

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Daniel McLoughlin, on 21 December 2022, following his release from HMP Leeds

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 is investigating post-release deaths that occur within 14 days of the prisoner's release.
3. If my office is to best assist HM 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 failure.
4. Mr Daniel McLoughlin was found hanged in accommodation in Keighley, West Yorkshire, on 21 December 2022, following his release from HMP Leeds eight days earlier. He was 50 years old. We offer our condolences to his family and friends.
5. Mr McLoughlin had few risk factors for suicide and self-harm. He was not managed under HMPPS suicide and self-harm prevention procedures (known as ACCT) at Leeds or during any previous time in prison. However, Mr McLoughlin was diagnosed with anxiety and depression and received medication for this. He had a history of using illicit drugs and was in debt in the community as a result.
6. We are satisfied that there was little to indicate that Mr McLoughlin was at heightened risk of suicide in the time leading up to his death or that there was any specific risk information that should have been shared between prison staff and his community offender manager or support agencies.
7. We did not find any issues of concern.

The Investigation Process

8. The PPO investigator obtained copies of relevant extracts from Mr McLoughlin's prison and probation records.
9. We informed HM Coroner for West Yorkshire (West) 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 wrote to Mr McLoughlin's mother to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond.
11. We shared the initial report with HM Prison and Probation Service. There were five factual inaccuracies.

Background Information

HMP Leeds

12. HMP Leeds is a local prison holding a maximum of 1,110 prisoners on remand, convicted or sentenced. The prison serves the courts of West Yorkshire. Practice Plus Group provides healthcare services, including mental health services.

HM Inspectorate of Prisons

13. The most recent full inspection of HMP Leeds was in June 2022, inspectors reported that prisoners sentenced to over a year in prison should have moved on to other prisons to access more intensive offender management support and offending behaviour work but, due to the lack of places elsewhere, many stayed at Leeds for too long. As some prisoners experienced long delays in moving on to training prisons, a few Prison Offender Managers had delivered some offence-focused interventions to promote prisoners' progression. Inspectors reported that there was no specific practical support on the day of release other than a stock of clothing that prisoners could choose from if they had little of their own to wear.
14. In July 2023, inspectors conducted an independent review of progress at Leeds. They reported that prison managers had secured funding to develop the employability skills of prisoners nearing release. While support for prisoners' resettlement needs had improved, inspectors found that much work between community agencies and prison staff was uncoordinated.

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 which, where appropriate, they refer people for resettlement services. Post-release, the Probation Service supervises people throughout their licence period and post-sentence supervision.

HM Inspectorate of Probation

16. The most recent inspection of the West Yorkshire Community Rehabilitation Company (WYCRC) (in June 2021, the WYCRC became part of a unified Probation Service Yorkshire and the Humber) was in March 2020. Inspectors reported that staffing levels and staff development required urgent attention to raise the quality of work with individuals. Inspectors were disappointed that a new case management and assessment system, commissioned through a private supplier, had not been and would not be available to use.

Key Events

17. On 4 November 2019, Mr Daniel McLoughlin was convicted of burglary and sentenced to five years and three months in prison. On 17 June 2022, Mr McLoughlin was released on licence. His licence was revoked on 17 November, and he was recalled to HMP Leeds. Mr McLoughlin's prison records did not contain any markers identifying a history or risk of suicide and self-harm, and he had never been monitored under suicide and self-harm prevention procedures (known as ACCT).
18. At his initial health screen, Mr McLoughlin told a nurse that he had anxiety and depression. Mr McLoughlin said that he used illicit drugs and bought £60 of heroin and crack cocaine daily. He later said that he had injected heroin and crack cocaine the day before he entered custody. Mr McLoughlin said that he was under the care of a community substance misuse team where he received a methadone prescription. The nurse referred Mr McLoughlin to the psychosocial substance misuse service.
19. On 18 November 2022, a nurse saw Mr McLoughlin for substance misuse support. She recorded a Clinical Opiate Withdrawal Scale (COWS) score of 16, which indicated moderate opiate withdrawal. She telephoned Mr McLoughlin's community pharmacist, who said that he had a prescription for 70ml of methadone per day. Another nurse prescribed Mr McLoughlin incremental doses of methadone in accordance with the induction regime.
20. On 23 November, a probation service officer, who was Mr McLoughlin's community offender manager (COM), referred him to Bradford District Council because he said that he would be released homeless. (The Homelessness Reduction Act 2017 requires prisons and probation services to refer anyone who is homeless or at risk of becoming homeless within 56 days to a local housing authority.)
21. On 25 November, Mr McLoughlin was allocated a prison offender manager.
22. On 25 November, a probation service officer noted that Mr McLoughlin was previously living in a council flat but had been evicted because he had not paid the service charge. Mr McLoughlin said that he would like support to find accommodation on release. The officer made a Commissioned Rehabilitative Services (CRS, who coordinate the process to find accommodation for prisoners being released homeless) referral to St Giles Trust (a registered charity which delivers personal wellbeing services and support the Probation Service in reducing re-offending). Mr McLoughlin said that he had significant debts before he came into custody. The officer made a referral to the Growth Company (a social enterprise with a mission to create jobs, education opportunities and rehabilitative support) for finance, benefit and debt support. He also referred Mr McLoughlin to Ingeus (who deliver services across employment, health, justice and youth) for personal wellbeing support.
23. On 1 December, the COM referred Mr McLoughlin to the Community Accommodation Service (CAS3, which provides temporary accommodation for up to 84 nights for homeless prison leavers).

24. On 8 December, Mr Loughlin told an Ingeus mentor that he felt anxious about his release because he was unsure if he would have accommodation. Mr McLoughlin asked for help to claim Universal Credit. He told her that he would like training to keep him focused and away from drugs and agreed to look at training for a Construction Skills Certification Scheme (CSCS) card, as he previously had joiner experience.
25. On 8 December, a St Giles Trust worker told Mr McLoughlin that he would be released to CAS3 accommodation in Keighley. She said that she would support him to secure permanent accommodation before the end of his stay at the accommodation.
26. On 9 December, a healthcare administrator referred Mr McLoughlin to Change Grow Live (CGL - community substance misuse service) in Bradford and made an appointment for him for continuation of his methadone treatment.
27. On 13 December, a nurse gave Mr McLoughlin his discharge medication, which included antidepressants and medication for anxiety.
28. On 13 December, Mr McLoughlin was released from HMP Leeds. His licence conditions required him to report at 1.00pm, to the duty officer at the Bradford Probation Office.

Post-release

29. On 13 December, Mr McLoughlin reported to a probation officer at the Bradford Probation Office. Mr McLoughlin completed the induction process and signed the paperwork. He told her that he felt very anxious because he was in debt to someone. She and a colleague walked Mr McLoughlin to the railway station and watched him get onto the train to Keighley.
30. On 14 December, a residential welfare officer telephoned the COM and informed her that Mr McLoughlin had not arrived at the CAS3 accommodation.
31. On 15 December, Mr McLoughlin telephoned the COM and told her that he had not been able to get into the accommodation because the key code did not work. She told Mr McLoughlin to go back to the accommodation and she would give him the key code over the phone. Mr McLoughlin was able to access the accommodation as a result. She gave Mr McLoughlin a telephone number to arrange to collect his prescription medication.
32. On 15 December, Mr McLoughlin did not attend a CRS appointment with the St Giles Trust worker.
33. On 16 December, Mr McLoughlin did not attend an appointment with the COM at the Bradford Probation Office. Before the appointment, she telephoned Mr McLoughlin, who told her that he was on his way. She later telephoned Mr McLoughlin another five times, but he did not answer her call. She sent Mr McLoughlin a compliance letter informing him that he had not been recalled to prison but that he needed to attend his probation appointments.

34. On 19 December, an integrated offender manager telephoned the COM and told her that Mr McLoughlin's mother had contacted West Yorkshire Police because Mr McLoughlin had come to her home and asked her for money. This was in breach of his licence conditions, and the manager said that his behaviour indicated that he was potentially using illicit drugs. He said that Mr McLoughlin might not be staying at his CAS3 accommodation, and that the police needed to confirm this with a home visit.
35. On the same day, Mr McLoughlin saw the COM at the Bradford Probation Office. She noted that Mr McLoughlin looked okay but had clearly not washed in a while. She told Mr McLoughlin that he had a 'fail to attend' recorded which related to his failure to attend his planned probation appointment on 16 December. She also said that he now had a licence condition to keep away from his mother and aunt.
36. Mr McLoughlin told the COM that he had spent the weekend in Ilkley, which she noted as probably being where he obtained drugs. She noted that Mr McLoughlin said that he had accumulated £700 of drug debts and that a dealer was "after him" as a result. There is no record that Mr McLoughlin spoke of being the victim of violence or of an explicit threat to do him harm.
37. The COM told Mr McLoughlin that his next probation appointment was on 30 December. She gave Mr McLoughlin the bus fare for him to get back to his accommodation in Keighley.
38. On 20 December, the integrated offender manager told the COM that Mr McLoughlin had not attended his CGL appointment and had not collected his prescription.
39. On 21 December, a senior probation officer from the Homeless Prevention Team asked the COM to contact Mr McLoughlin and explain the importance of attending appointments. She told the COM that if Mr McLoughlin continued to miss appointments that his bedspace could be removed in the new year.
40. A residential welfare officer telephoned Mr McLoughlin many times, but he did not answer his phone.

Circumstances of Mr McLoughlin's death

41. At about 3.35pm on 21 December, a residential welfare officer went to the CAS3 accommodation with two colleagues to complete Mr McLoughlin's induction. She carried out two welfare checks on other residents but did not see Mr McLoughlin. She went to the basement to top up the energy meter and found Mr McLoughlin hanged from a beam under the basement staircase.

Post-mortem report

42. The post-mortem report concluded that Mr McLoughlin died from hanging.
43. Toxicology tests showed that Mr McLoughlin had taken a very low level of methadone in the hours before his death and very low levels of cocaine. Alcohol was also detected in Mr McLoughlin's blood, which the consultant histopathologist said could have been from post-mortem production.

Inquest

44. At an inquest held on 2 January 2024, the Coroner concluded that Mr McLoughlin's death was suicide.

Contact with Mr McLoughlin's Family

45. On 21 December, police officers informed Mr McLoughlin's mother that he had died.

Support for staff

46. After Mr McLoughlin's death a senior probation officer signposted the COM to available support services.

Findings

47. Mr McLoughlin had some risk factors for suicide and self-harm, most significantly a drug debt that he indicated was worrying him. He had also been diagnosed with anxiety and depression and was prescribed medication for this. However, Mr McLoughlin had no recorded history of having harmed himself in either prison or in the community and was not managed under ACCT procedures at any time.
48. We are satisfied that there was little to indicate that Mr McLoughlin was at heightened risk of suicide in the time before his release from prison, or that there was any specific risk information that should have been shared between prison staff and his community offender manager or support agencies.

Good practice

49. Mr McLoughlin was referred to several different community services ahead of his release. This included substance misuse services, support services to help him find accommodation, for support with his personal wellbeing, and help with finding employment. When it became apparent that Mr McLoughlin had missed appointments and was not answering his phone his community offender manager promptly took steps to locate him.

Adrian Usher
Prisons and Probation Ombudsman

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