

**Prisons &
Probation**

Ombudsman
Independent Investigations

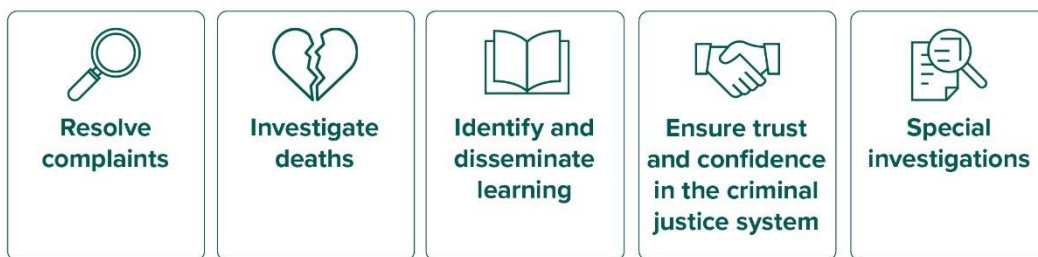
Independent investigation into the death of Mr Ian Stewart, a prisoner at HMP Altcourse, on 1 December 2022

A report by the Prisons and Probation Ombudsman

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. 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 failure.
3. Mr Ian Stewart died in hospital on 1 December 2022, after he was found hanging at his home on 26 November. He was 55 years old. We offer our condolences to Mr Stewart's family and friends.
4. Mr Stewart's licence was revoked on 16 September 2022, after he was arrested for intent to supply drugs, tested positive for drugs and missed a probation appointment. Police could not locate him, so he remained unlawfully at large. On 26 November, Mr Stewart's son found him hanging at his home. He was taken to hospital and on 29 November, while still in hospital, he was transferred into the custody of HMP Altcourse. He died in hospital two days later.
5. We found no issues of concern and make no recommendations.

The Investigation Process

6. HMPPS notified us of Mr Stewart's death on 1 December 2022.
7. The PPO investigator obtained copies of relevant extracts of Mr Stewart's prison and probation records.
8. The PPO family liaison officer wrote to Mr Stewart's next of kin, his partner, to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond.
9. We shared our initial report with HM Prison and Probation Service (HMPPS). There were no factual inaccuracies.

Previous deaths at HMP Altcourse

10. Mr Stewart was the 23rd prisoner to die at Altcourse since December 2019. Of the previous deaths, 17 were from natural causes, and five were self-inflicted.

Key Events

Release on licence

11. In May 2016, Mr Ian Stewart was sentenced to 156 months in prison for armed robbery. He was released on licence on 1 April 2021.
12. Mr Stewart's licence conditions included that he must attend appointments with his probation officer, must not commit a further offence, and must not display poor behaviour. Up to June 2022, Mr Stewart appeared to comply with no issues.
13. On 9 June 2022, the Probation Service reintroduced drug testing for prisoners on licence, which had been stopped due to COVID-19 restrictions. Mr Stewart had a history of drug use, and drug testing was part of his licence condition to not display poor behaviour. Mr Stewart was now required to attend the probation appointments in person, as he had previously been seen on his home doorstep.
14. Mr Stewart tested positive for cocaine on 9 June, 21 June, 19 July and 4 August. Probation staff issued Mr Stewart with breach of licence warning letters about his drug use on 15 and 28 June. Probation staff considered Mr Stewart's position and, rather than recall him to prison at that stage, they issued a 'Decision Not to Recall' letter and referred him to We Are With You, a community drug service.
15. Mr Stewart tested positive for cocaine again on 15 August, but probation staff again decided not to recall him, allowing him time to engage with drug services. Mr Stewart failed to attend a supervision appointment on 2 September, and tested positive for cocaine again on 12 September. Mr Stewart had breached three of his licence conditions.
16. On 14 September, Mr Stewart was arrested for intent to supply drugs. He was released from police custody pending a police investigation. On 16 September, police told the Probation Service about Mr Stewart's arrest. Probation staff revoked Mr Stewart's licence on the basis of this information, and also because Mr Stewart had missed an appointment with his probation officer and continued to test positive for cocaine. Probation staff notified the police so they could arrest Mr Stewart and return him to custody, but police could not find Mr Stewart to serve the revocation licence, and he was considered unlawfully at large.
17. On 26 November, Mr Stewart's son found him hanging at his home address. Paramedics and police attended their home and found Mr Stewart unconscious. They took him to Royal Liverpool Hospital where he remained in a coma. Police notified HMP Altcourse on 29 November, that Mr Stewart was a licence recall, and in Royal Liverpool Hospital. Responsibility for Mr Stewart was transferred from police to Altcourse, and prison staff took over bedwatch duties at the hospital the same day.

Return to custody

18. A prison custody officer was appointed as the prison's family liaison officer (FLO). A senior nurse told the FLO that Mr Stewart's prognosis was poor, and, in their opinion, he would not recover. The FLO met with members of Mr Stewart's family,

who had already visited Mr Stewart and were aware of the situation. On 30 November, prison staff facilitated a visit from a family member, who was in custody at HMP Buckley Hall. Other members of Mr Stewart's family continued to visit him.

19. At around 3.00pm on 30 November, hospital staff withdrew Mr Stewart's life support. A hospital doctor told Mr Stewart's family that it was likely Mr Stewart would pass away the next day.
20. Mr Stewart died at 2.00pm on 1 December.
21. The prison contributed to the cost of Mr Stewart's funeral in line with national instructions.

Post-mortem report

22. The post-mortem report was not available at the time of issuing this report.

Findings

23. Once probation staff were aware of Mr Stewart's arrest, they revoked his licence and initiated recall procedures. However, the police could not locate Mr Stewart and he remained unlawfully at large until the end of November, when his son found him hanging at his home and he was taken to hospital. The delay in locating Mr Stewart is outside the remit of our investigation.
24. While Mr Stewart was technically in the custody of HMP Altcourse when he died, he had remained in hospital and had not returned to prison. We make no recommendations.

Adrian Usher
Prisons and Probation Ombudsman

July 2023

Inquest

The inquest, held on 15 November 2023, concluded that Mr Stewart died by suicide.

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