Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Brian Tait, following his release from HMP Durham, on 11 September 2025

A report by the Prisons and Probation Ombudsman

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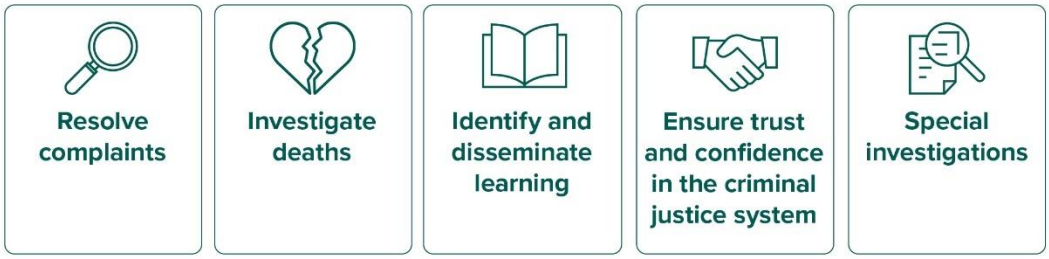
OUR VISION

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 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 Brian Tait died from the combined effects of methadone, diazepam and pregabalin on 11 September 2025, following his release from HMP Durham on 28 August. He was 62 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 for or post-release supervision of Mr Tait. While Mr Tait did not sign an opt-out form when he declined naloxone (medication used to reverse the effects of an opiate overdose), his refusal was documented in his medical records on multiple occasions and this information was given to the community substance misuse service. We make no recommendations.

The Investigation Process

6. HMPPS notified us of Mr Tait's death on 17 September 2025.

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

8. We informed HM Coroner for Newcastle and North Tyneside 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 Tait's next of kin, his partner, to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond to our letter.

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

Background Information

HMP Durham

11. HMP Durham is a category B prison which holds convicted and remanded male prisoners. The healthcare and clinical substance misuse treatment provider at HMP Durham is Spectrum. The psychosocial substance misuse treatment provider is Humankind.

Probation Service

12. 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.

Deaths following release from prison

13. Since September 2021 to the end of February 2026, the PPO has started investigations into just over 300 deaths of people who die within 14 days of release from prison. The PPO has published two learning lessons bulletins about post-release deaths, most recently in July 2024. Our investigations highlight the acute vulnerability of prison leavers, especially during the first few days post-release, and indicate that prison leavers often have multiple risk factors such as mental health issues, substance misuse and homelessness which further increase their vulnerability and risk of death following release from prison.

Previous deaths following release from Durham

14. Mr Tait was the eleventh man to die within 14 days of release from Durham since September 2022, and the seventh drug-related death in that period. Since Mr Tait's death to March 2026, there have been two further deaths within 14 days of release from Durham, one of which was also drug-related. As in this investigation report, we did not make any recommendations following our investigations into the previous deaths at Durham.

Key Events

Background

15. On 27 August 2025, Mr Brian Tait was convicted of possession a bladed article in a public place. He was sent to HMP Durham having spent just over four months electronically tagged while on bail. He was sentenced to five months in prison.

Pre-release planning

16. When he arrived at Durham on 27 August, a nurse completed Mr Tait's initial health screen. He tested positive for cocaine, opiates and benzodiazepine. The nurse referred him to the mental health team as he said he found it hard to cope with his daughters' deaths.

17. At 7.30pm, a nurse saw Mr Tait. He reported that he was taking 80ml of prescribed methadone daily but the community substance misuse team had only given him 40ml that day. He said that he used benzodiazepine once a month and cocaine three times a week. The nurse arranged for substance misuse monitoring overnight.

18. At 10.37am on 28 August, a nurse saw Mr Tait. He asked to be put back on 80ml of methadone. As he displayed some withdrawal symptoms, the nurse increased his methadone from 40ml to 50ml and recorded that he would look to increase it by a further 10ml in four days' time.

19. At 12.09pm, a nurse saw Mr Tait for a drug and alcohol assessment. He disclosed a history of heroin and crack cocaine use. During the assessment, Mr Tait began to cry and said that he felt suicidal due to his daughters' deaths. He said that he had had thoughts of hanging himself the previous night. The nurse started suicide and self-harm prevention procedures, known as ACCT, and staff agreed to monitor him hourly.

20. Healthcare received information that Mr Tait was to be released from prison immediately as he had served time tagged while on bail. Mr Tait told the nurse that he had previously engaged with Newcastle Waythrough (a community service which provides support with drug use and mental health) so the nurse referred him to this service and told him to present there on 29 August between 11.00am and 3.00pm. She arranged for Mr Tait to continue to receive his methadone treatment in the community and gave him harm reduction information.

21. The nurse offered Mr Tait naloxone (medication used to reverse the effects of an opiate overdose). He declined this but completed the training on how to use it. The nurse completed a continuity of care form and sent it to Newcastle Waythrough. This documented Mr Tait's substance use, that he had been monitored under ACCT procedures and that he had not been given naloxone. Mr Tait told the nurse that he had his own home but he consented to engaging with housing support services if his circumstances changed. He was given information about and contact details for NHS Reconnect (a care after custody service that seeks to improve the continuity of care for people leaving prison with an identified health need).

22. At 3.41pm, the Mental Health Clinical Lead saw Mr Tait to complete a mental health assessment. Mr Tait denied thoughts of suicide or self-harm. He said he had been taken into custody the previous day for the first time in ten years and was very shocked. However, he said he felt much better knowing that he was being released. The Mental Health Clinical Lead contacted the community Crisis team (which provides urgent support for those facing a mental health crisis) to inform them of Mr Tait's release and give them information about him. She also gave Mr Tait the Crisis team's phone number. The Mental Health Clinical Lead told Mr Tait to go to his GP the next day for antidepressants. Mr Tait's medical records indicate that he did not arrive at Durham with an active prescription so needed to go to his community GP for a medication review before restarting treatment.

23. At 4.03pm, an officer completed Mr Tait's ACCT review. He said that he was happy to be returning to his home and his dog. It was noted that healthcare staff had arranged for Mr Tait to receive substance use and mental health support from Newcastle Waythrough and that prison staff would continue to monitor him hourly under ACCT procedures until his release.

Release from HMP Durham

24. At 5.00pm on 28 August, Mr Tait was released from Durham. (His licence instructed him to attend the probation office at 3.00pm but he missed this appointment as he was still in prison at the time.)

25. On 29 August, Mr Tait was allocated a Community Offender Manager (COM). A senior probation officer told us that Durham did not inform them that Mr Tait had been subject to ACCT procedures. However, the COM identified this from the Probation Service's electronic information system.

26. The COM contacted Newcastle Safeguarding and Safe Living (a local authority housing provider) to ask if Mr Tait's tenancy was still available to him and they confirmed that it was. The COM passed information to them about the safeguarding risks Mr Tait posed to himself in line with the ACCT information on the electronic information system. The COM tried to call Mr Tait but he did not answer. She then wrote to him, asking him to attend an appointment at 9.00am on 2 September.

27. That day, the substance misuse team manager at Durham called Newcastle Waythrough to discuss Mr Tait's risk of suicide and self-harm. She told them that a continuity of care form had been sent to them. They told her that they would pass this information to Mr Tait's allocated worker.

28. On 2 September, Mr Tait failed to attend his appointment with the Probation Service. The COM recorded that she had tried to call Mr Tait multiple times but he failed to answer or return her call. The COM submitted a request to recall Mr Tait to prison. She recorded that she had considered an unplanned home visit as an alternative to recall but decided that this would be unsafe due to his index offence (possession of a knife).

Circumstances of Mr Tait's death

29. On 17 September, the COM received information from the Coroner that Mr Tait had been found dead at his home on 11 September. They told her that he was found at

the side of his bed. Drug paraphernalia and uncapped needles had been found at the scene.

Post-mortem report

30. The post-mortem report concluded that Mr Tait died from the combined effects of methadone, diazepam and pregabalin.

Inquest

31. At an inquest held on 7 May 2026, the Coroner concluded that Mr Tait's death was drug related.

Findings

32. Mr Tait died from the combined effects of mixed drugs 14 days after he was released from prison. He had only been in prison for one day so there was little that prison or healthcare staff could reasonably have done to prepare for his release. Despite this, a nurse and the Mental Health Clinical Lead completed referrals and contacted relevant services to ensure appropriate community support was in place for Mr Tait. This was good practice.

33. Prison and probation staff routinely share information about a prisoner's risk and support needs when they are released. A senior probation officer told us that as Mr Tait was already released from custody when he was allocated a COM, probation staff did not have the opportunity to work with the prison to obtain this information or undertake any release planning in advance of his release. She said that this was usually communicated through a prison leaver's Prison Offender Manager (POM). However, Mr Tait was not allocated a POM in custody as he was sentenced and released the following day. This was outside the control of HMPPS.

34. A Safer Custody Officer told us that when someone is released while subject to ACCT procedures or if they have recently been monitored under them, the prison would email the COM and community agencies to support the individual. However, the prison did not inform the COM that Mr Tait was subject to ACCT monitoring. Mr Tait was an unplanned release, so the COM found ACCT information on the Probation Service's electronic information system. This is not related to Mr Tait's death, and we do not make a recommendation about this.

Governor to note

35. While it may not have been avoidable in this case, Mr Tait was released from prison at 5.00pm. This meant that he missed his appointment with the Probation Service. Releasing prison leavers late in the day can mean that they miss important community appointments which help them prepare for life in the community. We bring this to the Governor's attention.

Head of Healthcare to note

36. Durham's Naloxone Issue Policy states that if a prison leaver refuses naloxone, they should complete an opt-out form to confirm this. The substance misuse team manager told us that Mr Tait did not sign an opt-out form. However, as his refusal is clearly documented in the medical records on multiple occasions and this information was passed to Newcastle Waythrough in the continuity of care form, we do not make a recommendation about this but bring it to the Head of Healthcare's attention.

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

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