

A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man in July 2013,
while a resident at Plas-Y-Wern Approved Premises,
North Wales**

Our Vision

*'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision'*

This is the investigation report into the death of a man in July 2013, at Plas Y Wern Approved Premises in Wrexham. He was 22 years old. A toxicology report indicated that his death was due to a fatal combination of prescribed and illicit drugs. I offer my condolences to his family and friends.

Plas Y Wern cooperated fully.

The investigation has identified that probation staff responsible for the man's supervision and those from other agencies managed him appropriately, with regular contact and active support to help him deal with problems. They took steps to assist him to remain drug-free but after his death it became clear that he had deceived them when taking drug tests.

I am satisfied that staff at Plas Y Wern could not have foreseen or prevented the man's death, but the investigation has identified some areas for improvement. While it appears it would have been too late to save him, an early morning welfare check was not carried out on the day he died and there was a significant delay in calling the emergency services. Family liaison arrangements were very poor and no contribution towards funeral expenses was offered as national guidelines require.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and residents involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman

August 2014

CONTENTS

Summary

The investigation process

Plas Y Wern Approved Premises

Key events

Issues

Recommendations

SUMMARY

1. The man was arrested on 15 January 2013. He was released on bail from HMP Altcourse on 24 January and directed to stay at Plas Y Wern Approved Premises in North Wales. He had a history of alcohol and drug misuse and was subject to a Community Order, which involved drug testing and treatment, unpaid work and supervision.
2. During his stay at Plas Y Wern, the man had regular contact with his offender manager and they attended court monthly to report progress and compliance with his Community Order. He settled well into life at Plas Y Wern and appeared to meet the requirements of the court order. His drugs support worker conducted frequent drug tests. Staff suspected that he might have been taking illicit drugs, but his drug tests were consistently clear. He took antidepressants and diazepam for anxiety, which staff dispensed daily.
3. On the morning of 29 July, the man went to a friend's home. He had with him a bottle of methadone which his friend advised him to pour away. Later that evening, his friend was concerned about his presentation and believed he might have taken the methadone. When he returned to Plas Y Wern at 11.00pm, he told staff he had not taken any illicit drugs and was given his medication.
4. After the man received his medication, he went to a room shared by two other residents and watched television. He fell asleep in a chair and was found unconscious the next morning. Attempts to resuscitate him were unsuccessful and paramedics confirmed his death at 10.35am. After his death, a bottle containing a liquid assumed to be urine was found strapped to his leg, indicating he had been providing false samples for drug tests. A toxicology report revealed that he had taken a combination of prescribed and illicit drugs which had caused a fatal overdose.
5. The investigation found that the man had been well managed and supported during his time at Plas Y Wern. However, on the morning of his death, the first care check of the day was not completed and, when staff were alerted to his condition, there was a lengthy delay in calling an ambulance. At that time, Plas Y Wern did not meet the requirement for all supervisory staff to have first aid training. No one from the approved premises or the Probation Trust contacted his nominated next of kin and it took over three months for the Trust to contact his mother who the police had informed of his death at the time.

THE INVESTIGATION PROCESS

6. The investigator issued notices to staff and prisoners at Plas Y Wern Approved Premises to inform them of the investigation and asking anyone who had relevant information to contact him.
7. On 7 August, the investigator visited Plas Y Wern, met the manager, collected the man's probation records and interviewed two residents. He interviewed seven probation staff at Plas Y Wern on 4 and 5 October.
8. The investigator informed HM Coroner for North Wales of the investigation. A copy of this investigation report has been sent to the Coroner.
9. Healthcare Inspectorate Wales reviewed the man's clinical care.
10. One of the Ombudsman's family liaison officers (FLO) spoke to the man's mother to explain the purpose of our investigation and enable her to identify any issues she wished the investigation to consider. She wanted to know more about the circumstances of her son's death.
11. The man's mother received a copy of the draft report. She raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

PLAS Y WERN APPROVED PREMISES

12. Approved premises (formerly known as probation and bail hostels) accommodate offenders released from prison on licence and those directed to live there by the courts as a condition of bail. Their purpose is to provide an enhanced level of residential supervision in the community, as well as a supportive and structured environment.
13. Plas Y Wern, in Wrexham, is managed by the Wales Probation Trust. It accommodates 23 adult men, the majority of whom are supervised on licence. The premises occupy two buildings. The Coach House, where the man lived from April onwards, is detached from the main building and allows six residents to live more independently.
14. As part of the induction process, new residents are required to sign to say they understand the rules and agree to abide by them. Possession of alcohol, illicit drugs and solvents on the premises is strictly forbidden. Staff are expected to carry out "care checks" on each resident at set times between 9.00am and 11.00pm. Residents are responsible for their own health and are expected to register with a GP at a local surgery. Prescribed medication is stored in the medication room and dispensed daily.
15. While residents have to comply with their individual licence or bail conditions, curfews and the approved premises' rules, they are essentially free to go in and out of the building as they choose using a signing in and out book.
16. There has been one previous death at Plas Y Wern, in 2011. There are no similarities between the circumstances of the previous death and that of the man's.

Drug Rehabilitation Requirement (DRR)

17. A DRR is a community sentence imposed by the court for offenders whose offences resulted from their dependency on drugs. It lasts for at least six months and combines treatment, drug testing and regular supervision by a probation officer (offender manager). The court conducts progress reviews at least monthly.

KEY EVENTS

18. The man was born in February 1991, in Bangor, North Wales. He had a history of alcohol and drug misuse and had been convicted many times. On 15 January 2013, he was arrested by North Wales Police and charged with burglary and possession of cannabis. He was subsequently remanded to HMP Altcourse. At the time of his arrest, he was subject to a 12-month Community Order which he had breached twice.
19. At a court hearing on 23 January 2013, the man was granted bail on condition he lived at Plas Y Wern Approved Premises. When he arrived at Plas Y Wern on 24 January, he had an induction with a probation service officer, and signed the compacts agreeing to abide by the rules. This was the first time he had stayed at approved premises and his curfew hours were 6.00pm to 10.00am daily. He registered at the local GP practice the next day. The GP prescribed zopiclone to aid sleep and diazepam for anxiety. These were delivered to Plas Y Wern and stored in the medication room and he collected his medication daily.
20. The man's drug support worker conducted a weekly drug test from a urine sample. He usually completed the test at the drug services' premises but as he was also a relief probation service officer at Plas Y Wern, he sometimes conducted them there.
21. The man's offender manager spoke to him each week and had a monthly meeting with him to monitor his well-being and progress. Staff at Plas Y Wern updated her on his compliance with his bail conditions and premises' rules and she wrote a monthly progress report for the court.
22. Plas Y Wern staff recorded that the man settled well and had started his unpaid work. However, he tested positive for cannabis on 30 January and twice in February. He attributed this to having smoked cannabis in prison as it can be detected up to 28 days from the date it was last taken. After discussion, the drug support worker and his offender manager gave him the benefit of the doubt.
23. On 27 February, while conducting a drug test at Plas Y Wern, the drug support worker noticed that the man's pupils were dilated and suspected that he was under the influence of cannabis. However, the test was negative for illicit substances. His urine sample was cold and the drug support worker did not believe it was genuine. He told him that he would repeat the test, which he did on 1 March. The test was again negative, except for prescribed medication. This time, the sample was warm, so he accepted it as genuine.
24. The offender manager's monthly reports noted the man had complied with the Drug Rehabilitation Requirement. He had completed the unpaid work element and his recent drug tests had been negative. His apparently positive behaviour continued and he was given a vacant single room in the Coach House on 15 April.
25. In May, Plas Y Wern staff were more vigilant of the man as there was a dispute about the paternity of his unborn child but they thought he was managing his anxieties well. On 29 May, his GP prescribed mirtazapine, an antidepressant.

On 6 June, in recognition of his progress, the court reduced his curfew to the standard Plas Y Wern curfew hours of 11.00pm to 7.00am,

26. On 10 July, Plas Y Wern staff reported to the offender manager their concerns that the man might be taking illicit drugs as he appeared to be anxious. However, a drug test proved negative and he explained that the wait for the outcome of the paternity test was causing his anxiety. The manager of Plas Y Wern asked staff to monitor and support him.
27. At the man's court hearing on 12 July, his offender manager noted that his appearance was better than it had been in the previous months. He attributed this to his ongoing abstinence from drugs. She reminded him of the support he could get while he waited for the outcome of the paternity test. Plas Y Wern staff suggested that she consider a mental health screening so he could access further support, if necessary, as they were concerned that stress of the paternity proceedings would lead to him taking illicit drugs. This was not considered urgent as he attended weekly counselling at Plas Y Wern. Staff told the offender manager that he was taking his diazepam sporadically and did not always collect all three of his daily doses. However, he took his zopiclone and mirtazapine each night.
28. A probation service officer told the investigator that at the time of the paternity issue the man became distant, isolated, withdrawn and guarded. His routine changed from staying at Plas Y Wern throughout the day to spending long periods and often whole days out. She said that, although his drug tests had consistently been negative, staff suspected from his physical signs that he was taking illegal drugs, but they had no firm evidence to support this.
29. It subsequently came to light that the man had been seeing his girlfriend. After the paternity test confirmed that he was the father of the child, staff noticed a positive change in his demeanour and felt he was "back on track".

Events leading up to the incident

30. On the morning of 29 July, the man left Plas Y Wern at 10.45am and arrived at the home of a friend at around 11.00am, with a medicine bottle containing 200ml of methadone. He tried to sell it to his friend, who advised him to pour it down the kitchen sink. His friend thought he had taken his advice. Afterwards, they both went into town and returned to his friend's house at approximately 6.00pm.
31. The friend said that around an hour later the man's behaviour changed. He said he was slumped in a chair and kept falling asleep. He said he had seen him smoke cannabis earlier and now suspected he had also taken the methadone. However, the man denied this. At about 9.30pm, the friend woke him and told him to wash his face and get ready to return to Plas Y Wern. He was worried about him, but thought he looked better once he had washed his face. He walked him part way to the bus station to ensure he did not miss the last bus at 10.10pm.
32. A member of staff was on duty when the man returned Plas Y Wern, just before the curfew at 11.00pm. She said he appeared to have been running. He had missed the dispensing time (9.00pm - 9.30pm) but wanted his medication. She

was initially concerned about his presentation as his speech was rushed and he seemed slurred. She said she looked for signs that he was under the influence of drugs and challenged him but he denied taking any illicit drugs and said he was happy to take a drug test. His speech improved and his eyes looked clear. The relief night supervisor was also in the medication room and had no concerns about his presentation. She therefore gave him his medication. CCTV footage from the premises that night does not show him behaving in an unusual manner.

33. Two residents shared a room on the first floor of the Coach House. Resident 1 told the investigator that sometime after 11.00pm the man visited them in their room, which he often did. The relief night supervisor carried out a check at about 11.30pm when he was talking to the other two residents, who were both lying on their beds. The supervisor said that he appeared fine at the time.
34. Resident 1 told the investigator that they watched television, talked and joked together. The man sat on a chair at the end of his bed. He noticed nothing unusual about his appearance or behaviour. However, after a short telephone conversation with a woman on his mobile phone, he said, "she thinks I've taken meth". He said nothing further about the conversation and rolled a cigarette. He soon fell asleep in the chair and was snoring. Resident 1 and his room mate fell asleep shortly afterwards. The room light was on. Resident 1 said that the man had fallen asleep like this once or twice before and, as previously, he expected that he would wake up in the middle of the night, turn the light off and go to his room.
35. Resident 1 woke up and went to the toilet at around 8.00am. The man was still apparently asleep in the chair. He went back to bed. He said he thought he had heard a grunt from him but fell asleep and woke again at what he estimated to be around 9.40am. When they awoke, both residents tried to wake the man up. He did not respond so they shook and tapped him. They then examined him and found no pulse. Resident 1 said there was sweat on his forehead and his arms were cold, although his body was warm. His pupils were fixed.
36. At about 10.00am, Resident 2 went to the main office and asked for a member of staff to come to the Coach House but did not explain what was wrong. A probation service officer went with him to the Coach House and on the way he said that he could not wake the man.
37. The probation service officer found the man unconscious and slumped in an awkward position in the chair. She was unable to get a response from him and immediately pressed her panic alarm which sounded in the main office. (Plas Y Wern was unable to provide evidence of the time it was activated.) She checked him for signs of life. He had no pulse and was cold. She asked Resident 2 to call an ambulance and continued checking him while she waited for other staff to arrive. Staff responded to the alarm. The resident met them in the car park and said that an ambulance was needed.
38. As soon as a member of staff arrived at the room, he said he called to give the ambulance service directions to Plas Y Wern. While he was doing this another telephone call was made to update the emergency service operator about the man's condition. The operator instructed them to take a defibrillator to the room

and an officer went to collect one from the office. They followed the operator's instructions and placed the man on his back. The officer started chest compressions, assisted by the supervisor, who was first aid trained. The defibrillator found no electrical activity, so the staff continued chest compressions. Paramedics arrived at around 10.27am and confirmed death shortly after, at 10.35am. They said that it appeared that he had died sometime during the night.

After the man's death

39. The manager and the police arrived at Plas Y Wern soon afterwards. The police found that the man had a bottle containing what appeared to be urine strapped to his leg. It was presumed that he had managed to provide negative drug tests by using a home-made catheter attached to the bottle.
40. Although the man had nominated his girlfriend as his next of kin, the police decided to notify his mother instead as she was a blood relative. His mother lived in West Wales and in view of the distance involved they were unable to break the news until 2.00pm. Members of his family informed his girlfriend.
41. The manager spoke to all staff individually and offered support and counselling to them and to residents. The funeral was held on 8 August 2013. A member of staff from Plas Y Wern attended and gave the man's mother a condolence card on behalf of the staff and residents. Plas Y Wern also decided to plant a tree in his memory. No contribution towards funeral costs was offered, as national guidance requires.
42. After the man's death, the Area Chief Executive asked a manager to act as the Probation Trust's main contact for the man's mother. He agreed to meet her when he returned from leave but explained that neither he nor the man's offender manager had her contact details as his girlfriend had been listed as his next of kin. The manager did not visit the man's mother until 7 November, three months after his death. He returned his property at that visit.

Toxicology report

43. A toxicology report noted that methadone, amphetamine, amitriptyline, mirtazapine, zopiclone and diazepam had been found in the man's body. The levels of diazepam, zopiclone and mirtazapine detected were consistent with the therapeutic dosage prescribed to him. The other drugs had not been prescribed to him. The possibility was also noted that the additional presence of diazepam, zopiclone and amitriptyline in his blood (albeit at therapeutic concentrations) had exacerbated any toxic effects resulting from methadone use.

ISSUES

Assessment of the man

44. Throughout the man's stay at Plas Y Wern, he had frequent drug tests. Although staff suspected he might still be taking drugs, with the exception of those taken shortly after he had left prison, the results were negative and indicated he was clear of drugs. When he returned to Plas Y Wern on the night of 29 July, the officer on duty initially suspected that he might have been under the influence of drugs. However, her suspicion was dispelled after she assessed him visually and spoke to him. She then gave him his prescribed medication. Another member of staff present did not consider he was under the influence of drugs.
45. The Approved Premises Manual states that if staff believe a resident is under the influence of drugs, alcohol or other substances, or that the person may overdose, they should refuse to issue prescribed medication until medical advice has been obtained. In spite of the officer's initial suspicion, she did not consider that the man was under the influence of drugs and accepted his assurance that he had not taken anything. The supervisor also said he had no cause for concern. The two residents who last had contact with him had no concerns about him. We accept that this is a difficult judgement for staff to make and we are satisfied that, in the circumstances, it was not an unreasonable decision to give him his prescribed medication.

Care checks

46. The Approved Premises Manual, states that approved premises, "owe a duty of care to all residents, many of whom may be vulnerable for different reasons". Welfare or care checks are made to assist monitoring. On the morning of 30 July, the officer did not conduct the first check of the day at 9.00am. Had she done so the man would have been discovered at least an hour earlier. There has been an internal Probation Trust investigation into this.
47. The paramedics believed that the man had died during the night, so it is unlikely that he could have been saved at 9.00am. However, in other cases a failure to check residents' wellbeing could result in a delay in treating someone seriously ill and have grave consequences. We make the following recommendation:

The Manager of Plas Y Wern should ensure that staff carry out care checks promptly at the designated times. Staff should satisfy themselves of the wellbeing of the resident and that there are no immediate issues that need attention.

Emergency response

48. When the officer arrived at the room in the Coach House, she pressed her emergency alarm. While she waited for other staff to arrive, she continued to try to rouse the man. She was not first aid trained and did not attempt resuscitation immediately after discovering that he was not breathing. This was started on the instructions of the emergency service operator several minutes later.

49. Of the three members of staff who responded to the emergency, two had up-to-date first aid training. These were administrators, who are normally on duty between 9.00am - 5.00pm. First aid trained night staff had left the premises by around 7.30am which meant there were no first aid trained staff on site between 7.30am and 9.00am. Although it appears that the man had been dead for some time and could not be resuscitated, in other cases this could be vital. It is important that cardiopulmonary resuscitation (CPR) is started as soon as possible after a person is found unconscious, to improve the chances of survival.
50. The Approved Premises Manual states that all supervisory staff should be first aid trained. This was not the case at Plas Y Wern. We make the following recommendation:

Wales Probation Trust should ensure that all supervisory staff in approved premises have up to date first aid training.

Calling an ambulance

51. Staff were summoned at around 10.00am and said that as soon as they were aware that the man was unconscious, the emergency services were called. However, the ambulance log shows that the emergency services received the call at 10.23am and arrived at 10.27am. It is unclear why such a significant amount of time elapsed between finding him and calling an ambulance which does not accord with timings suggested by staff accounts. As noted above, this would not have changed the outcome for him but in other circumstances even a short delay can have a significant impact on a person's chance of survival. We therefore make the following recommendation:

The Manager of Plas Y Wern should ensure that an ambulance is called immediately when a resident is found unconscious or there are other grave concerns about their immediate health.

Family liaison and the payment of funeral expenses

52. When the man arrived at Plas Y Wern, he nominated his girlfriend as his next of kin. However, the police decided to treat his mother as his next of kin as she was a blood relative and they informed her of his death. Neither the manager of Plas Y Wern nor anyone else from the Wales Probation Trust attempted to contact either his mother or his girlfriend immediately after his death.
53. The manager believed that family liaison would be managed centrally by the Probation Trust, as the Trust had wanted a single point of contact. The Area Chief Executive had appointed a manager as the main probation contact for the family. However, in his correspondence with the investigator, his role was not defined as a family liaison officer and neither he, nor any other representative of Wales Probation Trust made any immediate efforts to contact the man's mother or girlfriend to offer support. Wales Probation Trust said they were unable to locate contact details for his mother so had been unable to contact her for some time. However, they were aware that the police had the details and made no effort to get them.

54. The manager told the investigator that the Wales Probation Trust had now agreed to implement family liaison roles. This would mean that, in the event of a serious incident involving a resident at Ty Newydd Approved Premises, he would act as the family liaison officer and the manager of Ty Newydd would do so for Plas Y Wern. Similar arrangements had been made to cover family liaison at the two approved premises in South Wales. He said he was still awaiting guidance about implementation and training for the new arrangements. We are surprised that the Trust should expect managers from other premises to take on this responsibility. In our experience bereaved families want to hear from members of staff where their family member died and preferably from someone who knew them.

55. The *Approved Premises Manual* states:

“All residents must be asked on their arrival to nominate two persons who are willing and able to act as their next of kin ... These will be the people whom staff should initially contact in the event of the resident’s death.”

Implicit in the instructions above, are that approved premises staff should contact the nominated person after a death. No exceptions are listed. In this case, the details of the man’s preferred next of kin, his girlfriend, were available, yet no attempt was ever made to contact her. A representative of Wales Probation Trust did not visit his mother until over three months after his death.

56. Paragraph 23.39 of the *Approved Premises Manual 2011*, states:

“Trusts are required to offer to pay reasonable funeral costs of up to £3,000 with the money being paid direct to the funeral director upon receipt of an invoice. The amount paid should cover the cost of the funeral only and not ancillary items such as clothing for those attending, or go towards the cost of a wake, etc”

57. The man’s family were not offered a contribution to the costs of his funeral. When the investigator explored this with the Probation Trust, there was no clear explanation for this omission. We make the following recommendation:

Wales Probation Trust should, in line with national guidance:

- **Ensure that after the death of a resident, a member of the Trust contacts the resident’s next of kin at the earliest opportunity, to offer information and support.**
- **Ensure that in the event of any death of a resident, funeral expenses are offered, irrespective of the circumstances of the individual or their family; and**
- **Pay the family a contribution towards the funeral expenses of up to £3,000, in line with national guidance.**

RECOMMENDATIONS

1. The Manager of Plas Y Wern should ensure that staff carry out care checks promptly at the designated times. Staff should satisfy themselves of the wellbeing of the resident and that there are no immediate issues that need attention.
2. Wales Probation Trust should ensure that all supervisory staff in approved premises have up to date first aid training.
3. The Manager of Plas Y Wern should ensure that an ambulance is called immediately when a resident is found unconscious or there are other grave concerns about their immediate health.
4. Wales Probation Trust should, in line with national guidance:
 - Ensure that after the death of a resident, a member of the Trust contacts the resident's next of kin at the earliest opportunity, to offer information and support.
 - Ensure that in the event of any death of a resident, funeral expenses are offered, irrespective of the circumstances of the individual or their family; and
 - Pay the family a contribution towards the funeral expenses of up to £3,000, in line with national guidance.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Manager of Plas y Wern should ensure that staff carry out care checks promptly at the designated times. Staff should satisfy themselves of the wellbeing of the resident and that there are no immediate issues that need attention.	Accepted	Disciplinary Procedures were completed for the staff member who had failed to follow expected process, with regards to undertaking Care Checks. All staff members had been reminded during one to one supervision sessions of the requirement for them to complete face to face Care checks at the designated times.	Completed 29 Oct 2013 Completed by the end of 2013	
2	Wales Probation Trust should ensure that all supervisory staff in approved premises have up to date first aid training.	Accepted	Training records of all staff working at Plas y Wern have been checked and all staff including new starters will have completed First Aid training by the end of February 2014. Plas y Wern Team Manager to have regular contact with the Health and Safety Officer and training department to ensure that all staff have the required first aid training and refresher training to meet the needs to their role.	28/2/14 Ongoing	
3	The Manager of Plas y Wern should ensure that an ambulance is called immediately when a resident is found unconscious or there are other grave concerns about their immediate health.	Accepted	Plas y Wern Team Manager to remind all staff during one to one supervision of the need to call an ambulance without delay and for this to be formally recorded in their individual supervision record.	31/10/14	

4	<p>Wales Probation Trust should, in line with national guidance:</p> <p>a) Ensure that after the death of a resident, a member of the Trust contacts the resident's next of kin at the earliest opportunity, to offer information and support.</p> <p>b) Ensure that in the event of any death of a resident, funeral expenses are offered, irrespective of the circumstances of the individual or their family; and</p> <p>c) Pay the man's family a contribution towards the funeral expenses of up to £3,000, in line with national guidance.</p>	Accepted	<p>Wales Probation will ensure that those individuals who have been identified to act as Family Liaison Officers understand the role, have appropriate support and training, and are provided with a task list of what the role involves.</p> <p>Fact Finding to be commissioned to consider why the appropriate work was not completed by the appointed individual in a timely manner.</p> <p>Lead ACE for Approved Premises to ensure that all ACE, Deputies and Approved Premises team managers are aware of this requirement via, Local Delivery Heads Meeting and Approved Premises Harmonisation Meeting.</p> <p>Wales Probation will contact the man's family to discuss making a contribution towards the funeral expenses in line with national guidance.</p> <p>Wales Probation will update their Policy for Dealing with Deaths in the Approved Premises to reflect the learning of these three points.</p>	<p>31/3/14</p> <p>28/2/14</p> <p>31/3/14</p> <p>28/2/14</p> <p>31/3/14</p>	
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