he had most likely taken heroin shortly before he died.

Findings

6. We concluded that staff appropriately supported Mr King-Hall both in prison and after his release. AP staff did not suspect Mr King-Hall was taking drugs. They spoke to him about the dangers of taking drugs and the risk of overdose.

7. We make no recommendations.

The Investigation Process

8. HMPPS notified us of Mr King-Hall's death on 9 July 2025.

9. The investigator issued notices to staff and residents at McIntyre House Approved premises informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

10. The investigator obtained copies of relevant extracts from Mr King-Hall's probation, prison and medical records. She interviewed the Approved Premises Manager and the Community Offender Manager on 13 August 2025 via MS Teams.

11. The investigator asked for CCTV camera footage from the AP but staff told her that this was no longer available due to a technical issue.

12. We informed HM Coroner for Warwickshire of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

13. The Ombudsman's office contacted Mr King-Hall's mother and sister to explain the investigation and to ask if they had any matters they wanted us to consider. They did not have raise any specific issues but asked for a copy of our report.

14. Mr King-Hall's family received a copy of the draft report. They did not make any comments.

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

Background Information

Approved Premises

16. Approved Premises (formerly known as probation and bail hostels) accommodate offenders released from prison on licence and those directed to live there by the courts as a condition of bail. Their purpose is to provide an enhanced level of residential supervision in the community, as well as a supportive and structured environment. Residents are responsible for their own health and are expected to register with a GP.

17. McIntyre House, in Nuneaton, is managed by HM Prison and Probation Service (HMPPS). The AP accommodates up to 18 residents. Residents are required to sign in and out of the building and follow agreed curfews. Each resident is allocated a keyworker to oversee their progress and wellbeing, and to ensure that they adhere to licence conditions and the rules of the AP. HMPPS employees are on duty at McIntyre House 24 hours a day.

HM Inspectorate of Prisons

18. The most recent inspection of Warwickshire Probation Delivery Unit (PDU) was in August 2022. The inspectors concluded that the PDU had a good foundation but required improvement, so they made nine recommendations. The recommendations included improving the quality of work to assess and manage risk of harm. Another recommendation sought to ensure that information sharing agreements were fully utilised. They also found that there were difficulties in pre-release provision due to staffing challenges.

Previous deaths at McIntyre House

19. Mr King-Hall was the first resident to die at McIntyre House since 2015. There are no significant similarities between his death and that of the previous resident.

Key Events

20. In August 2023, Mr Stephen King-Hall was charged with coercive behaviour, remanded to prison and taken to HMP Hewell. On 5 April 2024, he was sentenced to 198 weeks' (approximately three years and 9 months) imprisonment. On 17 May, he transferred to HMP Featherstone.

21. Healthcare staff from Hewell contacted Featherstone to ensure Mr King-Hall had a mental health review. Mr King-Hall had post-traumatic stress disorder (PTSD – symptoms include flashbacks, nightmares, anxiety and uncontrollable thoughts) and Emotionally Unstable Personality Disorder (EUPD – symptoms include impulsivity, unstable relationships and fluctuating emotions). On 24 May, a mental health nurse assessed him and referred him for blood tests and an electrocardiogram. On 29 May, he was formally allocated to a mental health nurse and had ongoing mental health support.

22. On 16 October, Mr King-Hall referred himself to the Drug Recovery Wing. Substance misuse staff assessed him on 25 October and accepted him onto their caseload, while they waited for a space to become available on the Drug Recovery Wing. Mr King-Hall said he had used cocaine in the past as well as synthetic cannabinoids. He had been prescribed methadone (an opiate substitute) previously but no longer needed this at the time of the assessment.

23. On 30 October, officers suspected that Mr King-Hall was under the influence of drugs and asked healthcare staff to assess him. Healthcare staff did not identify any signs that he was under the influence. They saw him again the following day and had no concerns. There was no further record of staff suspecting that Mr King-Hall was under the influence.

24. On 8 November, Mr King-Hall moved to the Drug Recovery Wing. The Head of Healthcare told us that Mr King-Hall engaged with all requirements of the Drug Recovery Wing and engaged well in group and one to one sessions.

25. On 14 November, Mr King-Hall was allocated a community offender manager (COM). The COM co-worked the case with a trainee probation officer. On 24 February 2025, they spoke to Mr King-Hall via videoconference and told him that he would be living in an approved premises on release. He said he was content with this.

26. On 14 March, Mr King-Hall's mental health nurse noted that his review with a psychiatrist was overdue and referred him to be seen.

27. On 31 March, the trainee probation officer referred Mr King-Hall to live in an approved premises after release.

28. On 1 April, a psychiatrist reviewed Mr King-Hall. They confirmed that he was prescribed quetiapine (antipsychotic) and venlafaxine (used to treat anxiety and depression). He also noted that Mr King-Hall should be referred to community mental health support on release, but did not need to be further reviewed before his release.

29. On 9 April, AP staff accepted the referral and, on 9 May, gave Mr King-Hall a place in McIntyre House AP.

30. On 30 May, substance misuse staff started planning for Mr King-Hall's release and completed harm minimisation work. They discussed tolerance levels after release, dangers of street drugs, and relapse prevention. Mr King-Hall refused support after release and declined to take naloxone (to reverse the effects of an opiate overdose) with him. Mr King-Hall later changed his mind and wanted to have naloxone on release, so staff trained him how to use it on 2 June.

31. On 3 June, Mr King-Hall completed the Drug Recovery Wing programme but remained on the wing and continued to attend group sessions. On 26 June, staff completed a community mental health referral. They also gave him his prescribed medication and naloxone.

Events after release on 26 June

32. On 26 June, Mr King-Hall was released and attended his probation appointment. The trainee probation officer recorded that he wanted to consider whether he wanted to engage with other agencies before they referred him. Mr King-Hall then went to McIntyre House where a sample was taken for drug testing. He told staff he was not using drugs. They confirmed he had naloxone with him.

33. During the induction, staff noted that Mr King-Hall was prescribed medication. The AP manager decided that, given Mr King-Hall's previous drug misuse, he should not have his medication in his possession. His medication was locked in a cabinet and staff dispensed it when Mr King-Hall asked.

34. The AP manager also decided that staff should carry out additional night checks because of Mr King-Hall's mental health issues and drug use history. These were an observational check at 1.00am and a rouse check (when staff would need to wake him up) at 3.00am for the first three weeks, on top of standard checks.

35. On 27 June, Mr King-Hall told the AP manager that he hoped to mentor other residents. The AP manager offered him the residents' representative role, which he accepted immediately and agreed to introduce himself at the next residents' meeting.

36. During his first week at the AP, staff noted that he was taking his medication as prescribed and having meaningful conversations with staff and other residents who he tried to discourage from using drugs.

37. On 30 June, Mr King-Hall attended his probation appointment where they discussed his initial sentence plan. He told the trainee probation officer he was doing well and, when discussing drug use, he said he was not taking drugs and that he the only thing that would jeopardise this would be if he suffered a bereavement.

38. On 3 July, the AP held the residents' meeting where Mr King-Hall introduced himself as the residents' representative.

39. On 7 July, the COM and the trainee probation officer visited Mr King-Hall at the AP. They discussed that his drug test was negative and asked him directly if he had

thoughts of using drugs. Mr King-Hall told them he had no thoughts of using drugs and was focused on his future. The COM told us that she planned to drug test him at the next appointment.

40. The COM told us that before release, Mr King-Hall had said he did not want to engage with the local substance use treatment in the community (CGL - Change Grow Live) because he felt he would be more likely to relapse if he were near other users.

41. The COM agreed to use the Dependency & Recovery Commissioned Rehabilitative Service (CRS) instead, which offered psychosocial support rather than clinical prescribing. She told us that she planned to do this after they had agreed on the sentence plan, which was due for completion by 11 July.

Events on 8 and 9 July

42. On the evening of 7 July, Mr King-Hall returned to the AP on time and ate dinner. He told staff he had spent the day helping his mother with gardening and had found it therapeutic. The AP manager told us that Mr King-Hall spoke to another resident about the risks of drug use.

43. At 11.00pm, AP staff completed a standard check and saw that Mr King-Hall was awake in his bed. He appeared to be doing well and responded to staff.

44. At about 1.00am on 8 July 2025, a residential worker went to Mr King-Hall's room to do the additional observation check and found him slumped in a chair. She noticed he had vomited, and his skin was blue. She radioed her colleague, a residential worker, and asked him to call 999 which he did and took the phone to Mr King-Hall's room.

45. The residential workers moved Mr King-Hall to the floor and started CPR as per the 999-call handler's guidance. One of the residential workers left the room to collect the defibrillator, while the other continued CPR. They applied the defibrillator, and it did not require a shock, so they continued CPR. Staff noticed drug paraphernalia, a pipe and a lighter, near Mr King-Hall.

46. At 1.07am, paramedics got to the room and continued life support treatment. At 1.39am, the paramedics stopped treatment and declared life extinct.

Contact with Mr King-Hall's family

47. Soon after paramedics arrived, they asked AP staff for Mr King-Hall's next of kin details and whether they would prefer to contact the next of kin themselves or if they would like the paramedics to call them. AP staff asked the paramedics to contact Mr King-Hall's mother, which they did and informed him that he had died. As a result, Mr King-Hall's mother and siblings went to McIntyre House a short time later and spoke to AP staff, paramedics and the police.

48. The AP manager later contacted Mr King-Hall's mother and offered her assistance with funeral expenses, in line with national guidelines.

Support for residents and staff

49. On the morning of 8 July, the AP manager debriefed the other residents at McIntyre House, offered her support, and asked for their understanding as undertakers and police completed their work.

50. The AP manager briefed staff involved in the emergency response and signposted them to further support, if needed. She also arranged reflective sessions for all members of staff at McIntyre House. She also made temporary working adjustments to one member of staff who was particularly affected.

Post-mortem report

51. The post-mortem report concluded that Mr King-Hall died of combined drug toxicity (morphine, heroin and cocaine). The report noted that Mr King-Hall had probably taken heroin between 40 minutes and three hours before his death. The morphine detected was most likely a result of Mr King-Hall taking heroin. The level of cocaine did not suggest recent or excessive use, but the report noted that the combined used of heroin and cocaine is likely to be more toxic than using either of the drugs separately.

Inquest

52. The inquest into Mr King-Hall's death was held on 23 September 2025. It concluded that his death was drug related.

Findings

Substance misuse

53. Mr King-Hall died of combined drug toxicity. He had a potentially fatal amount of morphine, heroin and cocaine in his system. While we cannot know for sure, we have found no evidence that he took drugs with an intention to take his own life or that staff should have assessed him as a risk to himself.

54. Mr King-Hall had engaged with substance misuse support while in prison, but he told probation staff in the community that he did not want to engage with clinical treatment in the community, as he felt that being near drug users would lead him to relapse. Probation staff intended to refer him to psychosocial support in agreement with him, as part of his initial sentence plan, which they had not the chance to complete before he died. This was reasonable, since engagement with substance misuse services is voluntary.

55. Staff did not suspect Mr King-Hall had taken drugs while he was at the AP. They also spoke to him about the risks of taking drugs and the risk of overdose. Mr King-Hall gave all overt indications that he was not using drugs and did not intend to use drugs. We do not think that probation or AP staff could have done any more to identify the risk or support him.

AP Manager to note

Naloxone

56. Although staff saw drug paraphernalia in Mr King-Hall's room, have access to naloxone, and are trained to administer it, there is no evidence they considered administering this to Mr King-Hall during the emergency response on 8 July.

57. We understand that staff were acting under instructions from the 999-call handler and under immense pressure. We also understand that paramedics administered naloxone once they arrived. On this basis, we make no recommendation, but we bring this of the attention of the AP manager who will want to ensure staff are confident to administer naloxone.

Staff Statements

58. The two members of staff that attended the emergency on 8 July wrote a statement together about the events they witnessed. Statements must be written separately in the first instance, as the discussing events with other witnesses may change an individual's recollection of events. We bring this to the attention of the AP manager.

Head of National Approved Premises Team to note

Guidance for contact with next of kin

59. When paramedics asked staff at the AP for Mr King-Hall's next of kin details and offered to contact them, staff agreed. This was reasonable in the circumstances.

60. We understand that paramedics routinely contact the next of kin if someone has died. However, APs present risks which need to be considered to determine if it is appropriate for families to visit the AP immediately. The importance of the family's needs must be balanced with their safety, the security of the AP and staff's ability to support the family under such stressful circumstances. There is no guidance for staff on this at present.

61. We wrote to the Head of National Approved Premises Team who told us she would look into this gap in guidance and address it. On this basis, we make no recommendation.

62. In this context, we consider that the AP staff who welcomed Mr King-Hall's family to the AP in the hours immediately after he died should be commended for their adaptability and for offering support in difficult circumstances.

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