

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Steven Fishwick a resident at Southview Approved Premises on 22 April 2016

**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.

Mr Stephen Fishwick died of a lung injury caused by the inhalation of his stomach contents at Southview Approved Premises on 22 April 2016. He was 33 years old. I offer my condolences to Mr Fishwick's family and friends.

Mr Fishwick had a history of drug use. I am satisfied that staff at Southview Approved Premises appropriately supported Mr Fishwick. However, I am concerned that they did not intervene further when he admitted using drugs again. Although it is unlikely to have affected the outcome for Mr Fishwick, I am also concerned that staff were unclear about the location of emergency medical equipment and about the use of the defibrillator, when they discovered Mr Fishwick unconscious.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

December 2016

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Summary

Events

1. On 7 January 2016, Mr Steven Fishwick was released on licence from HMP Hull, to live at Southview Approved Premises.
2. Mr Fishwick had a history of illegal drug use but at meetings with his probation officer, after his arrival at Southview, he told him that he no longer took drugs. However, at the end of March, Mr Fishwick admitted sporadic use of heroin and it appears this continued.
3. On 21 April, Mr Fishwick spent most of the day in York with another resident before they returned to Southview in the early evening. Both had been drinking and the other resident believed that Mr Fishwick had also taken heroin. At about 6.00pm, Mr Fishwick went to his room.
4. At 10.00pm that evening, during a curfew check, a member of staff confirmed that Mr Fishwick was watching television in his room. At a similar check, an hour later, he was still in his room, asleep on his bed. Shortly after 7.00am the next day, at another curfew check, staff confirmed he was still on his bed asleep.
5. At about 9.10am, Mr Fishwick's room mate and another resident told staff that they could not rouse Mr Fishwick and thought he had stopped breathing. Staff attended and called an emergency ambulance. They attempted cardiopulmonary resuscitation and used a defibrillator but when paramedics arrived they confirmed he had died.

Findings

6. We are satisfied that staff at Southview supported Mr Fishwick well. However, we are concerned that they did not intervene more proactively when it became apparent that he had started using heroin again.
7. We were also concerned that staff seemed unclear about the location and use of essential first aid equipment.

Recommendations

- The Approved Premises Manager should review the current directions given to staff dealing with residents suspected of taking illegal drugs, to ensure they are appropriate and sufficiently robust.
- The Approved Premises Manager should ensure that first aid training for staff is appropriate, including instructions on using a defibrillator, that regular refresher training is provided and that all staff are aware of the location of emergency medical equipment.

The Investigation Process

8. The investigator issued notices to staff and residents at Southview Approved Premises informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
9. The investigator visited Southview on 3 May 2016 and obtained copies of relevant extracts from Mr Fishwick's records.
10. The investigator interviewed a member of staff and two residents at Southview on 3 May. He later interviewed a second member of staff on the telephone, on 17 May, and a third member of staff provided a statement.
11. We informed HM Coroner for York of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
12. One of the Ombudsman's family liaison officers contacted Mr Fishwick's father, to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He asked what had caused Mr Fishwick's death as this was still unclear at the time.
13. Mr Fishwick's family received a copy of the initial report. They made comments that did not affect the factual accuracy of the report.
14. We shared the initial report with the National Probation Service. There was one minor factual inaccuracy and we have amended this report accordingly.

Background Information

Southview Approved Premises

15. 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. Residents are responsible for their own health and are expected to register with a GP.
16. The National Probation Service manages Southview Approved Premises in York. Southview can accommodate up to 22 residents in five twin and 12 single rooms. The staff team consists of one psychologist, one senior probation officer, six probation service officers, five night support workers plus ancillary staff. Staff are on duty at Southview 24 hours a day.

HM Inspectorate of Probation

17. The most recent inspection of Adult Offending Work in York and North Yorkshire was in February 2014. Inspectors reported, in relation to Southview, that constructive interventions had been delivered to all residents.

Previous deaths at Southview

18. Mr Fishwick was the second person to die at Southview. There were no similarities between Mr Fishwick's death and the previous death.

Key Events

19. On 7 September 2015, Mr Steven Fishwick was arrested for breach of a Sexual Offences Prevention Order and taken to HMP Hull. On 7 January 2016, he was released on licence to Southview Approved Premises.
20. Staff at Southview helped Mr Fishwick to register with a local GP. In April 2016, his doctor prescribed sertraline (an antidepressant), which staff at Southview kept and issued to him daily as prescribed.
21. Mr Fishwick had regular meetings with his probation officer and his link worker (link workers maintain contact with the resident during their reintegration into the community, and may provide support around housing, benefits, probation, training and employment). Mr Fishwick had a history of illegal drug use but, during these meetings, he frequently told staff that he no longer took drugs.
22. However, on 29 March, during a meeting with his probation officer, Mr Fishwick admitted to his sporadic use of heroin, which he said he took when he felt low and unable to cope. They discussed less harmful ways of coping.
23. On 8 April, Mr Fishwick told his probation officer that he used heroin regularly. He said this bothered him. The probation officer checked with other members of staff at Southview who confirmed that he had never appeared to be under the influence of drugs in their presence. They agreed to monitor and drug test him but there was no record of him ever being drug tested.
24. On 11 April, while collecting his medication, Mr Fishwick told a member of staff that he took heroin because it helped to calm him down but that he did not want to continue taking it. The next day, Mr Fishwick told his probation officer that he used drugs as a means of escape. The probation officer encouraged him to contact Lifeline (an organisation that works with individuals, families and communities to prevent and reduce harm, to promote recovery and to challenge the inequalities linked to alcohol and drug misuse) but he did not do so.
25. On 16 April, Mr Fishwick told his link worker that his mood was low and his stress levels high. He had a doctor's appointment arranged for 19 April, and his link worker told him that he should discuss his feelings with his doctor. Mr Fishwick asked him if he would go with him to his doctor's appointment. He explained that he could not because he had other client appointments. However, he wrote a letter to the doctor on Mr Fishwick's behalf.
26. Mr Fishwick shared a room at Southview with another resident. On 21 April, Mr Fishwick and Resident A went into York on their bicycles. The resident told the investigator that, during the afternoon, they spent a few hours, by the river, drinking. He said that, during that time, Mr Fishwick went off on his own a couple of times. He did not know where but he thought that he had gone to take drugs.
27. They returned to Southview in the late afternoon though no one could confirm the exact time. Mr Fishwick went to his room at about 6.00pm and did not come out again. Resident A said he carried on drinking and could remember very little about that evening.

28. At 10.00pm, a member of staff at Southview carried out a curfew check and confirmed that Mr Fishwick was in his room watching television. The purpose of the curfew check was to confirm that residents were present. Resident A and another resident were also in the room asleep. The member of staff said he suspected that they had been drinking or had used drugs and he removed a can of lager from the room.
29. The member of staff conducted another check at 11.00pm and, at that time, both the resident and Mr Fishwick were asleep. He recalled that both were snoring.

22 April 2016

30. Resident A had difficulty sleeping and woke the next morning, 22 April, sometime between 4.00am and 5.00am. Mr Fishwick was asleep on his bed but had his legs hanging over the side with his feet on the floor. He was wearing jeans and trainers but no shirt. The resident could hear him snoring and took a video of him on his mobile phone to show him later.
31. The link worker and another member of staff began the early morning curfew check shortly after 7.00am. They reached Mr Fishwick's room shortly after. Resident A was just leaving the room as they arrived but the link worker confirmed that Mr Fishwick was on his bed and appeared to be asleep.
32. Resident A returned to his room a short time later, he could not be sure about the time, but said he stayed there until about 9.10am when Resident B came in to see him. Resident B told the investigator that, when he went into the room, Resident A was watching television and Mr Fishwick was lying on his bed. Mr Fishwick's eyes and mouth were open but when he spoke to him he did not respond. He believed that Mr Fishwick was messing around but, when he nudged him, he still did not respond. He put his hand in front of Mr Fishwick's mouth but he could not feel any breath.
33. Resident B shouted to Resident A, who called out to Mr Fishwick, felt for a pulse and looked inside his mouth. He remained unresponsive and Resident A said he felt cold.
34. They ran to a downstairs office and spoke to a member of staff, who immediately went to Mr Fishwick's room with them. She described Mr Fishwick's skin as grey and his lips blue. She checked for a pulse in his wrist and neck, but could not find one, and she could not feel his breath. She told Resident B to go back downstairs and tell other members of staff to call an emergency ambulance. She was first aid trained but did not begin first aid immediately. She told the investigator that, on reflection, she was probably in shock.
35. A colleague joined the member of staff almost immediately. She felt for a pulse in Mr Fishwick's wrist and neck but could not be sure if he had one. She asked her colleague to go and get a facemask so that they could attempt resuscitation.
36. The member of staff returned within a minute or two together with the link worker, who had telephoned for an ambulance and was still speaking on his phone to the emergency services. The member of staff had brought a defibrillator but she did not find the facemask. None of the staff were familiar with the use of the

defibrillator but they moved Mr Fishwick onto the floor and followed the diagrams and instructions supplied.

37. The defibrillator advised to begin cardiopulmonary resuscitation (CPR) and then give two rescue breaths which, despite not having a protective mouthpiece, a member of staff did. They then continued CPR but almost immediately a dark red, brown fluid came out of Mr Fishwick's mouth and nose.
38. A staff member left to get some paper towels while colleagues continued CPR. Paramedics arrived at 9.35am and, after a brief examination, they confirmed that Mr Fishwick had died.

Contact with Mr Fishwick's family

39. Mr Fishwick did not give any next of kin details when staff at Southview asked him for them on his arrival. After Mr Fishwick's death, the police located his father at an address approximately 50 miles away. The police offered to ask their colleagues in the area to visit the address to inform the family in person. The Approved Premises Manager agreed that this was preferable to her contacting the family by telephone.
40. On 23 April at 7.25am, the police informed the Approved Premises Manager that they had spoken to Mr Fishwick's father. At 11.40am, she telephoned Mr Fishwick's father; she offered her condolences and discussed funeral arrangements.
41. Mr Fishwick's funeral was on 9 May 2016. The National Probation Service contributed to the cost in line with national policy.

Support for residents and staff

42. Residents at Southview told the investigator that they felt well supported by staff after Mr Fishwick's death and that they could approach staff personally and in private to discuss their feelings. They also spoke openly about the death at the next house meeting, a few days later.
43. Staff at the premises have discussed the incident with each other, particularly regarding things that went well or badly and any lessons that had been learned. Professional support was also available.

Post-mortem report

44. A post-mortem examination found that the immediate cause of Mr Fishwick's death was from aspiration pneumonitis (acute lung injury after the inhalation of regurgitated gastric stomach contents). This was caused by heroin use (heroin depresses the respiratory centre).

Findings

Drug use

45. Staff at Southview Approved Premises helped Mr Fishwick to register with a GP shortly after he arrived. They also collected his medication for him and gave it to him as prescribed. As with anyone else in the community, Mr Fishwick was responsible for managing his own health and attending medical appointments but a member of staff encouraged him to speak to his GP when he told him he felt low.
46. Mr Fishwick had regular meetings with his probation officer and link worker. He had a history of taking illegal drugs and, although he initially told them he was drug free, from 29 March he admitted to sporadic use of heroin. At future meetings he confirmed his continued drug but also expressed his wish to stop.
47. Staff agreed to monitor and drug test Mr Fishwick but he was never tested. They never searched his room for drugs or equipment used for drug taking. In discussions, staff encouraged Mr Fishwick to look for other means of managing his mood rather than resorting to drug taking and, on one occasion, they encouraged him to seek help from an outside drug agency.
48. Clearly residents at Southview have a significant amount of independence and autonomy, and staff can not monitor them all of the time. However, it was common knowledge among residents and staff at Southview that Mr Fishwick took drugs on a regular basis and we consider that they should have been more robust and proactive in dealing with him. We make the following recommendation:

The Approved Premises Manager should review the current directions given to staff dealing with residents suspected of taking illegal drugs, to ensure they are appropriate and sufficiently robust.

Emergency response

49. Staff were quick to call an ambulance when residents reported Mr Fishwick unconscious in his room. However, they were unable to find a protective facemask, an essential item of emergency equipment. Also, we are concerned that none of the staff who responded were confident in using the defibrillator or in performing CPR. A member of staff, who was not first aid trained, eventually initiated CPR and she gave mouth to mouth breaths without the use of a protective facemask. We make the following recommendation:

The Approved Premises Manager should ensure that first aid training for staff is appropriate including instructions on using a defibrillator, that regular refresher training is provided and that all staff are aware of the location of emergency medical equipment.

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