Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Kyle Tyler, on 8 February 2024, following his release from HMP High Down

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. Since 6 September 2021, the PPO has been investigating 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 Kyle Tyler died of mixed drug toxicity on 8 February 2024, following his release from HMP High Down on 2 February. He was 45 years old. We offer our condolences to those who knew him.

5. Mr Tyler had a history of substance misuse and mental health issues, including anxiety and depression. He regularly harmed himself while in prison and in the community. Staff appropriately started suicide and self-harm prevention procedures (known as ACCT) when Mr Tyler arrived at High Down in early 2024. These were closed two days before his release from prison, with little consideration to release planning or involvement of 'through the gate' agencies. A post-closure review, scheduled for the morning of Mr Tyler's release, did not take place.

6. Healthcare staff appropriately arranged for Mr Tyler to have naloxone (to reverse the effects of opiate overdose on release). His community offender manager found release accommodation and identified licence conditions relating to drug testing.

7. While we cannot be sure of his motivation, there is no indication that Mr Tyler's death was due to a deliberate attempt to take his own life.

Recommendation

- The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidance, including that:

    - ACCT case reviews are multidisciplinary and include all relevant people involved in the prisoner's care, including those providing through the gate services where relevant; and

    - Case reviews and care plans consider relevant actions to support those prisoners who are nearing release.

The Investigation Process

8. We were notified of Mr Tyler's death on 9 February 2024.

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

10. On 18 July, the investigator and an Assistant Ombudsman interviewed one member of prison staff.

11. We informed HM Coroner for Kent and Medway of the investigation. They gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

12. The Ombudsman's office contacted Mr Tyler's next of kin to explain the investigation and to ask if he had any matters he wanted us to consider. He did not respond.

13. We shared the initial report with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP High Down

14. HMP High Down is in Surrey. It was re-categorised from a local to a training and resettlement prison in April 2022. Central and North West London NHS Foundation Trust provides physical and mental healthcare services. Substance misuse services are provided by Forward Trust.

Probation Service

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

HM Inspectorate of Prisons

16. The most recent full inspection of HMP High Down was in August 2023. Inspectors reported that care for those prisoners being monitored under suicide and self-harm prevention procedures (known as ACCT) was variable and ACCT documentation was generally poor. Case reviews were often poorly attended and care plans did not always address the underlying reasons for a prisoner's self-harming behaviour.

17. Inspectors reported that the prison's substance misuse service had increased its focus on release planning, and referred prisoners to community substance misuse services where possible. On release, prisoners were offered naloxone (used to reverse the effects of an opiate overdose).

18. In May 2024, inspectors completed an independent review of progress at High Down. They found that the quality of ACCT documents remained poor.

Assessment, Care in Custody and Teamwork

19. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner.

20. As part of the process, support actions are put in place. The ACCT plan should not be closed until all the support actions have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

21. On 5 August 2023, Mr Kyle Tyler was recalled to HMP Elmley for breach of licence conditions. Mr Tyler had a history of self-harm and had been monitored under ACCT procedures several times in prison. He was diagnosed with depression and anxiety, for which he was prescribed medication. Mr Tyler also had a history of substance misuse.

22. On 25 August, Mr Tyler was transferred to HMP Rochester. Prison staff started ACCT procedures shortly before the transfer, when Mr Tyler cut his wrist as he did not want to move. Staff at Rochester closed the procedures around three weeks later.

23. On 28 September, a Community Offender Manager (COM) was allocated to Mr Tyler.

24. On 4 October, Mr Tyler was released from Rochester on licence, which was due to expire on 4 December. He would be on post sentence supervision (PSS) from 5 December to 4 October 2024.

25. On 10 November, Mr Tyler was recalled to Elmley for breach of his licence and on charges of criminal damage, common assault of an emergency worker, and theft. Prior to his recall, Mr Tyler was prescribed buprenorphine (medication used as an opiate substitute) in the community. Healthcare staff prescribed methadone as an alternative. (Methadone is widely used as an opiate substitute in prisons, as it is taken in liquid form and is therefore harder to trade than tablet medication.) Prison staff referred Mr Tyler for 1-2-1 support from Change, Grow, Live (CGL – substance misuse support services). Mr Tyler was also referred for 1-2-1 psychology treatment.

26. On 16 November, prison staff started ACCT procedures as Mr Tyler was in debt and because he was worried about the upcoming anniversary of a bereavement.

27. On 18 December, Mr Tyler told prison staff that he would be homeless upon release and requested housing support in the Swale area. Prison staff contacted the COM to offer support from the pre-release team.

28. On 19 December, the COM made a commissioned rehabilitative services referral for Mr Tyler (CRS - staff who are physically present in all prisons across England and Wales with a resettlement function).

29. On 28 December, prison staff closed the ACCT procedures.

HMP High Down

30. On 5 January 2024, Mr Tyler was transferred to HMP High Down. On arrival, staff referred him to the substance misuse team. Before leaving Elmley, Mr Tyler made a superficial cut to his arm, as he did not want to transfer. Escorting staff also told prison staff that Mr Tyler had a razor blade in his mouth. Prison staff spoke with Mr Tyler and he told them that he struggled with change. They restarted the ACCT procedures.

31. At the time of the transfer, Mr Tyler was prescribed methadone, mirtazapine (an antidepressant) and pregabalin (used to treat epilepsy, nerve pain or anxiety).

32. On 6 January, Mr Tyler attended an ACCT review with a supervising officer and a nurse. Mr Tyler said he had harmed himself because he did not want to transfer to High Down. He said he had told prison staff at Elmley that he was feeling the urge to self-harm prior to his transfer, however this was disregarded by prison staff there. Mr Tyler also expressed frustration at changes that were being made to his pain control medication. The nurse requested a medication review.

33. On 9 January, at an ACCT review, Mr Tyler said that he had attempted to overdose once before (in the community) by taking excessive amounts of paracetamol. The case review team noted that Mr Tyler was required to liaise with the Forward Trust (who provide support for people affected by drug or alcohol issues, past offending, homelessness or unemployment).

34. On 11 January, Mr Tyler put a razor blade in his mouth when he was informed of a potential cell move.

35. On 15 January, Mr Tyler declined to engage with an initial assessment with Forward Trust psychosocial services and therefore a care plan/assessment was not completed. Mr Tyler later told prison staff that he was now working with Forward Trust.

36. Substance misuse service staff provided Mr Tyler with harm minimisation advice. They encouraged him to accept naloxone on release and discussed the dangers of using and mixing substances and the dangers of low tolerance levels. They explained to Mr Tyler the risk of death by overdose if using other substances in addition to prescribed medication. Mr Tyler was advised of the dangers of injecting and discouraged from this method of use.

37. On the same day, prison staff emailed the clinical team to inform them of Mr Tyler's release date (which was 2 February) and let them know that he wanted to swap from methadone to buprenorphine prior to his release. Mr Tyler also told prison staff he did not have release accommodation and they advised him to put an application to the resettlement team as a matter of urgency.

38. On 22 January, Mr Tyler again told prison staff that he did not have accommodation on release and would return to Chatham. He intended to claim benefits on release and told prison staff he was worried about a clash of appointments with housing and the Department for Work and Pensions (DWP) on release. Staff sent an email to St Mungo's (a homeless charity) about housing, and referred Mr Tyler to the mental health team.

39. That day, Mr Tyler attended an ACCT review, with a supervising officer and nurse also present. Mr Tyler appeared well and said he had no thoughts of self-harm or suicide and had no plans for this to change. He engaged throughout the review, raised no immediate concerns and the panel recorded that he was settled. There is no record that Mr Tyler's impending release was discussed.

40. On 31 January, Mr Tyler attended an ACCT review with a Supervising Officer (SO) and a member of the Forward Trust. This was the first of Mr Tyler's case reviews

that the SO had been involved in. He told us that he led the case review because Mr Tyler's usual case co-ordinator was absent.

41. The SO recorded that Mr Tyler said he was good, and his main concern was obtaining his coat on release. Mr Tyler said that he was worried about obtaining his medication on release and was encouraged to register with a GP as soon as possible so he could continue this. The SO said that they did not discuss Mr Tyler's release arrangements any further, as his main concern was for his coat. Mr Tyler said that he had no current thoughts of suicide or self-harm, and the panel decided to close the ACCT procedures. As Mr Tyler was to be released on 2 February, the SO scheduled his post-closure review for that day.

42. The COM told us that prior to release, Mr Tyler was given CAS3 housing and a travel warrant. He was due to be on the Integrated Offender Management scheme (IOM - which brings together police forces, local authorities, and the probation service to work with former prisoners to help rehabilitate them) which would have resulted in additional police support and monitoring, as well as GPS tagging. Mr Tyler was referred to the Forward Trust in the community and would be regularly drug tested. She also said that, once settled in the community, Mr Tyler could have been referred to CGL for additional support, if he was willing to engage.

43. On 2 February, Mr Tyler was released from prison on licence. He was given a naloxone kit. There was no ACCT post-closure review on the day of his release.

Post release

44. On 2 February, Mr Tyler attended his initial probation appointment with one of the COM's colleagues, who had met him before. The colleague was able to see Mr Tyler early to ensure he could attend his CAS3 housing induction on time. The COM told us she was aware that Mr Tyler had a history of mental health issues but did not say if she knew he was on an ACCT before release.

45. The COM told us that Mr Tyler did not attend his housing induction. He later called her and told her that he had stayed at his step-father's house, who confirmed this was correct. Mr Tyler was given a new induction appointment. He attended the second induction on time with no issues.

Circumstances of Mr Tyler's death

46. Mr Tyler was found deceased at an address in Sittingbourne on the night of 7 February. This address was not the CAS3 accommodation that probation had provided for him.

Post-mortem report

47. The post-mortem report concluded that Mr Tyler died of mixed drug toxicity (morphine, pregabalin, cocaine, benzoylecognine, metonitazene, protonitazene, xylazine and methadone).

48. The toxicologist reported that morphine was present at an elevated and potentially fatal level, and pregabalin at a slightly elevated level. They highlighted that

metonitazene and protonitazene are strong synthetic opioids. Xylazine is a sedative usually used in veterinary medicine. Benzoylecognine is a metabolite of cocaine.

Contact with Mr Tyler's family

49. The coroner informed us that Mr Tyler's death was reported to the police, who informed Mr Tyler's next of kin.

Findings

50. Mr Tyler had a history of substance misuse in the community. He worked with substance misuse services in prison and was appropriately issued with naloxone on his release. Mr Tyler's licence conditions required him to be drug tested, and he was signposted to community drug support agencies.

Management of ACCT procedures

51. Prison Service Instruction (PSI) 64/2011 provides instructions and guidance on managing prisoners at risk of suicide and self-harm. It states that ACCT procedures can be closed when the risk of harm has been reduced to a level where this is no longer considered raised, and all support actions have been completed with their intended outcome achieved. Following closure of ACCT procedures, post-closure monitoring must be completed for a minimum of seven days, before the case co-ordinator chairs a post-closure review.

52. PSI 64/2011 provides action points for the case co-ordinator when a prisoner being managed under ACCT procedures is due to be released from custody. These include inviting relevant professionals from the Probation Service (both internal and external to the prison) to case reviews in the lead up to release and sharing relevant information, including key information from the ACCT document, with them. PSI 64/2011 also identifies that relevant specialists providing 'through the gate' services to the prisoner should be invited to participate in case reviews.

53. Prison staff appropriately restarted ACCT procedures when Mr Tyler arrived at High Down on 5 January 2024. The procedures were closed on 31 January, two days before he was due to be released. A SO appropriately scheduled a post-closure review for the morning of Mr Tyler's release, but this did not happen. This meant an important opportunity to identify any outstanding through the gate issues such as support with drug/alcohol issues, housing, and access to release medication for Mr Tyler was missed.

54. Although staff knew that Mr Tyler was due for release on 2 February, other than a discussion about release medication at his final case review – which did not lead to healthcare input to reassure Mr Tyler about these arrangements – there is little evidence that his wider release arrangements were discussed at any of the ACCT case reviews. Agencies involved in Mr Tyler's release arrangements, including his community offender manager (COM), were not invited to any of the case reviews, and it is unclear whether the COM was aware that Mr Tyler had been managed under ACCT procedures so close to his release. The SO said that he did not know what the pathway was for ensuring ACCT/risk information was shared with the COM and other relevant community providers.

55. While we cannot be sure of his motivation, there is no indication that Mr Tyler's actions on the night of his death were a deliberate attempt to take his own life.

56. We make the following recommendation:

The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidance, including that:

- **ACCT case reviews are multidisciplinary and include all relevant people involved in the prisoner's care, including those providing through the gate services where relevant; and**
- **Case reviews and care plans consider relevant actions to support those prisoners who are nearing release.**

Inquest

57. The inquest into Mr Tyler's death concluded on the 28 August 2024. The coroner confirmed that Mr Tyler's death was drug related.

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

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