

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Ms Stacey MacDonald on 10 September 2021, following her release from HMP Peterborough**

**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

**OGI**

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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. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.
3. Ms Stacey MacDonald died of cocaine toxicity on 10 September 2021, in a hostel in Nottingham following her release from HMP Peterborough three days earlier. She was 43 years old. We offer our condolences to Ms MacDonald's family and friends.
4. We are concerned that there were gaps in information sharing about Ms MacDonald's substance misuse and her substance misuse history. Some relevant information was not shared effectively between the prison and probation services, and with the hostel to which she was released. This meant that key information that may have informed decision-making was not available.
5. We are also concerned that Ms MacDonald's substance misuse licence condition was not accurate. This would have made enforcement of this licence condition hard. It also meant that Ms MacDonald was given conflicting information about the substance misuse service she was required to engage with.
6. There is no evidence that Ms MacDonald was referred to the Nottingham Integrated Offender Management (IOM) Unit following her release as she should have been.
7. We are mindful of the recommendation made by HM Inspectorate of Prisons in 2017 and 2021 about accommodation for women released from prison. We view Ms MacDonald's placement in a hostel as another example of a woman with complex needs being placed in short term accommodation. We note that the provision of accommodation for women leaving prison is an issue that extends beyond the remit of HMP Peterborough or local probation services.

## Recommendations

- The Director, Head of Healthcare and Senior Probation Officer at HMP Peterborough should review how substance misuse information is shared internally, and with key partners including Community Offender Managers and housing providers.
- The Head of East and West Lincolnshire Probation Delivery Unit should ensure that staff create licence conditions which are accurate and relevant for the service user.
- The Head of East and West Lincolnshire Probation Delivery Unit should ensure that when a service user moves to a new area, staff make the appropriate Integrated Offender Management referral.

## The Investigation Process

8. The PPO investigator obtained copies of relevant extracts from Ms MacDonald's prison and probation records.
9. The investigator interviewed two prison-based staff on 1 November 2021 and two community-based probation staff on 3 November 2021.
10. We informed HM Coroner for Nottingham City and Nottinghamshire of the investigation. The Coroner gave us the results of the post-mortem examination and toxicology report. We have sent the Coroner a copy of this report.
11. The Ombudsman's family liaison officer contacted Ms MacDonald's mother, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She had no questions, but asked for a copy of our report. We have sent her a copy of this report.
12. We shared a copy of our initial report with HM Prison and Probation Service (HMPPS). They pointed out some minor factual inaccuracies which have been amended in this report. They provided an action plan which is annexed to this report.
13. Ms MacDonald's mother did not notify us of any factual inaccuracies in our initial report.

## Background Information

### HMP Peterborough

14. HMP & YOI Peterborough is a local and medium security prison. It is a 'split-site' prison with capacity to hold 624 men and 360 women in separate prison units. It is managed by Sodexo Justice Services under contract from the Ministry of Justice.
15. The female site at HMP Peterborough, serves as the female prison for the East of England. It serves the courts of the region and provides resettlement services for women held there.
16. Substance Misuse Services (SMS) are provided by Northampton Healthcare NHS Foundation Trust (NHFT).

### Probation Service

17. Probation services supervise individuals serving community orders, provide offenders with resettlement services while they are in prison (in preparation for 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.
18. During 2021, probation services went through structural reforms. The private probation services (known as Community Rehabilitation Companies (CRCs)) were re-nationalised and merged with the public sector National Probation Service (NPS) to form the Probation Service. The merging of services was staggered across the regions of England and Wales starting in June 2021.
19. Ms MacDonald's 2021 sentence was appropriately allocated to the Humberside, Lincolnshire and North Yorkshire (HLNY) CRC in June. She was already known to HLNY CRC due to previous sentences and was managed by CRC staff on release from prison. Probation services unified on 26 June 2021. Former CRC staff moved to line management of a former National Probation Service line manager from this point under the new Probation Service.

### HM Inspectorate of Prisons

20. The last full inspection of HMP & YOI Peterborough's female site was an unannounced inspection held between 11 and 21 September 2017. Inspectors were concerned about the numbers of women being released with no fixed accommodation. They recommended that the Ministry of Justice and HM Prison & Probation Service (HMPPS) commission a review of accommodation. HMPPS partly accepted this recommendation.
21. Inspectors also recommended that the prison should develop a women-specific drug recovery strategy and that women should have a review of their resettlement plan prior to release.
22. The most recent inspection of HMP & YOI Peterborough's female site was a short scrutiny visit (which replaced full inspections as a response to the COVID-19

pandemic) on 2 and 9-10 March 2021. Inspectors found that the prison delivered good resettlement services and robust substance misuse processes.

23. Inspectors raised the same concern they found in 2017, that many women, “were released either without any housing or into emergency, short-term accommodation. This was not directly the fault of the prison but was symptomatic of a broader concern about the provision of suitable accommodation for women leaving prison”. Inspectors found that 20% of women at HMP Peterborough were released this way, which they assessed was too high given the level of need many of the women had.

## **HM Inspectorate of Probation**

24. The most recent inspection of HLNy CRC was published in May 2020. Inspectors found that staffing levels were insufficient with around 25% of vacancies at the start of 2019. They found that two thirds of staff had more than 50 cases each. Inspectors recommended that all staff receive effective case-focused supervision by managers.

## **Home Detention Curfew (HDC)**

25. The Home Detention Curfew (HDC) scheme provides a managed transition from prison to community for supervised individuals serving short sentences. People released early from prison on HDC are subject to an electronically monitored (EM) curfew via an ankle tag. EM is a tool to monitor compliance with the curfew, which is part of the sentence, and so enhance supervision in the community.
26. Probation services supervise individuals on HDC through face-to-face and phone appointments. Any breaches of the licence (except curfews) are managed by probation staff. The curfew is monitored by a Ministry of Justice (MoJ) approved Electronic Monitoring Service (EMS) provider. Significant breaches of curfew are reported to the Ministry of Justice who take curfew breach recall decisions on behalf of Governors.

## Key Events

27. On 12 May 2021, Ms Stacey MacDonald was sentenced to a Suspended Sentence Order (SSO) at Lincoln Magistrates Court for theft. This sentence was a suspended prison sentence that could be activated if Ms MacDonald committed further offences or failed to engage with probation services. Her SSO was supervised by an offender manager from Lincolnshire CRC.
28. On 10 June, Ms MacDonald was convicted of theft, breach of an SSO and breach of a Criminal Behaviour Order (CBO) at Lincoln Magistrates Court and was sentenced to 50 weeks imprisonment. She was sent to HMP Peterborough.
29. On reception at the prison, Ms MacDonald had an initial health screening. Nursing staff assessed her and identified she was suffering from heroin and alcohol withdrawal. She was prescribed methadone (a synthetic opiate substitute) and was placed on an alcohol detoxification pathway. Ms MacDonald was located on the drug recovery unit on the female site. Healthcare staff referred her to the prison's Substance Misuse Service (SMS) and allocated a case worker (who had been Ms MacDonald's case worker on previous sentences at HMP Peterborough).
30. On 15 June, a resettlement worker completed a Basic Custody Screening (BCS) with Ms MacDonald. The BCS tool is a standardised HMPPS assessment used to identify a prisoner's needs (both in custody and on release) and any risk they pose. She completed the assessment with Ms MacDonald over the prison phone system due to COVID-19 restrictions.
31. In the BCS, the resettlement worker identified a number of issues, including housing, health and substance misuse. She identified that Ms MacDonald needed to be referred to a community housing service and noted that Ms MacDonald was being supported by SMS.
32. On 17 June, Ms MacDonald's community housing provider closed her case due to her being in prison. This would make her homeless on release. Ms MacDonald had been living in Grantham.

## Pre-release planning

33. On 21 June, the prison's Offender Management Unit (OMU) wrote to Ms MacDonald telling her that she was eligible for early release from prison on Home Detention Curfew (HDC – tagging). They asked her if she wanted to be considered for release on HDC and to think about an address she could be released to. They advised that if Ms MacDonald did not have a place to stay, then the prison could refer her to the Bail and Accommodation Support Service (BASS). If an address was found, Ms MacDonald would be eligible for release from 6 September instead of 1 December.
34. On 2 July, the SMS case worker met with Ms MacDonald and they discussed her drug recovery. Ms MacDonald wanted to complete a 'rapid detox,' which would mean she would reduce her methadone dose to nil over a period of weeks. This was something Ms MacDonald had done at Peterborough previously. This was agreed and her methadone prescription was reduced by 5ml each week.

35. On 15 July, Ms MacDonald completed the HDC form, confirming that she wanted to be considered for HDC. She said that she did not have a place to live and that she wanted to go back to Grantham but would live “anywhere”.
36. On 28 July, Ms MacDonald stopped taking her methadone. She was down to a low dose and felt it was no longer helping her. Her ‘rapid detox’ was due to be completed that week.
37. On 17 August, the SMS case worker met with Ms MacDonald. They discussed her completed detox and her plans. They discussed Ms MacDonald being prescribed naltrexone (a drug that reduces drug cravings and opiate euphoria) prior to her release. Ms MacDonald said that she was interested in this medication. The process for prescribing naltrexone required a set of blood tests, followed by a GP prescribing the medication. Best practice indicated that a prisoner would be monitored for several days to assess the impact of the medication. This process would take over a week to deliver.
38. On 20 August, the prison’s OMU completed a referral to NACRO BASS as part of the HDC process. The form was completed by an OMU administrator. In the sections on substance misuse need, the OMU administrator wrote that Ms MacDonald did not have any substance misuse needs. She also wrote that she had been ‘clean’ for five weeks and would continue her drug rehabilitation on release.
39. Ms MacDonald had signed the NACRO BASS referral, saying she was happy for the referral to be made and for her details and circumstances to be shared. Ms MacDonald chose Nottingham and Peterborough as release options. Probation services felt that moving away from Grantham would offer her a “clean break”.
40. On 31 August, NACRO BASS wrote to the OMU administrator offering Ms MacDonald a room in their Nottingham hostel from 7 September. The letter said that the prison needed to return a signed copy of the offer along with Ms MacDonald’s HDC licence.
41. Ms MacDonald accepted the offer that day. The OMU administrator signed the letter the following day and enclosed the copy of the HDC licence.
42. On 2 September, the OMU administrator wrote to Ms MacDonald’s offender manager (OM), asking for a probation appointment on 7 September. As the OM was on leave that week, another OM arranged the appointment.
43. The prison asked if Ms MacDonald could have a telephone appointment. The OM told the prison that due to Ms MacDonald’s poor attendance at probation appointments on previous sentences, she needed to attend a face-to-face appointment. Due to the short notice of the release, Lincolnshire CRC were unable to arrange for Nottinghamshire CRC to see Ms MacDonald. The appointment was arranged for 12.00pm at the Grantham probation office.
44. On 6 September, the prison resettlement team and the substance misuse team only found out that Ms MacDonald was to be released the next day on 7 September. A resettlement worker reviewed Ms MacDonald’s BCS. In her update, she noted that

Ms MacDonald had accommodation arranged and that SMS would be arranging support for her on her release.

45. The same day, the SMS case worker met with Ms MacDonald as part of her release planning. As part of the meeting she gave Ms MacDonald the details of the drug service in Nottingham – the Nottingham Recovery Network (NRN). They also discussed the risks of mixing drugs and overdosing. NRN would not book Ms MacDonald an appointment as she was not receiving opiate substitute medication. Ms MacDonald would need to refer herself to the service.
46. Ms MacDonald's HDC licence included a curfew and additional licence conditions to comply with the hostel rules and address her "alcohol abuse and drug abuse problems at We Are you With you" (We Are With You is a substance misuse and mental health services based in 80 locations across England and Scotland).
47. Shortly after 9.00am on 7 September, Ms MacDonald was released from HMP Peterborough. She was given her licence and train fare.
48. That day, the OM completed an Initial Sentence Plan (ISP) for Ms MacDonald. She identified work to maintain drug abstinence, emotional wellbeing support and building a social network of people not involved in crime or substance use. She planned to share this with Ms MacDonald during supervision over the coming weeks.

## **Post-release**

49. Ms MacDonald was on time for her appointment with the OM in Grantham. Ms MacDonald appeared well and positive. The OM went through Ms MacDonald's licence with her and set out the probation service expectations. The appointment finished at around 12.30pm.
50. The OM gave Ms MacDonald her train fare and a map of Nottingham with the hostel marked. The train journey between Grantham and Nottingham was around 35 minutes and there was a regular service.
51. Ms MacDonald was required by her HDC licence to arrive at the hostel by 3.00pm. Ms MacDonald did not arrive until around 6.45pm. This was a breach of her licence.
52. As the hostel was not permanently staffed, Ms MacDonald was let in remotely by her allocated NACRO BASS key worker. The electronic monitoring contractor was able to attend the hostel that evening to fit Ms MacDonald's ankle tag.
53. On 8 September, the key worker inducted Ms MacDonald into the hostel. She also rang her OM and told her that Ms MacDonald had arrived late the night before. She reported that Ms MacDonald had told her that she had got drunk before coming to the hostel.
54. The OM then spoke with Ms MacDonald. She reminded Ms MacDonald of the terms of her licence. Ms MacDonald told the OM that she had had a few drinks to calm her nerves following her release.

55. Later that day, NACRO BASS staff attended the hostel to carry out room checks. They found Ms MacDonald drinking alcohol in her room with an unknown male visitor, who she had tried to hide. The presence of a visitor outside the designated times was a breach of the hostel rules, which in turn was a breach of her licence.
56. That evening Ms MacDonald was 45 minutes late returning to the hostel. This was recorded by her tag. This was another breach of her licence.
57. On 9 September, Ms MacDonald's key worker rang the OM to tell her what had happened the previous evening.
58. That morning, the key worker and an emergency locksmith attended the hostel. Ms MacDonald had reported that the lock on her bedroom door was faulty. While the locksmith began to fix the door, Ms MacDonald began to undress. The key worker challenged Ms MacDonald and asked her if she had taken anything. Ms MacDonald said that she had drunk a can of lager and smoked cannabis.
59. That afternoon, Ms MacDonald rang her OM. Ms MacDonald was worried she was going to be recalled to prison. The OM reminded her of her licence terms and told her that she would be receiving a warning letter. She also told Ms MacDonald that she had arranged a probation appointment for her at the Nottingham probation office with a member of staff there. The appointment was set for 16 September.
60. The OM posted Ms MacDonald her formal warning letter. Ms MacDonald was warned for her late arrival at the hostel on 7 September. The letter advised that further warnings could lead to Ms MacDonald being recalled to prison.

### **Circumstances of Ms MacDonald's death**

61. At around 2.00pm on 10 September, another hostel resident found Ms MacDonald lying on a sofa in the communal living room. She noted that Ms MacDonald appeared not to have moved since the night before. The resident rang her mother and told her about Ms MacDonald.
62. At around 3.15pm, the resident's mother rang the key worker and told her what her daughter had said. The key worker immediately called 999. The key worker, who was in Peterborough at the time, then made her way to the hostel.
63. Paramedics arrived at the hostel at 4.28pm. They assessed that there were no signs of life, and that resuscitation would be inappropriate. They declared Ms MacDonald dead at 5.22pm. Paramedics contacted the police.
64. That afternoon NACRO BASS contacted the OM, the Probation Service and HMP Peterborough to inform them that Ms MacDonald had died.

### **Post-mortem report**

65. The pathologist gave Ms MacDonald's cause of death as cocaine toxicity.

## **Contact with Ms MacDonald's family**

66. On 10 September, Nottinghamshire Police contacted Ms MacDonald's mother to tell her that Ms MacDonald had died.

## **Support for Staff**

67. Following Ms MacDonald's death, BASS NACRO provided support and care for the staff and other residents at the hostel.
68. On 14 September, the OM met with her manager to talk about Ms MacDonald's death and see what support she might need.

# Findings

## Substance misuse information sharing

69. Ms MacDonald had a significant history of substance misuse and her offending was linked to her substance misuse. Ms MacDonald's recent sentences reflected a cycle of offending, short prison sentences and community supervision that had been part of her life for a number of years.
70. Since 2018, Ms MacDonald was supervised in the community by her offender manager. During the two most recent periods of community supervision, Ms MacDonald often did not comply with the terms of her licence, including missing appointments.
71. Ms MacDonald was known at HMP Peterborough where she had served previous prison sentences. The SMS case worker had worked with Ms MacDonald for several years when she was in prison.
72. The OM and SMS case worker had a good understanding of Ms MacDonald's substance history, her recovery attempts and her engagement with services in the community.
73. When Ms MacDonald arrived at HMP Peterborough nursing staff identified that she was withdrawing from heroin and alcohol. The SMS case worker knew Ms MacDonald's main drug use was heroin and crack cocaine. Ms MacDonald told nursing staff that her alcohol consumption had been very high in the community. She was clinically assessed as suffering from severe withdrawal. The SMS case worker's experience of Ms MacDonald's drinking was that it was a substitute for using heroin or crack cocaine. However, the BCS completed on 15 June only recorded Ms MacDonald's self-assessment that her use of alcohol was not dependant or an area of concern. There was no objective assessment of her alcohol use, which was clearly problematic.
74. When the accommodation referral was made to BASS NACRO an OMU administrator completed the form. This was in line with policy and process. However, the information provided to BASS NACRO was brief. It did not capture Ms MacDonald's long-term substance misuse, her alcohol misuse, or the pattern of her rapidly detoxing while in prison. The administrator also recorded that Ms MacDonald had no substance misuse needs.
75. We found that information sharing between departments at HMP Peterborough missed important information about Ms MacDonald's substance misuse needs and risk. As a result, this information was not available to the community OM and BASS NACRO staff. This meant that these staff made decisions based on incomplete information. We do not consider that the gaps in information sharing between the agencies contributed to Ms MacDonald's death.
76. In interview we were told that there was limited information sharing between different departments in the prison. The SMS case worker told us that SMS were rarely asked for information on prisoners applying for BASS accommodation and often found out about prisoner releases at short notice. The resettlement worker

told us that she and her team were only told of Ms MacDonald's release the day before and that to complete the BCS review she rang round the prison getting updates from the departments that answered the phone.

77. Some of the gaps in information sharing were not helped by the short timeframe available to staff when Ms MacDonald was accepted by BASS NACRO. When the place was offered on 31 August, prison and healthcare staff were left with four working days to arrange all release preparations. This hindered resettlement and substance user workers in making discharge arrangements and meant that naltrexone could not be prescribed. We are aware that it is not uncommon for prisoners to be released on HDC at short notice.
78. We also note that information that might have been helpful to the OM in her supervision of Ms MacDonald was not shared with her. We note that on 9 September, the BASS NACRO key worker found Ms MacDonald behaving erratically. When she questioned Ms MacDonald about this, she admitted to drinking and drug taking.
79. When Ms MacDonald breached her curfew on 8 and 9 September, this was not shared with the OM. The curfew was monitored by the Electronic Monitoring Service (EMS). National policy means that only very significant time breaches are reported to the Ministry of Justice (MoJ) who enforce the curfew on behalf of Governors. Curfew breach data is shared with the probation service in arrears.
80. However, breaches of curfew can give OMs information on service users engagement with their licence and can be considered alongside other information. BASS NACRO and EMS are organisations that are out of scope of our investigation.
81. We make the following recommendation.

**The Director, Head of Healthcare and Senior Probation Officer at HMP Peterborough should review how substance misuse information is shared internally and with key partners including Community Offender Managers and supported housing providers.**

## **Licence conditions**

82. Ms MacDonald had an additional condition added to her probation licence when she was released from prison on 7 September 2021. This was appropriate given her substance misuse history and its link with her previous offending. The licence condition read;  
  
"viii. To comply with any requirements specified by your supervising officer for the purpose of ensuring that you address your alcohol abuse, drug abuse problems at the We Are you With you".
83. There was an issue with this licence condition, which made the licence condition harder for probation staff to enforce. The "We Are With You" service was named incorrectly on the licence and it was not available in Nottingham. It would have been unreasonable to expect Ms MacDonald to travel out of Nottingham for such services.

84. On 6 September, when Ms MacDonald met with the SMS case worker, she referred her to the Nottingham Recovery Network (NRN), the substance misuse provider in Nottingham. This meant Ms MacDonald was given conflicting information as to where to get help and support.
85. It is not clear that Ms MacDonald was planning to engage with community substance misuse services. However, inaccuracies and errors when setting licence conditions can impact on the effectiveness of the licence and supervision. We make the following recommendation:

**The Head of East and West Lincolnshire Probation Delivery Unit should ensure that staff create licence conditions which are accurate and relevant for the service user.**

### **Referral to the Integrated Offender Management (IOM) Unit**

86. In 2021, Ms MacDonald was managed by Lincolnshire Integrated Offender Management (IOM) Unit known as ARC. This was because Ms MacDonald had a high risk of reoffending, and because of the number and type of offences she had previously been convicted of.
87. During her imprisonment in 2021, it was assessed that a move away from Grantham might help Ms MacDonald. This was a reasonable and appropriate consideration. There is no evidence to indicate that once Ms MacDonald had a release address in Nottingham, she was referred to the Nottinghamshire IOM unit for them to assess, as she should have been. A referral would have enabled Nottingham IOM to determine whether Ms MacDonald needed extra support and monitoring. We make the following recommendation:

**The Head of East and West Lincolnshire Probation Delivery Unit should ensure that when a service user moves to a new area, staff make the appropriate IOM referral.**

**Sue McAllister CB  
Prisons & Probation Ombudsman**

**November 2022**

### **Inquest**

88. The inquest into Ms MacDonald's death took place on 5 June 2023. The Coroner concluded that Ms MacDonald's death was drug-related.

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