

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Alan Yeomans on 26 February 2023, following his release from HMP Ranby

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. 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. If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic process failures.
4. Mr Alan Yeomans was found hanged on 26 February 2023, following his release from HMP Ranby on 15 February. He was 46 years old. We offer our condolences to those who knew him.
5. While Mr Yeomans had a history of self-harm and had been managed under Prison Service suicide and self-harm prevention procedures (known as ACCT) in the past, his most recent period in custody (of over two years) did not reveal any heightened risk. At the time of his release and before his death, there was little to indicate that he was at increased risk.
6. We did not find any issues of concern.

The Investigation Process

7. We were informed of Mr Yeomans' death on 3 March 2023.
8. The PPO investigator obtained copies of relevant extracts from Mr Yeomans' prison and probation records.
9. We informed HM Coroner for Derbyshire Area 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 Yeomans' next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They did not respond.
11. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS found no factual inaccuracies in the report.

Background Information

HMP Ranby

12. HMP Ranby is a Category C prison in Nottinghamshire, holding over 1,000 men. Nottinghamshire Healthcare NHS Foundation Trust provides primary healthcare services.

Probation Service

13. 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 supervise people throughout their licence period and post-sentence supervision.

Key Events

14. On 18 January 2021, Mr Alan Yeomans was remanded to HMP Nottingham. He had been to prison before and had a history of self-harm. Mr Yeomans had been subject to suicide and self-harm prevention procedures (known as ACCT) during previous stays in prison. He had used drugs in the community and began a methadone detoxification programme, which he completed on 15 March. (Methadone is used to counter withdrawal symptoms from opiates such as heroin.)
15. On 16 February, Mr Yeomans was convicted of burglary offences and sentenced to four years in prison.
16. Between 5 March 2021 and 9 February 2022, Mr Yeomans lived at HMP Ranby. No suicide attempts or self-harm incidents or concerns about Mr Yeomans' wellbeing were recorded in prison records during this time.
17. On 9 February, Mr Yeomans was transferred to HMP Five Wells.
18. On 21 February, Mr Yeomans completed a safety induction and staff identified a history of self-harm and previous support through ACCT. They added Mr Yeomans to the Safer Custody database of prisoners with a self-harm history and signposted him to support services. Staff raised no other concerns about Mr Yeomans' wellbeing during his time at Five Wells.
19. On 14 March, Mr Yeomans was transferred back to Ranby. At his initial health screening, a nurse recorded a history of substance misuse and post-traumatic stress disorder (PTSD). They referred Mr Yeomans to the mental health team. Mr Yeomans chose not to engage with Ranby's substance misuse service prior to his release. Staff told him how to contact the service for a referral should he wish to engage during his stay.
20. Following assessment, Mr Yeomans was not added to the mental health team's caseload as they judged that he did not require any follow-up care. He was not prescribed medication for mental ill-health during his time at Ranby.
21. Mr Yeomans was referred for accommodation support and issued with a no fixed abode (NFA) release pack. His Community Offender Manager (COM) supported him to set up a bank account and organised a universal credit appointment on release. Mr Yeomans' COM advised him that his drug use would be monitored on release and advised him to engage with community substance misuse services.
22. On 7 December, Mr Yeomans' COM made a referral to the Star Project (project run to help people sleeping rough or in danger of becoming homeless). They told Mr Yeomans that he would need to engage with accommodation providers in custody and on release and attend all appointments arranged on his behalf.
23. On 13 December, Mr Yeomans met with a prison-based key worker. She explained to Mr Yeomans the importance of engaging in key worker sessions and how valuable they could be in providing him support if he wanted it. She asked Mr Yeomans if he was in contact with his prison offender manager (POM) and if he needed anything between now and his release. Mr Yeomans informed her that

everything had been taken care of. She said that Mr Yeomans appeared to be healthy, both physically and mentally, and no issues were raised.

24. On 10 January 2023, a key worker recorded that Mr Yeomans was in regular contact with friends and family. She noted no issues or concerns regarding Mr Yeomans' mental wellbeing.
25. On 31 January, an appointment was booked for Mr Yeomans for 15 February at 3.00pm at Derby City Jobcentre. Mr Yeomans was sent the appointment letter while in prison.

Post Release

26. On 15 February, Mr Yeomans was released on licence from Ranby. As part of his licence conditions, Mr Yeomans was to reside at the Star Project accommodation in Derby until an electronic tag was fitted.
27. Mr Yeoman's COM was on leave when Mr Yeomans was released but arranged for him to be met by a colleague and two police officers in the Integrated Offender Manager team (IOM – an increased level of risk management for prolific offenders whereby offenders are jointly managed by partner agencies including the Probation Service and the police).
28. On 20 February, Mr Yeomans met with his COM and his allocated drug worker in the IOM team. His COM described the meeting with Mr Yeomans as "good". She said Mr Yeomans was in good spirits, having success with his artwork, and supporting his mother. Mr Yeomans had a drug test and she said he told her he had had a drugs lapse. She said she arranged to meet Mr Yeomans again on 27 February.

Circumstances of Mr Yeoman's death

29. On 26 February, Mr Yeomans was found hanged in the flat where he had lived since his release from prison.

Post-mortem report

30. The post-mortem report concluded that Mr Yeomans died of hanging with mental health issues a secondary contributory factor.

Findings

31. Mr Yeomans had some risk factors for suicide and self-harm. He had harmed himself in the past and had been monitored under ACCT procedures during previous periods in prison. He had a diagnosis of PTSD and a history of substance misuse.
32. During his most recent time in prison (from January 2021 until his release two years later), Mr Yeomans was not monitored under ACCT procedures at any time and there is no record that he harmed himself during this time. He was assessed by the mental health team and judged not have any symptoms that required follow up or medication. There is no evidence that he reported a deterioration in his mental health in the time before his death. Mr Yeomans was appropriately referred to the substance misuse team but chose not to engage with them.
33. We are satisfied that there was little to indicate that Mr Yeomans was at heightened risk of suicide in the time before his release or that there was any specific risk information that should have been shared between prison staff and his community offender manager or support agencies.

Inquest

34. The inquest, heard on 8 February 2024, concluded that Mr Yeomans' death was suicide.

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