

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Stephen Taylor, on 22 December 2025, following his release from HMP Altcourse

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. 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. Mr Stephen Taylor died from a pulmonary embolism and pneumonia on 22 December 2025 following his release from HMP Altcourse on 8 December. He was 59 years old. We offer our condolences to those who knew him.
5. We did not identify any significant learning relating to the pre-release planning or post-release supervision of Mr Taylor.
6. We make no recommendations.

The Investigation Process

7. HMPPS notified us of Mr Taylor's death on 24 December 2025.
8. The PPO investigator obtained copies of relevant extracts from Mr Taylor's prison and probation records.
9. We informed HM Coroner for Liverpool and Wirral of the investigation. We have sent the Coroner a copy of this report.
10. The Ombudsman's office contacted Mr Taylor's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They had no questions but asked for copy of our report.
11. We shared our initial report with HMPPS. They found no factual inaccuracies.
12. We sent a copy of our initial report to Mr Taylor's next of kin. They did not notify us of any factual inaccuracies.

Background Information

HMP Altcourse

13. HMP Altcourse is a category B men's prison and Young Offender Institution. It is managed by Sodexo.

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

Key Events

Background

15. On 3 October 2024, Mr Stephen Taylor was convicted of possessing a Class A controlled drug with intent to supply. He was sentenced to 28 months in prison.
16. On 9 September 2025, he was released from prison on licence.
17. On 11 November, Mr Taylor was recalled to prison for breaching his licence conditions and was sent to HMP Altcourse.
18. During his reception health screen, Mr Taylor told the nurse he had several serious health conditions including chronic obstructive pulmonary disease (COPD, lung disease), asthma and diabetes. He said he was a drug user and regularly used cocaine and had used heroin in the past but not for seven years. The nurse referred him to the substance misuse team.
19. On 12 November, a substance misuse worker saw Mr Taylor. He told them he had a history of cocaine and heroin use. He said he had used crack cocaine in the last week. Mr Taylor said that he did not see that as problematic and did not wish to engage with the substance misuse team. The substance misuse worker advised him about the risk of substance misuse in prison and how to contact the team if he needed to. Mr Taylor also confirmed he was aware of the local drug services in the community.
20. On 14 November, a nurse carried out Mr Taylor's secondary health screen. Mr Taylor said he had a stent in his heart and was under the care of the Royal Liverpool Infirmary for his physical health conditions. He did not report any current symptoms and said he knew how to access health services in prison if needed.
21. On 20 November, Mr Taylor attended a prison healthcare clinic. He told staff he had regular appointments at the Royal Liverpool Infirmary and was seen there around six weeks earlier and had blood tests. He did not report any health concerns and confirmed he had access to his medication. He declined assistance to stop smoking.

Pre-release planning

22. On 12 and 17 November, Mr Taylor completed his basic custody screening which includes a standardised assessment of a prisoner's needs, and to provide support in preparation for release. The assessment identified Mr Taylor would be homeless on release from prison.
23. On 20 November, a community offender manager (COM) was allocated Mr Taylor's case.
24. On 23 November, the COM submitted an application for accommodation in the community for Mr Taylor and he was provided temporary accommodation by the Community Accommodation Service (CAS).

25. On 7 December, a nurse saw Mr Taylor prior to his release. Mr Taylor said he had no issues and was looking forward to his release. The nurse gave him a GP referral letter and seven days medication.

Post-release management/release from HMP Altcourse

26. On 8 December, Mr Taylor was released from Altcourse. He attended the probation office as required, where he was compliant and engaged. He completed his induction but refused permission for the Probation Service to contact his GP. He later arrived at his accommodation. He was due to attend his next probation appointment on 17 December.

Circumstances of Mr Taylor's death

27. On 13 December, Mr Taylor was admitted to Arrowe Park Hospital with shortness of breath and was moved to the Critical Care Unit on 15 December. He died in hospital on 22 December.

Cause of death

28. The Coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave Mr Taylor's cause of death as multiple organ system failure caused by a pulmonary embolism (when a blood clot blocks a blood vessel in the lungs) and pneumonia (lung infection).
29. At the inquest, held on 31 December 2025, the Coroner concluded that Mr Taylor died of natural causes against a backdrop of opiate dependency.

Findings

30. Mr Taylor had multiple physical health conditions when he arrived at Altcourse, including COPD and heart issues. He was at Altcourse for less than a month and reported no physical health issues during that time. A nurse saw him before his release and gave him a GP referral letter and seven days' medication. We are satisfied that appropriate continuity of care was in place. Mr Taylor's COM also arranged accommodation for Mr Taylor so he was not homeless on release.
31. We are satisfied that Mr Taylor had appropriate pre-release planning and post-release supervision. We make no recommendations.

Adrian Usher
Prisons and Probation Ombudsman

June 2026

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