

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of a man, a resident at McIntyre House Approved Premises, in February 2015

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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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.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

The man died of a drug overdose at McIntyre House Approved Premises in February 2015. He was 34 years old. I offer my condolences to his family and friends.

The man had been released from prison on 11 February and had been at McIntyre House just a few days. On the morning he was found, a member of staff should have made a routine check of all residents at 10.00am, but this was not done. At 11.45am, staff found him collapsed on the bathroom floor, surrounded by drug taking equipment. They could not revive him.

I do not consider that staff at McIntyre House could have anticipated the man's actions. While we cannot know whether an earlier check would have helped save his life, it is important that required checks take place. I am concerned that the probation service did not offer to contribute towards funeral costs as national policy requires. This is a matter I have raised in a number of recent investigations into deaths in approved premises.

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 prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman

November 2015

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Summary

Events

1. The man was released on licence from HMP Parc on 11 February 2015. He arrived at McIntyre House that evening, after reporting to his offender manager then visiting his father. He failed a drug test when he arrived and said that he had taken drugs in prison before his release.
2. In the next two days, the man registered with a local GP, and reported to a local agency that helps people with drug and alcohol problems. He complied with his curfew, and did not cause any problems. Staff saw nothing to indicate that he was under the influence of drugs at any time.
3. On 13 February a member staff spoke to the man, who he said he was okay. A routine check of the premises, which usually happened at 10.00am, did not take place. At 11.45am, a member of staff found him collapsed on the bathroom floor, surrounded by drug taking equipment. Staff and paramedics attempted to resuscitate him but, at 1.22pm, the paramedics said that he had died. A post-mortem examination concluded that he had died of heroin toxicity.

Findings

4. The man had been at McIntyre House for only three days. He had failed an initial drug test when he arrived, but otherwise did not give staff any further reason to suspect that he was using drugs. The staff who found him collapsed responded appropriately, although we are concerned that a routine check on all residents at 10.00am was not completed. We do not know whether this would have altered the outcome for him. The probation service did not offer to contribute to the cost of the funeral as national policy requires and liaison with his family after his death was not well co-ordinated.

Recommendations

5. The manager of McIntyre House Approved Premises should ensure that all staff understand the importance of checking the welfare and safety of residents and carry out all checks as scheduled.
6. The National Probation Service, Midlands Division, should ensure that when a resident dies:
 - An appointed family liaison officer contacts the resident's next of kin at the earliest appropriate opportunity, to offer information and support; and
 - Funeral expenses are offered in line with national guidance; and that the man's family are offered such a contribution.

The Investigation Process

7. The investigator issued notices to staff and residents at McIntyre House Approved Premises informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
8. The investigator visited McIntyre House on 24 July 2015, and obtained relevant copies of the man's records. He interviewed four members of staff, and spoke to one resident. He also visited The Recovery Partnership, a local agency which helps people with drug and alcohol problems, and spoke to two members of staff. He interviewed the man's offender manager by telephone. The police investigated the death, and he spoke to the officer in charge of the investigation, who shared documents and statements with him.
9. We informed HM Coroner for Coventry and Warwickshire District of the investigation, and the coroner's office gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
10. One of the Ombudsman's family liaison officers contacted the man's father to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He asked about checks on residents, and whether anyone had visited his son the night before he died.
11. The man's family received a copy of the initial report. They raised a number of issues that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

Background Information

McIntyre House

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. The National Probation Service, Midlands Division, manages McIntyre House Approved Premises in Nuneaton. It accommodates up to 18 men. There is an overnight curfew between 11.00pm and 7.00am, when all residents are expected to be on the premises. When the man was at the hostel, staff checked residents at 8.00am during the week or 10.00am at weekends, midday, 3.00pm, and 11.45pm. They also checked the communal areas of the building at 6.00pm and 9.00pm, but these did not include checks of residents' rooms.
14. Residents are not allowed in each other's rooms. Residents who are considered to be at risk of drug or alcohol abuse are routinely tested. Residents are responsible for their own health and register with a local GP.

Previous deaths at McIntyre House

15. This is the first time we have investigated a death at McIntyre House.

Key Events

16. On 11 February 2015, the man was released on licence from HMP Parc. One of the conditions of his release was that he lived at McIntyre House, where he had lived before. Staff at McIntyre House were familiar with him, and knew that he had a history of drug use.
17. The man reported to his offender manager at the probation service office in Leamington Spa. There had been an issue about the conditions on his licence, which did not include the requirement that he should live at McIntyre House. The offender manager rectified the problem, and arranged with the hostel manager and the man that he would arrive at the hostel by 10.00pm. After seeing his offender manager, the man visited his father, and then went to McIntyre House. He arrived before 10.00pm.
18. One of the hostel's probation officers conducted the man's induction. As he had lived at McIntyre House before, he was familiar with the hostel rules and signed to say he would comply. While she did the induction, one of the hostel's supervisors checked the man's bags and possessions to ensure he did not bring anything into the hostel that was not allowed. There were no unauthorised articles, and the supervisor told the investigator that he found no drug taking equipment. The probation officer said that there was nothing out of the ordinary during the induction process. The supervisor said that he had no reason to suspect that the man was under the influence of any substances.
19. Staff gave the man a drugs test, which is routine for all new arrivals. The test showed positive. He said that he had taken cocaine two days previously, while still in prison.
20. The man had a leg injury from a fall in prison, and had some mobility problems. He said that he did not want an upstairs room and staff agreed he could have the one ground floor room with a private bathroom. However, another resident already had the room and it was too late to ask him to move that night. He therefore slept on a camp bed in the conservatory, which was on the ground floor.

Thursday 12 February

21. As a new resident, the man had to register with the local GP practice. The prison confirmed his medication, and the doctor prescribed dihydrocodeine, pregabalin (both for pain relief), amatryptiline (an antidepressant) and cyclizine (used to treat nausea). A local pharmacy delivers prescribed medication directly to McIntyre House, which staff hold securely and issue as required.
22. Before he was released, Parc had made an appointment for the man with the Recovery Partnership, a local agency that helps people who have drug and alcohol problems. He had engaged with the Partnership previously. The appointment was for 2.00pm on 12 February, but he did not attend.
23. All residents are assigned a keyworker, who looks after their welfare, helps with any problems, and works to address offending behaviour. The probation officer was the man's keyworker, who he had known from his previous stay. She saw him on the afternoon of 12 February, who said that he had seen the GP and

organised his medication, but had forgotten to ask for a doctor's note which would allow him to claim sickness benefit. She advised him to go back to the surgery to get this, (which he later did). They discussed the failed drug test and his use of drugs. He told her that he would be going to the Recovery Partnership. She told the investigator that she did not think that he was under the influence of drugs at this meeting.

24. Although residents are not allowed in each other's rooms, staff noticed another resident going into the man's room on the afternoon of 12 February. The hostel manager said that for a single infringement staff would not take any action. The investigator asked the resident about this, but he was unable to recall the incident.

Friday 13 February

25. The Recovery Partnership operates drop-in sessions. Although he had missed his appointment the previous day, the man went to their office on the morning of 13 February and saw one of the Partnership workers. She told the investigator that his behaviour and demeanour were appropriate throughout the session, and there were no signs that he was under the influence of anything. He did not ask for any drug-substitution medication, but said that he was concerned that his prescription medication for his leg pain was not adequate. He said that he had taken heroin once since coming out of prison, to help him cope with the pain. She advised him to discuss pain relief with his GP, and told him that if he wanted to address this properly he should not take any illicit drugs. These would mask the symptoms of his pain, affect any assessment of what pain relief he actually needed, and might also affect which medication the doctor would prescribe. She also warned him about the risk of overdose, as his tolerance level would probably have reduced while he was in prison. She agreed that the Partnership would be able to work with him, and made an appointment for the following week.
26. A probation officer at McIntyre House was on duty on the afternoon of 13 July. He knew the man from previous stays. At 9.00pm, the man went to the office and the probation officer gave him the prescribed doses of his medication and noted this in the records. He told the police that the man seemed well and in good spirits, and there was nothing to indicate that he was under the influence of any alcohol or drugs.
27. CCTV footage shows another resident coming out of the man's room at 9.16pm. He went back to the man's door at 10.33pm, but did not go in. There is no further information about his contact with him, but the police examination of the man's phone showed no evidence that he and the resident had been in contact with each other by phone. The police told us that they did not have any reason to suspect that either resident had done anything wrong. The probation officer checked residents as scheduled, at 11.45pm. When he went to the man's room, he was sitting in bed, smoking a cigarette. He told the probation officer he was all right and they said goodnight.
28. Unless they believe there is a problem, staff would not usually check residents again during the night. On Saturdays, the next scheduled check was supposed to be at 10.00am. Staff had no reason to look in on the man during the night, and

CCTV footage confirms that nobody went into his room after the probation officer saw him at 11.45pm.

29. Residents can have breakfast in a communal dining room, but they do not have to and staff do not check on them if they do not. The procedures at the time, required staff to check residents at 10.00am at weekends. In the morning, two staff were on duty. There was some confusion about who should do the check and, as a result, no 10.00am check was carried out.
30. Staff were due to make the next checks around midday. At approximately 11.45am, a hostel worker checked the man's room but he was not there. She could hear the sound of running water from the bathroom and knocked on the door, but he did not respond. In case he was undressed, she went to the office and asked the probation officer to check on him.
31. The probation officer was also unable to get a response and opened the bathroom door. The man was lying on the floor, with drug taking equipment, including a syringe, next to him. (Tests later showed that some 'wraps' found in his room contained crack cocaine and heroin.) The probation officer asked his colleague to call an ambulance. He was first aid trained, and checked the man for signs of life. He then began cardiopulmonary resuscitation.
32. After calling an ambulance, the hostel worker passed the telephone to the probation officer and ambulance service staff told him to use a defibrillator (a life-saving device that gives the heart an electric shock in some cases of cardiac arrest). A resident was nearby and passed the defibrillator to the probation officer. He attached the defibrillator, which found no shockable heart rhythm. He continued to try to revive the man until paramedics arrived and took over emergency treatment. At 1.22pm, paramedics agreed that he had died.

Contact with the man's family

33. The hostel manager discussed with her manager and with the police who would contact the man's family to inform them of his death. They agreed that the police would do so. The next week, she wrote to the man's father, offering her condolences and giving her contact details. The man's father then telephoned her and arranged for him and his son to visit the hostel to collect his son's belongings. The offender manager also contacted the man's father and offered his support. He told the investigator that a member of the family telephoned him to ask if the National Probation Service would be able to contribute to the costs of the funeral. He discussed this with his manager. Neither of them was aware of any guidance about this and did not offer a contribution.

Support for residents and staff

34. After the man's death, the hostel manager spoke to the probation officer and hostel worker and offered them counselling if they wanted it. The offender manager told the investigator that support was available to him if he needed it.
35. Staff observed other residents to see if any of them were affected by the man's death. As he had been in at McIntyre House for such a short period of time, he had not yet formed any close relationships and none of the residents asked for

extra support. One resident told the hostel manager that as soon as he arrived at the hostel, the man had asked where he could buy drugs

Cause of death

36. The post-mortem examination concluded that the man died of heroin toxicity. HM Coroner for Coventry and Warwickshire held an inquest into his death. The inquest also concluded that he died from heroin toxicity.

Findings

Risk of overdose

37. The man was at McIntyre House for less than three full days. When he was released from prison, he reported to his offender manager and, even though there was an oversight on his licence about where he should live, he complied with instructions. He had stayed at McIntyre House previously and was familiar with the rules, but still received a full induction.
38. The man failed a drug test when he arrived. He claimed that he had taken drugs in prison, which the hostel manager said was not unusual. A probation officer discussed the failed test with him, and informed the offender manager of the result. They were not able to know whether the result meant that he had taken any drugs since his release. We consider that their decision not to take any further action but to assess him over the coming days was reasonable.
39. The man observed his curfew times and did not cause any problems at McIntyre House. Staff did not have any suspicion that he was under the influence of drugs. He told a substance misuse worker at the Recovery Partnership that he had taken heroin once since he had been released from prison. The Recovery Partnership is a confidential service so could not pass this information to staff at McIntyre House. The substance misuse worker warned him that he was at greater risk of overdose after being in prison.
40. The police found some notes in the man's room he had apparently written before being released from prison, in which he indicated that the first thing he wanted to do was to get some drugs. A resident told the hostel manager that as soon as he was in the hostel he asked where he could obtain drugs. Sadly, it seems that he began to use drugs again when he left prison.
41. Previous drug users who have recently been released from prison are at high risk of relapse and of drug overdoses. Opiate users are particularly vulnerable in the immediate post-release period. Mainly this is caused by reduced tolerance levels after limited access to drugs in prison, but there is also a risk that the strength and purity of heroin might have increased from what users were previously accustomed to. Using other medication also increases the risk. We are satisfied that the man was warned of and was aware of the risks and staff at the approved premises could not have prevented his actions.

Checks on residents

42. At the time the man was in McIntyre House, the last daily check on residents was at 11.45pm. The next check was at 8.00am on weekdays and 10.00am at weekends. At the 11.45pm check on 13 February, the probation officer spoke to the man, and he said he was all right. Staff did not complete the 10.00am check. The manager told the investigator that this was simply an error and said that all other checks during the man's time in the hostel were made. Since the man's death, the manager has changed the procedure so that staff check all residents at 7.00am every day, including at weekends to help avoid checks being missed in future.

43. We recognise that the man was not regarded as especially vulnerable and we cannot know whether it would have been possible to save him if the 10.00am check had been completed. The Approved Premises Manual, issued by the National Offender Management Service requires that “Residents’ presence, behaviour and wellbeing within the AP are monitored through staff interaction, security tours, room checks and CCTV”. While missing the 10.00am might have been an aberration, it is important that staff complete scheduled checks. We make the following recommendation:

The manager of McIntyre House Approved Premises should ensure that all staff understand the importance of checking the welfare and safety of residents and carry out all checks as scheduled.

Emergency response

44. When the probation officer found the man unconscious, he asked a hostel worker to call an ambulance and immediately tried to resuscitate the man. She brought the telephone to him, and he followed the ambulance service operator’s instructions while the ambulance was on the way to the hostel. He used a defibrillator as instructed. There were no delays in the ambulance staff getting to the man. We are satisfied that the emergency response when staff found him was appropriate.
45. Following a recent death in another approved premises, where the resident took an opiate overdose, we made a national recommendation that the National Probation Service should ensure that all supervising staff in approved premises (where there is a high risk of residents overdosing, especially shortly after they have been released from prison) should have specific training in responding to drug overdoses and in particular the use of opioid antagonists such as naloxone. This is in preparation for a change in medicine regulations in October 2015, which will allow drugs such as naloxone to be prescribed differently. We do not repeat the recommendation, but this case again highlights the risks of overdose for recently-released prisoners and the role that staff in approved premises might be able to take to help save lives.

Contact with the man’s family

46. The Approved Premises Manual sets standards for family liaison following the death of a resident. The organisation responsible for the hostel should contact the family immediately, in most cases face-to-face, unless this is being done by the police because a GP has certified death. If not sending a representative, the organisation should ensure that the person delivering the news provides a name and telephone number to allow the family to contact the hostel directly. The guidance says that the premises operator should offer ongoing contact.
47. The manager of McIntyre House sought advice from her manager, who decided that the police should break the news to the man’s family. She then wrote to the man’s father three days later offering condolences and providing contact details. The man’s father contacted her and she was able to provide him with advice, and arranged for him to visit the hostel to collect his son’s belongings. She told the investigator that after this she was told that the offender manager would be the

single point of contact. The offender manager telephoned the man's father on 25 February and said he would be available if his family wanted any further contact.

48. The hostel manager said that she discussed with her managers whether to offer a contribution to the funeral. Because the man's possessions included a cheque for £2500, they decided not to make an offer. The offender manager said that a member of the man's family contacted him to ask if the probation service could contribute to funeral costs. He discussed this with his manager, but neither of them were aware of any guidance. He told the family that they would not contribute.
49. Although there was no delay in the man's father being notified of his death, we do not consider that the National Probation Service's contact with the family was sufficiently prompt or adequately co-ordinated. The first contact from the probation service was not until three days later, and that was by post.
50. The Approved Premises Manual says that the Probation Service is required to offer to pay reasonable funeral costs of up to £3000. The manual says that offers should not be made where the deceased has a pre-paid funeral plan. We do not consider the fact that the man had a personal cheque in his possession was sufficient reason not to offer a contribution as directed by the manual. We make the following recommendation:

The National Probation Service, Midlands Division, should ensure that when a resident dies:

- **An appointed family liaison officer contacts the resident's next of kin at the earliest appropriate opportunity, to offer information and support; and**
- **Funeral expenses are offered in line with national guidance; and that the man's family are offered such a contribution.**

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