

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr Nicolas de Launay on 19 December 2022, following his release from HMP Lewes**

**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 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 Nicolas de Launay died of heroin toxicity on 19 December 2022, following his release from HMP Lewes on 7 December. He was 46 years old. We offer our condolences to his family and friends.
5. Mr de Launay had a long history of substance misuse. We found that he received good support at Lewes and that appropriate support was arranged for his release. We make no recommendations.

## The Investigation Process

6. HMPPS notified us of Mr de Launay's death on 14 February 2023.
7. The PPO investigator obtained copies of relevant extracts from Mr de Launay's prison and probation records. The investigation was then transferred to one of the investigator's colleagues.
8. We informed HM Coroner for Sussex 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 de Launay's parents to explain the investigation and to ask if they had any matters they wanted us to consider. They raised concerns about the care their son had received. Some of these have been addressed in this report, but others fell outside our remit and have been addressed in a separate letter.
10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

## **Background Information**

### **HMP Lewes**

11. HMP Lewes is a category B local prison which holds up to 659 male prisoners who have either been convicted or are on remand. It is managed by HMPPS. Practice Plus Group provides physical health, mental health and substance misuse services.

### **Probation Service**

12. 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.

### **HM Inspectorate of Probation**

13. The most recent inspection of West Sussex Probation was in May 2022. Inspectors reported that the overall service was inadequate and made several recommendations that would have a positive impact on the quality of probation services. They reported that caseloads for probation practitioners were high and 79% of staff said their workload was not manageable. They reported the range and quality of services did not support a tailored and responsive service for all people on probation. They also reported not a high enough percentage of their risk assessments focused sufficiently on keeping other people safe - a critical part of the risk assessment. Additionally, they found that only just over half of the cases had a sufficient focus on engaging the person on probation within their planning.

## Key Events

14. On 21 April 2021, Mr Nicolas de Launay was convicted of drug offences and was sentenced to three years in prison. He was sent to HMP Lewes.
15. On 30 April, Mr de Launay was moved to HMP Rochester.
16. On 10 June 2022, Mr de Launay was released on Home Detention Curfew (HDC- allows some prisoners to serve the last part of their sentence in the community on an electronic monitoring tag).
17. After his release, the Electronic Monitoring Service (EMS) made five visits to Mr de Launay's home address to fit his tag, but he was out on each occasion. (His parents told us that the EMS did not arrive at the scheduled times hence why Mr de Launay was not at home.) The HDC team recalled Mr de Launay back to prison on 16 June, but Mr de Launay was unlawfully at large (when an offender's licence has been revoked but they fail to take all the necessary steps to return to prison) until he was arrested by the police on 4 August.

## HMP Lewes

18. On 4 August, Mr de Launay was sent to Lewes. During his reception screening, Mr de Launay told the nurse that he had been diagnosed with bipolar disorder and depression (this appeared to be self-reported).
19. A mental health nurse saw Mr de Launay in reception. Mr de Launay told her that he was struggling to express himself and needed to see the substance misuse team (he had a long history of substance misuse), and that due to the short amount of time he had in prison, therapy would not be realistic. However, he said he would like to know more about post-traumatic stress disorder (PTSD) and coping techniques, so it was agreed she would send him some self-help. The mental health triage nurse made a note of this on Mr de Launay's records and said he did not require further input.
20. Later that day, a practitioner from the substance misuse team saw Mr de Launay. Mr de Launay told her he had not used any illicit drugs for the first two weeks after he was released but then he relapsed. He said he had injected heroin and crack into his groin daily, with the occasional use of cannabis and illicit methadone. Mr de Launay admitted that he had used heroin on the morning of 4 August.
21. On 5 August, a nurse prescribed Mr de Launay with a methadone (an opiate substitute used to help people to stop using heroin) prescription.
22. On 6 August, Mr de Launay began his detoxification programme and was given 20ml of methadone.
23. On 8 August, a GP at Lewes confirmed Mr de Launay had been given self-help for PTSD and he said he did not require any support from the mental health team at that time and his referral could be closed. The GP said Mr de Launay knew how to refer himself for support in the future if he needed to. Mr de Launay was discharged from the mental health services.

24. On 27 September, Mr de Launay was allocated a community offender manager (COM). That day, his COM sent Mr de Launay an email introducing herself and telling him that she planned on booking a video link with him soon in preparation for his release.
25. On 2 November, a nurse saw Mr de Launay again. He had requested to reduce his methadone script by 3ml each week in preparation for his release. Mr de Launay was aware he would be a high risk of overdosing due to his loss of tolerance and harm reduction advice was given. Mr de Launay was also aware he would be given a naloxone kit (medication that can rapidly reverse the effects of opiate overdose) on release.
26. Later that day, a nurse had a one-to-one meeting with Mr de Launay. Mr de Launay was on a daily prescription of 17ml of methadone and despite medical advice, he still wanted to reduce his methadone each week. He was made aware of the overdose risks again and a plan was made for him to continue to reduce his methadone as requested.
27. On 11 November, a substance misuse practitioner completed a structured psychosocial intervention with Mr de Launay who said he felt optimistic about the future. He said he did not want to be released on methadone as he thought this would lead to him being around people who were a bad influence on him. Mr de Launay also said he wanted to stay abstinent from drugs when released.
28. On 15 November, a nurse completed a prescription review with Mr de Launay. During the review, Mr de Launay said he wanted to remain on the current dose of 11ml of methadone until he felt ready to reduce again. Mr de Launay said he still wanted to reduce his methadone before his release.
29. On 22 November, a substance misuse practitioner met with Mr de Launay again and he said he wanted to fully engage with services in the community and felt better prepared to work with mental health to discuss the reasons and causes of his prolific drug use during his adult life. Following this review the practitioner requested an appointment for Mr de Launay with Change, Grow, Live (CGL – a service that provides support to those facing challenges with drug and alcohol misuse, mental and physical health and housing), but there is no evidence documented that he received a response.
30. The same day, a nurse saw Mr de Launay and he requested to reduce his methadone to 8ml. The nurse informed Mr de Launay of her concerns and the risks involved.
31. On 28 November, a nurse completed a one-to-one drug dose reducing regime with Mr de Launay who had requested to reduce his methadone to 5ml.
32. On 2 December, Mr de Launay's COM emailed his GP surgery to inform them of his upcoming release from prison and to ask if an appointment could be made for Mr de Launay to discuss his mental health medication. (Mr de Launay had previously been prescribed pregabalin in 2021 but was not prescribed it while he was in prison. Pregabalin is used to treat nerve pain and anxiety but is also widely abused as it enhances the euphoric effects of opiates.)

33. On 6 December, Mr de Launay's COM received an email from Lewes telling her that they had completed the release checks and Mr de Launay was due to be released one day earlier than originally calculated so on 7 December instead of 8 December. His COM was unaware of this, as the information had not been updated on the probation database (nDelius). His COM was on leave, so she had arranged for a colleague to see Mr de Launay on the day of his release.
34. On 7 December, prior to his release, a substance misuse practitioner completed a structured psychosocial intervention with Mr de Launay. He told Mr de Launay that he had a clinical assessment with CGL in Crawley on 8 December at 2:00pm and he had a psychosocial assessment with CGL on 21 December at 2:00pm.
35. A nurse gave Mr de Launay a naloxone kit and training information for his release. Mr de Launay was given his methadone the morning of his release and whilst he was in reception, he was given his methadone prescription. His drug chart had already been emailed to CGL West Sussex community team, prior to his appointment the next day.

### **Release from HMP Lewes**

36. On 7 December, Mr de Launay was released from prison. There were train strikes that day which led to Mr de Launay being late for his appointment, but he still attended his initial appointment at Crawley Probation Office.
37. Another probation practitioner completed the initial appointment with Mr de Launay in the absence of his COM. Mr de Launay was aware of his upcoming appointments with CGL and his next appointment with his COM on 13 December. Mr de Launay signed his licence and understood what was expected of him.
38. The probation practitioner provided Mr de Launay with a travel warrant for him to be able to get home that day. He was also given a travel warrant to enable him to return for his appointment the next day, and another travel warrant for him to be able to attend his appointment with his COM on 13 December.
39. On 8 December Mr de Launay was due to have his initial appointment at CGL with his keyworker. However, his keyworker was ill, and the appointment was covered by another colleague. Mr de Launay was prescribed 5ml of methadone to be taken daily, this was the same amount he was prescribed in prison.
40. On 9 December, Mr de Launay's COM contacted him, and he said he had used a crack pipe on the day of his release and said it was a negative experience and had put him off drugs. Mr de Launay said he was keen to get a prescription for Espranor (a medication used to treat opiate addictions) and he did not want a prescription for methadone. (The West Sussex Quality and Governance Lead for CGL said Mr de Launay's medication would have not been changed without the correct checks and assessment being completed by a pharmacotherapist. Mr de Launay did not have any checks or an assessment prior to his death.)
41. On 9 December, Mr de Launay's COM emailed the GP surgery on his behalf and was told that Mr de Launay was not registered, and he would need to complete the necessary forms before an appointment with the GP could be booked.

42. On 13 December, his COM had a face-to-face probation appointment booked with Mr de Launay, however there were train strikes happening on that day, and therefore she changed the appointment to a telephone appointment instead. During this appointment, Mr de Launay told his COM that he had a bad back and she agreed to send Mr de Launay the registration forms for the GP surgery by post and would then try to make an appointment for him once he had told her he had completed the forms and returned them. There is no evidence documented as to whether Mr de Launay registered with the GP surgery and whether he was able to get an appointment with the GP.

### **Circumstances of Mr de Launay's death**

43. On 18 December, Mr de Launay called a friend and asked him if he could take him out to buy some drugs. They both went to an address and bought some drugs. Mr de Launay's friend said that he bought heroin and cocaine.
44. That evening, Mr de Launay and his friend both injected drugs.
45. The following morning, at approximately 7.30am, Mr de Launay woke up and said he was having withdrawal symptoms and felt unwell, and then Mr de Launay took approximately 10-15ml of methadone.
46. At approximately 9.00am, Mr de Launay tried to call CGL but was not able to speak to anyone. Mr de Launay's friend then heard strange noises coming from Mr de Launay and he thought he was having a seizure. Mr de Launay's friend called the emergency services and started CPR, he also tried to give Mr de Launay naloxone, but it did not work.
47. When the paramedics arrived on scene Mr de Launay was unresponsive and not breathing. The paramedics started CPR and delivered eight shocks with the defibrillator, but Mr de Launay was pronounced dead at 10.05am.

### **Post-mortem report**

48. The post-mortem report concluded that Mr de Launay died from heroin toxicity, with the presence of methadone and left ventricular hypertrophy with interstitial myocardial fibrosis (heart disease, associated with cocaine use).
49. At the inquest held on 28 March 2024, the coroner concluded that Mr de Launay died of heroin toxicity.

# Findings

## Substance misuse services

50. We found that Mr de Launay was given appropriate support to address his substance misuse issues while at Lewes. Mr de Launay was reviewed in a timely manner when he was recalled to prison and placed on a methadone detoxification programme. Mr de Launay was also referred to the community substance misuse team, CGL, to provide him with substance misuse support in the community. He was trained to use naloxone and given a naloxone kit on release.
51. We make no recommendations.

**Adrian Usher**  
**Prisons and Probation Ombudsman**

**February 2024**

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Third Floor, 10 South Colonnade  
Canary Wharf, London E14 4PU

Email: [mail@ppo.gov.uk](mailto:mail@ppo.gov.uk)  
Web: [www.ppo.gov.uk](http://www.ppo.gov.uk)

T | 020 7633 4100