

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Simon Watson on 11 December 2021, following his release from HMP Leeds

A report by the Prisons and Probation Ombudsman



Our vision

To carry out independent investigations to make custody and community supervision safer and fairer



Our values

We are:

Impartial: we do not take sides

Respectful: we are considerate and courteous

Inclusive: we value diversity

Dedicated: we are determined and focused

Fair: we are honest and act with integrity



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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 a person's release from prison.
3. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.
4. Mr Simon Watson died from the toxic effects of methadone (a heroin substitute), pregabalin (used to treat epilepsy, nerve pain and anxiety) and morphine (an opioid painkiller) on 11 December 2021, nine days after his release from HMP Leeds. He was 43 years old. I offer my condolences to those who knew him.
5. Mr Watson had a history of substance misuse and was on a methadone programme. He was also prescribed pregabalin. He was not prescribed morphine so must have obtained this illicitly.
6. The clinical reviewer concluded that the clinical care that Mr Watson received at Leeds was equivalent to that which he could have expected to receive in the community. Mr Watson had access to substance misuse support and counselling while in prison and was given advice about his reduced drug tolerance before he was released.
7. We did not find any issues of concern. We make no recommendations.

The Investigation Process

8. The PPO investigator obtained copies of relevant extracts from Mr Watson's prison and probation records.
9. We informed HM Coroner for West Yorkshire of the investigation. They gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
10. The Ombudsman's family liaison officer contacted Mr Watson's friend and father to explain the investigation and to ask if they had any matters they wanted us to consider. Mr Watson's friend did not raise any issues but asked for a copy of our report. Mr Watson's father did not respond to our letter.
11. We shared the initial report with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies. We sent a copy of our initial report to Mr Watson's friend and father. They did not respond to us.
12. We sent a copy of our initial report to Mr Watson's friend and father. They did not notify us of any factual inaccuracies.

Background Information

HMP Leeds

13. HMP Leeds is a local prison holding a maximum of 1,218 prisoners who are on remand or have been convicted or sentenced. The prison serves the courts of West Yorkshire. Practice Plus Group (previously known as Care UK) provides healthcare services, including mental health services. The prison has 24-hour primary healthcare cover.

Probation Service

14. Probation services supervise individuals serving community orders, provide offenders with resettlement services while they are in prison (in anticipation of their release) and supervise all individuals sentenced for offences committed after the Offender Rehabilitation Act 2014, for a minimum of 12 months after they are released from prison.

Key Events

15. On 2 November 2021, Mr Simon Watson was convicted of motoring offences and was sentenced to two months in prison. He was released from HMP Leeds on 2 December.

Pre-release planning

16. Mr Watson had a history of drug use and was on a methadone programme. (Methadone is an opioid drug and is used to reduce a person's dependence on heroin or other opioids.) Mr Watson was already working with Turning Point, a community-based drug and alcohol support service. They arranged an appointment for 6 December, after his release.
17. On 2 December, healthcare staff provided Mr Watson with a seven-day supply of his prescribed medication (pregabalin, apixaban, mirtazapine and omeprazole). They also provided him with a form which would enable him to get his methadone for three days until he could attend his appointment with Turning Point who could prescribe further methadone.
18. Mr Watson was also advised to take naloxone (a medication to reverse opioid overdose rapidly) with him when released, but he refused.

Post-release

19. On 2 December, Mr Watson reported to Wakefield Probation Office, where he had a supervision appointment with his community offender manager (COM). Mr Watson told her that the prison had arranged a pharmacy appointment for him later that day. She instructed Mr Watson to attend another probation appointment on 8 December. She gave Mr Watson the contact details for his key worker at Turning Point.
20. On 3 December, staff at a company on Eastfield Lane, Castleford, saw Mr Watson walking across wasteland and private property. They challenged Mr Watson, but he ignored them and walked away.
21. On 6 December, the COM received a phone call from Mr Watson's key worker at Turning Point who told her that a colleague had seen a post on social media which said that Mr Watson was missing. The key worker later emailed the COM to say that Mr Watson had missed his pharmacy appointment on 2 December.
22. On 7 December, Mr Watson's friend left a voicemail for the COM and said that Mr Watson was missing. The COM rang the police to ask if Mr Watson was being treated as a missing person. The police told her that they had received a call of concern the previous day but, after reviewing the information, they decided not to treat Mr Watson as missing.
23. The COM called Mr Watson's friend to give her this update. Mr Watson's friend said she was concerned because she had not seen him since 3 December, he had never collected money she had for him, and he had left his medication with her. She explained this was all out of character for Mr Watson.

24. The COM called the pharmacy to ask if Mr Watson had collected his medication. The pharmacy confirmed he had not.
25. The COM called the police again to report him as missing and called Mr Watson's friend to give her the log number for the police.

Circumstances of Mr Watson's death

26. On 10 December, the staff saw a press release and recognised Mr Watson as a missing person. They forced entry to the wasteland, where they had last seen Mr Watson a week earlier and found his body in some tall grass. They called the police, who attended.

Post-mortem report

27. The post-mortem report concluded that Mr Watson died from combined toxicity of pregabalin, methadone and morphine (an opioid painkiller).

Support for staff

28. Mr Watson's COM's manager informed her of Mr Watson's death and offered support.

Findings

29. Mr Watson was prescribed pregabalin and methadone. He was not prescribed morphine, so he must have obtained this illicitly.
30. Mr Watson had a history of substance misuse and was on a methadone programme to reduce his dependence on opioid drugs. He was appropriately warned that he would have a reduced tolerance to drugs when he left prison and was also offered naloxone, which he declined.
31. Mr Watson was already working with Turning Point at the time of his release and had an appointment organised for 6 December but died before then.
32. The clinical reviewer found that Mr Watson received appropriate support for his substance misuse issues.
33. We found no issues of concern. We make no recommendations.

Caroline Mills

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