

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Jeffrey Poyser, on 9 July 2023, following his release from HMP Wandsworth

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 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 HMPPS in ensuring the standard of care received by those within service remit is appropriate then our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic process failures.
4. Mr Jeffrey Poyser died of heroin, methadone and cocaine intoxication, with a secondary contributing factor of chronic obstructive pulmonary disease, on 9 July 2023, following his release from HMP Wandsworth on 7 July. He was 56 years old. We offer our condolences to those who knew him.
5. Mr Poyser had a long history of crack cocaine and heroin use, having first started using drugs when in his 20s. Mr Poyser had a significant number of offences linked to his drug use, but probation staff said he did not recognise it was a problem.
6. We did not find any issues of concern.

The Investigation Process

7. We were informed of Mr Poyser's death on 13 July 2023.
8. The PPO investigator obtained copies of relevant extracts from Mr Poyser's prison and probation records.
9. We informed HM Coroner for Southwark of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
10. Mr Poyser did not have a recorded next of kin.
11. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS found no factual inaccuracies in the report.

Background Information

HMP Wandsworth

12. HMP Wandsworth is a local Category B prison in London, with a Category C unit. It holds up to 1,452 men in eight residential wings. St George's University Hospital NHS Foundation Trust provides physical healthcare services at the prison. Mental health and clinical substance misuse services are provided by South London and Maudsley NHS Foundation Trust. Change Grow Live (CGL) provide psychosocial services.

Probation Service

13. 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.

Key Events

14. On 29 April 2023, Mr Jeffrey Poyser was remanded to HMP Thameside for breach of post sentence supervision (PSS). He had been to prison before and had spent time homeless. Mr Poyser had a long history of substance misuse (often heroin and cocaine) and had worked with community substance misuse services in the past. During his most recent time in prison, earlier in 2023, Mr Poyser had chosen not to engage with the substance misuse service as he said that he did not have any substance misuse issues at the time.
15. On 4 May, Mr Poyser had a Turning Point (providing substance misuse advice and support) assessment. He said that he would be homeless upon release from prison.
16. On 9 May, Mr Poyser completed a release plan, harm reduction advice and DIP (drug intervention programme) appointment. The release plan was sent to Mr Poyser's community offender manager (COM).
17. On 10 May, Mr Poyser was released on licence. Mr Poyser chose not to accept support offered to find accommodation. Probation staff recorded that this was not unusual behaviour for Mr Poyser and that, in the past, he had disengaged with offers of temporary accommodation.
18. On 18 May, Mr Poyser was recalled to HMP Thameside.
19. On 19 May, Mr Poyser completed a Turning Point assessment and was referred to the substance misuse team for further support.
20. On 21 May, Mr Poyser completed another Turning Point assessment, at which he told staff that he would be homeless upon release.
21. On 31 May, Mr Poyser was released on licence. It is unclear whether he had accommodation on release, but as previously, Mr Poyser did not engage with support to find accommodation.

HMP Wandsworth

22. On 12 June, Mr Poyser was recalled to HMP Wandsworth for breach of licence conditions. Healthcare staff referred him to the substance misuse service. A GP prescribed methadone (for withdrawal from opiates, such as heroin) and healthcare staff completed five days of clinical observations.
23. On 16 June, Mr Poyser completed a five-day substance misuse assessment, where it was agreed that he would stabilise on methadone in prison and continue treatment in the community on release. Mr Poyser also engaged with Change Grow Live (CGL, psychosocial substance misuse service) while at Wandsworth.
24. On 3 July, Mr Poyser's release plan was provided to his COM. Prior to his release, his prison offender manager sent a Duty to Refer on behalf of Mr Poyser. (Public authorities have a duty to refer people to local authorities/councils whom they believe to be homeless or threatened with homelessness within 56 days.)

25. On 7 July, CGL gave Mr Poyser naloxone (used to reverse the effects of opiate overdose) ahead of his release that day.

Post Release

26. On 7 July, Mr Poyser was released from prison. On release, Mr Poyser attended his probation office with a substance misuse worker. His usual COM was not available that day, so she arranged for a colleague to meet Mr Poyser in her place. Mr Poyser refused to complete the induction pack. Probation staff gave Mr Poyser an appointment to see his COM the following Monday.
27. Mr Poyser's COM told us that during the initial probation appointment, he was encouraged to call the council for assessment for temporary accommodation. However, the waiting time on the phone line was long and Mr Poyser chose to leave the probation office to attend another appointment. Therefore, at the time of release, Mr Poyser remained homeless.
28. Later that afternoon, Mr Poyser had an appointment at the Community Drug and Alcohol Team (CDAT). A CGL worker also attended. Mr Poyser was prescribed methadone for the weekend, which he was due to pick up on 8 July from a pharmacy. (We do not know if Mr Poyser collected this prescription.) An appointment was also made for him with CDAT on 10 July.

Circumstances of Mr Poyser's death

29. On 9 July, Mr Poyser was found by members of the public collapsed on the pavement. He was unresponsive, so an ambulance was called. A bystander commenced cardiopulmonary resuscitation (CPR), which was continued by ambulance staff when they arrived. Unfortunately, they were not successful and Mr Poyser was pronounced dead at 2.52pm.
30. Probation records state that a friend of Mr Poyser's said he had taken both heroin and crack cocaine.

Post-mortem report

31. The post-mortem report concluded that Mr Poyser died of heroin, methadone and cocaine intoxication and chronic obstructive pulmonary disease (a group of lung conditions that cause breathing difficulties).

Findings

32. Mr Poyser was referred to several different community services ahead of his release. This included substance misuse support, accommodation providers, support with his personal wellbeing, and help with finding employment. Mr Poyser's COM also ensured that another colleague met him on release from prison when she was not available on the day. However, Mr Poyser's lack of structure and routine remained a concern for probation who said it would impact his ability to reduce his likelihood of reoffending. They said his general lifestyle of using drugs and offending also raised concerns.
33. We found evidence that the COM, prison staff, and community support staff made consistent efforts to understand Mr Poyser's needs and how to address them, and encouraged him to engage with the help he was given.

Inquest

34. The inquest into Mr Poyser's death concluded on the 22 December 2025. The coroner confirmed that Mr Poyser's death was drug related.

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