

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Louis Taylor on 18 October 2022, following his release from HMP Parc

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 detained people 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 Louis Taylor died from fatty liver on 18 October 2022, following his release from HMP Parc on 10 October. He was 39 years old. We offer our condolences to those who knew him.
5. Mr Taylor had a long history of substance misuse. Although toxicology tests showed that Mr Taylor had several drugs in his system when he died, the pathologist concluded that they were not at levels likely to have caused his death. The pathologist recorded the cause of death as fatty liver, which can cause fatal arrhythmias (irregular beating of the heart leading to death).
6. We found no issues of concern and make no recommendations.

The Investigation Process

7. The PPO investigator obtained copies of relevant extracts from Mr Taylor's prison and probation records.
8. We informed HM Coroner for South Wales Central of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
9. The Ombudsman's family liaison officer contacted Mr Taylor's mother 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 found no factual inaccuracies but asked for some additional detail about the Probation Service and pre-release planning, which has been included in this final report.

Background Information

HMP Parc

11. HMP Parc is a medium security prison run by G4S. It holds around 1,600 adult and young adult prisoners who are either on remand or convicted. It also has a unit for up to 60 young people aged under 18. G4S Medical Services provides primary physical and mental healthcare services. There is 24-hour general healthcare and palliative care facilities. A local GP practice provides GP services, including a daily clinic and out of hours cover.

HM Inspectorate of Prisons

12. The most recent inspection of HMP Parc was in June and July 2022. Inspectors reported that release planning arrangements had deteriorated since the unification of probation services and were not good enough. Some commissioned service providers had not returned to the prison since the COVID-19 pandemic which weakened the resettlement service. The remaining resettlement team assessed prisoners' needs at 12 weeks and one month before release, providing support with DWP appointments, bank accounts and ID. The prison had no reliable data to show how many prisoners had been released to sustainable accommodation or employment.

Probation Service

13. The Probation Service work with all individuals subject to custodial and community sentences. HMPPS in Wales became an early adopter of the Resettlement Model in June 2021. In the Model, resettlement planning for all people in prison was brought to seven and a half months pre-release and included embedded dedicated resettlement staff into that journey. In line with the Offender Management in Custody (OMiC) model, Resettlement Staff would commence working with an individual from the point of the Prison Offender Manager (POM)/Community Offender Manager (COM) handover and would be a support to the COM and the Person in Prison (PiP) through to release. Post-release, the Probation Service supervise people throughout their licence period and post-sentence supervision.

Key Events

14. On 26 June 2021, Mr Louis Taylor was remanded to HMP Cardiff, charged with possessing Class A drugs with intent to supply. He was subsequently sentenced to 31 months in prison for supplying heroin and cocaine.
15. Mr Taylor had been taking medication for epilepsy and depression for many years, and these were continued in prison. He told the prison that he had previously had medication for attention deficit hyperactivity disorder (ADHD) and wanted to start it again. He was assessed for this in November and was subsequently prescribed medication. Mr Taylor was otherwise physically well, and apart from collecting his medications, he had little contact with healthcare staff while in prison.
16. On 11 January 2022, Mr Taylor was sent to HMP Parc.
17. On 29 August, staff saw Mr Taylor trying to conceal his ADHD medication and it was stopped as a result. He asked to discuss this with a GP but failed to attend any of the arranged appointments. At his pre-release meeting on 3 October, staff encouraged him to engage with his community GP on release to discuss this with them.
18. On 10 October, Mr Taylor was released from prison on licence.

Mr Taylor's substance misuse and treatment

19. Mr Taylor had a long history of substance misuse. He said that prior to his imprisonment he had been a regular heroin user and smoked crack cocaine daily. When he entered prison, he tested positive for opiates and methadone. He was on a methadone treatment programme in the community and was on a daily dose of 90ml, which was very high. The prison's substance misuse services (SMS) started Mr Taylor on his community dose, but Mr Taylor was keen to be on a reducing methadone programme, with the aim of being completely free of it by the time he left prison.
20. Mr Taylor tested positive for ketamine (a controlled Class B drug) on 17 November 2021 but he was not suspected of taking any further drugs in prison.
21. By the time Mr Taylor was sent to Parc, his methadone dose was down from 90ml to 40ml. With the help of the SMS at Parc, he had reduced this to 15ml by the end of April, and by 11 August, he had completed his programme and stopped taking methadone.
22. On 25 August, Mr Taylor attended an overdose awareness session, which included naloxone training. (Naloxone is a medication that can rapidly reverse the effects of opioid overdose.)
23. On 3 October 2022, just before he was released from prison, he agreed to a voluntary drugs test, which was negative.

24. When Mr Taylor was released from prison on 10 October, he did not take a naloxone kit. His substance misuse worker at Parc said that Mr Taylor was sure that he would not use heroin again so thought that he did not need it.

Pre-release planning

25. At a case allocation meeting on 25 February 2022, between a Senior Probation Officer (SPO) and the new COM, they identified a timeline of pre-release planning priorities. The first of these was the handover POM/COM meeting, which took place on 22 March at Parc with Mr Taylor present. In April the COM completed a pre-release Offender Assessment System (OASys; an assessment of offending, risks and rehabilitation of offenders) report, and made referrals for accommodation support, and substance misuse rehabilitation with the charity, the Forward Trust. In April Mr Taylor was also given a resettlement questionnaire (a COVID-19 outbreak prevented a face-to-face interview with his resettlement officer) which he completed, and which identified his support needs, including substance misuse issues and homelessness.
26. On 22 August, a meeting between the SPO and COM identified further actions and collaborations with other agencies for help with Mr Taylor's release needs, including referral for CAS3 accommodation (a government initiative providing temporary accommodation for up to 84 nights for homeless prison leavers), which the COM followed up. On 5 September the COM and POM met with Mr Taylor at Parc for his one month pre-release meeting to prepare him for his return to the community.
27. On 7 September, Mr Taylor's COM, completed a housing risk assessment for Mr Taylor, and at the end of September, a resettlement officer at Parc, confirmed that the housing application had been submitted to the local authority. However, there was no housing available for Mr Taylor on release. He said that he would live with his mother (but it appears that he did not do so).
28. On 3 October, Mr Taylor's SMS worker, and the SMS Team Manager, met with Mr Taylor to discuss his imminent release. They warned him about the risk of overdosing due to reduced tolerance following time in prison. They assessed that Mr Taylor was at risk of relapsing into past behaviours, as despite insisting he would not go back to using drugs, he said that he would take cocaine at weekends with friends. He was unenthusiastic about engaging with the community SMS, but the prison SMS team made him aware of his appointment with them on the day of his release.

Release from Parc

29. Mr Taylor was released from Parc on 10 October and reported to the probation office as planned. An acting COM went through Mr Taylor's licence conditions with him. Mr Taylor did not attend the community SMS appointment, even though it was in the same building as the probation office and scheduled for one hour after his initial probation appointment, and it was one of his licence conditions to go that day.
30. Mr Taylor attended a follow up appointment with the acting COM on 14 October. He said he did not have any problems at that time and did not appear to be under the influence of drugs or alcohol. He said that his father had died three days earlier and

as a result had not yet taken steps to sort out his accommodation and was staying with his mother. He said he did not need any support from other agencies. Mr Taylor died before his next appointment with his COM scheduled for 24 October and there is no record that he attended the community SMS before he died.

Circumstances of Mr Taylor's death

31. At around 5.30pm on 18 October, a friend of Mr Taylor, found him cold and lifeless in bed and telephoned the emergency services. Police officers were the first to arrive and assessed that Mr Taylor had been dead for some time. Paramedics arrived later and confirmed Mr Taylor's death.
32. Mr Taylor's friend said that before he went to bed, he had drunk alcohol and taken a diazepam tablet which he had not been prescribed. Mr Taylor's friend thought that he had taken drugs with other friends before arriving at her address.

Post-mortem report

33. Toxicology tests found that Mr Taylor had several illicit drugs in his body, including heroin, which appeared to have been taken in the 24 hours before he died. However, the pathologist considered that the drugs were not at concentrations either individually or in combination, that were likely to have caused death. They noted that Mr Taylor had severe fatty change in his liver and that this condition can cause fatal arrhythmias (irregular beating of the heart leading to death) and recorded the cause of death as fatty liver.

Findings

34. Mr Taylor had a long history of substance misuse. We are satisfied that he received appropriate support in prison and that before his release, he was warned about reduced tolerance and risk of overdose. He was offered naloxone but refused it, as he said he did not intend to use heroin again. It is unfortunately a recurring theme in our investigations that prisoners refuse naloxone on the basis that they are not going to return to opioid use, only for this to be disproved very shortly after release from prison. Mr Taylor took heroin shortly before he died although it did not cause his death.
35. There was a good level of support and pre-release planning from the POM and COM. However, the local authority was unable to offer Mr Taylor accommodation on release. Mr Taylor's COM told the investigator that Mr Taylor had been approved for CAS3 accommodation and that he was waiting for this to become available. Mr Taylor said that he would be living with his mother, but he mostly stayed at the address where he died.
36. The provision of suitable accommodation for people leaving prison is an issue that extends beyond the remit of HMP Parc or local probation services, and the local authority may want to be aware of the issues raised in this case.
37. We make no recommendations.

38. The Coroner determined that the cause of death was from natural causes and that no inquest was required in this case.

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