Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Stephen Silvester on 4 September 2022, following his release from HMP Leeds

A report by the Prisons and Probation Ombudsman

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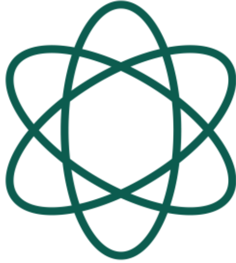
Our vision

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

OGL

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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. 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 Stephen Silvester died on 4 September 2022, following his release from HMP Leeds on 26 August. The post-mortem examination was unable to establish his cause of death. Mr Silvester was 37 years old. I offer my condolences to those who knew him.

5. While Mr Silvester received good support with his mental health and substance misuse issues at Leeds, the clinical reviewer found that there had been no handover between the prison's mental health team and community mental health services when Mr Silvester was released.

6. Mr Silvester was monitored using suicide and self-harm procedures (known as ACCT) on three occasions while he was at Leeds. The last period of monitoring ended on 3 August. We found that documentation from his most recent ACCT had not been shared with community probation staff as it should have been.

Recommendations

- The Head of Healthcare at HMP Leeds should ensure that prisoners on the mental health team's caseload are discussed with the community mental health team prior to release.

- The Governor should ensure, in line with the Annex to PSI 64/2011, that where a prisoner has been subject to ACCT monitoring within 12 months of release, staff share relevant risk information with probation colleagues, including the community offender manager, prior to release.

The Investigation Process

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

8. The clinical reviewer interviewed three members of prison healthcare staff; a psychiatrist, a nurse and a substance misuse recovery worker.

9. We informed HM Coroner for Wakefield of the investigation. He 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 Silvester's brother to explain the investigation and to ask if he had any matters he wanted us to consider. He had a question about the support Mr Silvester received regarding the death of his sister. This has been covered in the report.

11. We shared our initial report with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies.

12. We sent a copy of our initial report to Mr Silvester's brother. He did not notify us of any factual inaccuracies.

Background Information

HMP Leeds

13. HMP Leeds is a local prison holding up to 1,218 prisoners who are on remand, convicted or sentenced. The prison serves the courts of West Yorkshire. Practice Plus Group (PPG) is the lead provider of health care at the prison with subcontracted services for substance misuse, mental health specialisms and dentistry. The prison has 24-hour primary healthcare cover.

HM Inspectorate of Prisons

14. The most recent full inspection of HMP Leeds was in June 2022. Inspectors found that mental health services were reasonably good, with some gaps in non-urgent care. Mental health practitioners were available 8am-6pm each weekday and they worked closely with prison staff to make sure that those in urgent need or crisis received prompt support, with mental health practitioners available to participate in ACCT meetings. HMIP found that there was a gap in service for those with mild to moderate mental health disorders however they did receive suitable medical care. Support was also provided through the substance misuse team, chaplaincy, bereavement and professional counselling services, and the Samaritans. Patients' ongoing needs were considered before their release, including liaison with GPs and community mental health teams, through the use of the care programme approach and by supply of medicines to take home.

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 supervises people throughout their licence period and post-sentence supervision.

Key Events

16. On 25 February 2022, Mr Stephen Silvester was remanded in custody, charged with assault of an emergency worker and possession of a bladed weapon. He was sent to HMP Leeds.

17. On 28 April, Mr Silvester was convicted and sentenced to 12 months in prison. He remained at Leeds.

ACCT monitoring

18. When Mr Silvester arrived at Leeds, he told staff that he heard voices telling him to self-harm. Staff started suicide and self-harm prevention procedures (known as ACCT) which continued until 30 March. Staff monitored him using ACCT on two further occasions between May and August. He was given regular support from his ACCT manager and the mental health team as well as wing staff and his Prison Offender Manager (POM). The last period of ACCT monitoring ended on 3 August.

Mental health care

19. The reception nurse referred Mr Silvester for a mental health assessment when he arrived at Leeds.

20. On 31 March, a mental health nurse saw Mr Silvester for his initial assessment. She agreed to work with Mr Silvester on a one-to-one basis to help him develop coping strategies and alternatives to self-harm. As Mr Silvester had reported hearing voices and hallucinating, she referred Mr Silvester to the prison psychiatrist.

21. On 23 April, the prison psychiatrist saw Mr Silvester for an initial assessment. He was uncertain of the nature of Mr Silvester's psychotic symptoms and questioned whether they may be down to sustained substance abuse and personality issues. He prescribed antipsychotic medication. The introduction of this medication had a positive effect on Mr Silvester's sleep pattern and on his mental state.

22. Mr Silvester regularly mentioned how he was struggling to deal with the death of his sister in 2014, so he was referred for counselling with the prison chaplaincy team. He was also able to discuss this and was given support and advice during his regular ACCT reviews. A mental health nurse saw him for regular one-to-one sessions and he was also reviewed regularly by the prison psychiatrist.

Substance misuse support

23. On 4 April, Mr Silvester had an initial substance misuse assessment with a recovery worker from the prison Drug and Alcohol Recovery Team (DART). Mr Silvester told her that he was not dependent on drugs, but that he had used them in the past. They discussed the risks of mixing illicit and prescribed drugs. She was allocated as Mr Silvester's recovery worker, and she agreed to see him in one month's time.

24. On 4 May, the recovery worker saw Mr Silvester to discuss his needs and goals for the future. Mr Silvester told her that before going to prison, he used alcohol and

solvents (when someone intentionally breathes in or sniffs common toxic substances to get a high). He also said that he occasionally injected heroin. He told her that alcohol was the main issue for him and that he would like to focus on this during their sessions. She arranged for Mr Silvester to complete a workbook around his alcohol use.

25. Over the next four months, the recovery worker saw Mr Silvester for structured one-to-one sessions. They discussed the physical and psychological risks of alcohol abuse and on 11 August, Mr Silvester completed the alcohol workbook. Mr Silvester told her that he would need support from the community DART team once he was released into the community. She completed a referral to the Wakefield DART team.

26. On 16 August, the recovery worker saw Mr Silvester for a structured counselling session. She gave Mr Silvester details of a follow up appointment that she had arranged for him with the Wakefield DART team. They discussed the importance of him attending this appointment to reduce the risk of him relapsing into drug and alcohol use. She then advised Mr Silvester about the risks of mixing prescribed and non-prescribed drugs with alcohol. She also warned him about the risks of overdosing, given that he would have a lower tolerance level after a period of abstinence. She gave him advice on the signs and symptoms of overdosing and gave him advice on what to do in the event of an overdose. As Mr Silvester had finished his care plan and had a follow up appointment arranged with the community DART team, she closed his file.

Release from prison

27. At around 9.00am on 26 August, the day of Mr Silvester's release, a prison GP assessed Mr Silvester and raised no concerns. Mr Silvester told the GP that he had no thoughts of suicide or self-harm. Mr Silvester was released that morning.

28. At 11.00am, Mr Silvester attended his initial appointment at Wakefield Probation Office. He completed his induction before leaving to collect the keys to his new flat. He was issued his next appointment for 5 September at 3.00pm.

29. On 5 September, Mr Silvester did not attend his planned probation appointment. His Community Offender Manager (COM) attempted to ring Mr Silvester, but his phone was switched off. She then rang his housing worker to see if he had heard from Mr Silvester. The housing worker had also been unable to contact Mr Silvester. The COM sent a warning letter to Mr Silvester for missing his appointment and issued him another appointment for 13 September at 1.30pm.

Circumstances of Mr Silvester's death

30. On 5 September, a neighbour reported a foul odour coming from Mr Silvester's flat. Police gained entry and found Mr Silvester in a state of decomposition. The pathologist estimated that he died on the previous day, 4 September, at approximately 10.00pm.

31. On 6 September, Wakefield Coroner's Office informed Wakefield Probation Office that Mr Silvester had died.

Post-mortem report

32. The post-mortem report concluded that Mr Silvester’s cause of death was unascertained. As the body was found in an advanced stage of decomposition, the examination was difficult. The pathologist noted that he could not find any obvious evidence of a cause of death from both the internal and external examinations. He also noted that the toxicology results were negative. He could not exclude the possibility of Sudden Adult Death Syndrome. Also, as a bottle of butane gas was found next to Mr Silvester’s body, the pathologist could not rule out gas inhalation as the cause of death. He noted however, that there was no way to test for this during the post-mortem examination.

33. At the inquest held on 2 February 2023, the coroner recorded an open conclusion. The coroner concluded that the circumstances in which Mr Silvester died and Mr Silvester's intentions at the time were unknown, as was the significance of the butane cylinder found next to his body.

Findings

Clinical care

34. The clinical reviewer found that Mr Silvester was well supported by the mental health and substance misuse services at HMP Leeds and treatment focused on developing coping strategies that would support him in the community.

35. However, the clinical reviewer considered that Mr Silvester should have been given the details of his community mental health team and an appointment arranged before his release from prison. We recommend:

    The Head of Healthcare at HMP Leeds should ensure that prisoners on the mental health team's caseload are discussed with the community mental health team prior to release.

Sharing of information about Mr Silvester's risk of suicide and self-harm

36. Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody), says that when a prisoner has been supported by ACCT within 12 months of release, relevant information about their risk from their most recent ACCT should be shared with community probation staff. It specifies the ACCT documentation that should be shared.

37. We found that ACCT documentation was not shared with Mr Silvester's COM. We acknowledge that the COM was aware of Mr Silvester's risk of suicide and self-harm and had the information she needed to manage it. Nevertheless, the policy guidance was not followed in this case as specified ACCT documents were not shared. We recommend:

    The Governor should ensure, in line with the Annex to PSI 64/2011, that where a prisoner has been subject to ACCT monitoring within 12 months of release, staff share relevant risk information with probation colleagues, including the community offender manager, prior to release.

Susannah Eagle
Deputy Prisons and Probation Ombudsman **May 2023**

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