

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr Liam Harmon on 3 November 2022, following his release from HMP Forest Bank**

**A report by the Prisons and Probation Ombudsman**

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## 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 failure.
4. Mr Liam Harmon died of multi-drug toxicity on 3 November 2022, eight days after his release from HMP Forest Bank. He was 39 years old. We offer our condolences to those who knew him.
5. We found no issues of concern. We make no recommendations.

## The Investigation Process

6. HMPPS notified us of Mr Harmon's death on 8 December 2022.
7. The PPO investigator obtained copies of relevant extracts from Mr Harmon's prison and probation records.
8. We informed HM Coroner for Manchester of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
9. We requested details of Mr Harmon's next of kin from HMP Forest Bank, but they said they did not have any. We contacted the Coroner's office, but they said they were unable to share the details with us, and they would ask the next of kin to contact our family liaison officer if they had any questions or concerns. They did not contact us.
10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

## Background Information

### HMP Forest Bank

11. HMP Forest Bank is a Category B private prison managed by Sodexo. The substance misuse provider is Sodexo Justice 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.

## Key Events

13. On 11 August 2022, Mr Liam Harmon was charged with burglary and remanded in custody. He was sent to HMP Forest Bank.
14. Mr Harmon told the reception nurse that he smoked heroin and used seven to eight bags of crack stones daily. A GP prescribed methadone (medicine used to treat heroin dependence).
15. On 16 August, a nurse saw Mr Harmon and he told her he was feeling more agitated, was not sleeping, was aching, and had cramps. He asked if his methadone dose could be increased. Mr Harmon said he had been using drugs for years, but it had only become a problem in the last 18 months after his brother died. Mr Harmon said he wanted to change his life and wanted to work with the recovery team while in prison. Later that day, a GP increased Mr Harmon's methadone.
16. On 18 August, a GP changed Mr Harmon's methadone prescription to buprenorphine (another medicine used to treat heroin dependency) due to his low blood platelet levels (an ongoing issue that he had experienced for several years).
17. That day, a nurse noted in Mr Harmon's medical records that he had been diagnosed with a psychotic disorder (paranoid schizophrenia) and was previously prescribed olanzapine (an antipsychotic). However, he was non-compliant with taking his medication in the community and had not taken his medication for five months. A previous community mental health referral was rejected because they considered his needs could be managed by his GP, so he did not meet the criteria for the prison's mental health in reach team.
18. On 25 August, a GP increased Mr Harmon's buprenorphine because Mr Harmon said his current dose was not sufficient and his cravings were worse in the evening.
19. On 28 August, an officer found Mr Harmon's buprenorphine concealed in his pocket.
20. On 31 August, a recovery worker from the substance misuse team spoke to Mr Harmon about concealing his medication and he said he was being bullied on the wing for his medication and he did not want to get into a fight because of his low platelets. Mr Harmon would not tell her who was bullying him on the wing. He was moved to a different wing.
21. On 1 September, a GP reviewed Mr Harmon. He reduced Mr Harmon's medication back to his original dose because he said that Mr Harmon did not need more if he was concealing it.
22. On 7 September, a GP saw Mr Harmon following a request from him, because he had found a rash and was worrying about it. The GP assessed that Mr Harmon would benefit from restarting olanzapine. The GP prescribed olanzapine and noted that a psychiatric review was planned.
23. On 15 September, Mr Harmon was convicted of burglary and sentenced to 22 weeks in prison. He remained at Forest Bank.

24. On 3 October, a psychiatrist reviewed Mr Harmon and increased his olanzapine medication until his release date and requested that he was referred to the community mental health team (CMHT). There is no evidence on his medical records that a referral was made to the CMHT. The investigator contacted the operations manager for the mental health team at Forest Bank, who said this was an oversight by the nurse who should have completed the referral, and the nurse took responsibility for it. The operations manager said that this was being addressed with the nurse and their manager.
25. On 26 October, Mr Harmon was released from Forest Bank.

### **Pre-release planning**

26. On 20 August, a recovery worker from the substance misuse team met with Mr Harmon to complete his initial assessment. Mr Harmon declined the offer of naloxone (a medicine that can rapidly reverse the effects of opioid overdose). Mr Harmon said he used to be able to stop himself from using drugs before it became an issue, but after his brother died it became a big problem for him. Mr Harmon said he had not used drugs when he was released previously but he relapsed when he was homeless and got back into a relationship with his ex-partner.
27. On 20 October, Mr Harmon's community offender manager (COM) completed a Duty To Refer (DTR - 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). There is no evidence documented that the council received or acknowledged the DTR.
28. On 21 October, a recovery worker from the substance misuse team gave Mr Harmon his release appointment with Change Grow Live (CGL - community drug and alcohol recovery service). The appointment was booked for 27 October at 2.00pm. (There is no evidence recorded that Mr Harmon attended this appointment.)
29. That day, Mr Harmon's COM completed a CAS3 (a scheme that provides accommodation support for up to 84 nights after release) referral, and this was accepted by the On The Out service (OTO - Ministry of Justice funded accommodation for those who would be homeless on release) on 24 October. (Although OTO accepted the referral, they were not able to identify where Mr Harmon would be accommodated until the day of his release.)

### **Post-release planning**

30. On 26 October, Mr Harmon was released from prison and attended his initial appointment with the duty officer of the day. During this appointment Mr Harmon said he was told by his COM that accommodation would be available to him, but he had not yet been given any, so he would go and stay with his friend for now and text his COM later that day. He also said he would rather go back to prison than be homeless and start using drugs again. The duty officer told Mr Harmon that she would contact CAS3 for an update.
31. Later that day, Mr Harmon's COM called him and asked him to come to the probation office to meet a housing worker from OTO so that he could move into the

accommodation sourced for him. He was told on the phone that the housing worker would only wait until 4.00pm. Mr Harmon did not go back to the probation office that day.

32. On 27 October, Mr Harmon's COM called the housing worker from OTO to see if Mr Harmon had met him the previous evening, but he had not. The housing worker had tried calling Mr Harmon, but his phone was off. The housing worker told the COM they could keep his bed available over the weekend until the Monday.
33. The COM tried calling Mr Harmon several times but was unsuccessful, so she had a discussion with her line manager. They agreed to give him until the following day to attend the accommodation, and if he did not, recall proceedings would be actioned.
34. That day, Mr Harmon called his COM and said he had found out some bad information the night before but did not share what it was. His COM reminded him that he had to stay at the address provided by OTO (under the terms of a standard licence, Mr Harmon was expected to live at an address approved by the COM).
35. On 28 October, Mr Harmon called his COM and told her he had met with the housing worker from OTO and went to the property. He raised concerns about knowing a lot of the drug dealers in that area and feared repercussions if they knew his whereabouts. The COM said she would speak to the homeless prevention team to see if Mr Harmon could be moved to another property.
36. That day, OTO arranged for Mr Harmon to move into another property, but he declined.
37. Over the next few days, all agencies tried to call Mr Harmon, to support his move into another property as requested, but he did not answer the phone.
38. On 2 November, Mr Harmon failed to attend his probation appointment at 11.00am with his COM. She tried to call him several times, but he did not answer. She sent him his first warning letter.

### **Circumstances of Mr Harmon's death**

39. On 3 November, Mr Harmon and his friend had been taking various drugs, including pregabalin and diazepam. Mr Harmon's friend left him on the sofa while he went to the shop. When his friend returned from the shop approximately an hour later, Mr Harmon was unconscious, and his friend called 999.
40. The paramedics gave Mr Harmon adrenaline, glucose, and naloxone, but he failed to recover and was declared dead.
41. The police informed Mr Harmon's COM of his death.

### **Post-mortem report**

42. The post-mortem report concluded that Mr Harmon died of toxicity of multiple drugs together with ketoacidosis secondary to alcohol misuse.

43. At the inquest held on 10 August 2023, the coroner concluded that Mr Harmon's death was alcohol and drug related.

## Findings

### Substance misuse

44. Mr Harmon had a history of substance misuse. While he was in prison, he was seen regularly by the SMS team and warned about the risks and dangers of taking drugs. He was also offered to be trained in the use of naloxone, but he declined and therefore he was not released with a supply of this. The SMS team referred Mr Harmon appropriately to the community SMS team, to ensure he was given continued support in the community. We are satisfied that both the prison and probation services did all they could to manage the risks associated with his substance misuse.

### Accommodation

45. We consider that Mr Harmon's COM appropriately prepared for his release. She liaised with external support agencies, arranged accommodation through CAS3 accommodation services and advised Mr Harmon of the potential options prior to his release.
46. Furthermore, his COM continued to support Mr Harmon with finding appropriate accommodation once Mr Harmon raised his concerns about the suitability of the initial accommodation found for him. His COM was aware of the risks associated with this and tried to support Mr Harmon with relocating.

### Mental health services

47. Despite a psychiatrist recommending a referral to the community mental health team, this was not completed by the nurse at Forest Bank. The nurse did not remember why they did not complete the referral and took full responsibility for the oversight. The mental health team operations manager said all the team were aware that the practice of contacting criminal justice liaison teams in the community as a safeguard should be applied in every case. We are satisfied this is being addressed and make no recommendation.

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

**May 2024**

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