

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Christopher Elsworthy, a resident of Stonnall Road Approved Premises, on 21 July 2017

A report by the Prisons and Probation Ombudsman

PO Box 70769
London, SE1P 4XY

Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100
F | 020 7633 4141

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*



© Crown copyright 2017

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3 or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: psi@nationalarchives.gsi.gov.uk.

Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

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.

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

Mr Christopher Elsworthy died in New Cross Hospital, Wolverhampton on 21 July 2017 as a consequence of drug use. He was 26 years old. We offer our condolences to Mr Elsworthy's family and friends.

Mr Elsworthy was a resident at Stonnall Road Approved Premises but had only been released from HMP Birmingham a few hours before he died. He attended the hostel as directed, a member of staff took him through the initial phase of the induction process, then, less than an hour after arriving, he left the hostel having made it clear to other residents that he was determined to take illicit drugs. He died in hospital that evening.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman

May 2018

Contents

Summary	1
The Investigation Process	2
Background Information	3
Key Events	4
Findings.....	7

Summary

Events

1. Mr Christopher Elsworthy, who had a history of drug abuse, was due for release on licence from HMP Birmingham on 21 July 2017. One of the conditions of his licence was that he should reside in an approved premises on release. Following some miscommunication in the Probation Service, the manager of Stonnall Road Approved Premises agreed to provide accommodation for Mr Elsworthy. Hostel staff were aware of Mr Elsworthy's previous drug use, and had made arrangements to carry out drug tests, as well as wellbeing checks, during his stay at the hostel.
2. Mr Elsworthy was released on the morning of 21 July 2017. As arranged, police met him at the prison and drove him to a meeting with his offender supervisor. Mr Elsworthy engaged well at the meeting, said he was keen to change his lifestyle, avoiding acquaintances and areas where he might face temptation, and appeared motivated to abstain from drug abuse. The police then drove him to Stonnall Road.
3. On arrival at Stonnall Road, a member of staff took Mr Elsworthy through the induction process, including drugs issues. He had stayed in a hostel before and said he was comfortable with how they operated. He saw another resident he knew, and the resident later told staff that Mr Elsworthy asked him if he had any mamba (a synthetic drug, a type of New Psychoactive Substance). Hostel staff were unaware of this at the time. Approximately an hour after arriving at the hostel, Mr Elsworthy went out, as he was entitled to do.
4. Mr Elsworthy did not return in time to comply with his curfew that evening. Hostel staff telephoned the police, and were told that a man who was thought (and subsequently confirmed) to be Mr Elsworthy had died in hospital.
5. The inquest attributed his death to drug toxicity from synthetic cannabinoids.

Findings

6. There was some miscommunication about the arrangements for Mr Elsworthy's hostel placement. Mr Elsworthy was unaware of this, probation staff resolved the issue before his release, and it did not have any material effect on his death. Nevertheless, it could have proved problematic and if he had required any particular interventions it would have been difficult for the hostel to have addressed them at such short notice.
7. Beyond that, police and probation staff made arrangements for Mr Elsworthy to be collected from prison, escorted to his meeting with his offender manager, and then delivered to the hostel. This was all achieved without any problems. Once at the hostel, Mr Elsworthy handed in his medication correctly, received the first phase of his induction, and went out, as he was entitled to do. At both stages, issues of drug abuse were discussed and Mr Elsworthy gave no indication to staff of his intentions. It would have been hard for the hostel to have done more in the circumstances.

The Investigation Process

8. The investigator issued notices to staff and residents at Stonnall Road, informing them of the investigation and asking anyone with relevant information to contact him.
9. The investigator visited Stonnall Road on 3 August 2017. He obtained copies of relevant extracts from Mr Elsworthy's probation and medical records. He was also given access to police statements from West Midlands Police. He interviewed three members of staff and one resident. He also conducted a telephone interview with Mr Elsworthy's offender manager.
10. We informed HM Coroner for the Black Country of the investigation. He sent us the results of the post-mortem examination and we have given the Coroner a copy of this report.
11. One of the Ombudsman's family liaison officers, contacted Mr Elsworthy's sister to explain the investigation and to ask whether she had any matters she wanted the investigation to consider. She did not raise any specific issues. Mr Elsworthy's family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.

Background Information

Stonnall Road 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. Residents must abide by a curfew. They are responsible for managing their own healthcare and are expected to register with a GP.
13. Stonnall Road is an approved premises in Walsall, managed by the National Probation Service Midlands Division. It can accommodate up to 12 residents. All residents must be over the age of 18 and are required to live there as a condition of their licence, bail or a court-imposed Community Order.

Previous deaths at Stonnall Road

14. Mr Elsworthy was the second Stonnall Road resident to die since 2005. There are no significant similarities between these two deaths.

New Psychoactive Substances (NPS)

15. NPS, described in the Psychoactive Substances Act 2016, are an increasing problem across the prison and probation estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. People under the influence of NPS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

Key Events

16. On 26 June 2017, Mr Christopher Elsworthy was sentenced to eight weeks imprisonment for theft. He had a longstanding history of drug use including cannabis, cocaine and NPS. He had not stayed in Stonnall Road before but in 2016 had had a place withdrawn from another hostel because he had been found to be in possession of NPS.

Pre-release

17. Mr Elsworthy was due to be released from prison on Friday 21 July. One of the conditions of release was that he was to reside in a hostel for the duration of his licence. On 29 June, the area Multi Agency Public Protection Arrangements (MAPPA) co-ordinator, emailed the Stonnall Road hostel manager, and asked whether the hostel would be able to accommodate Mr Elsworthy on his release. Email correspondence followed, but did not reach a conclusion. On 17 July, Mr Elsworthy's offender manager, emailed the hostel manager, to say that she wanted to discuss arrangements for Mr Elsworthy's release. The hostel manager replied that she had not received confirmation of his arrival. Further discussion resulted in the hostel manager agreeing to accommodate Mr Elsworthy.

Post-release

18. On 21 July, Mr Elsworthy was released from Birmingham at 11.00am. In accordance with standard procedure, he was given seven days' supply of his medication (olanzapine, an antipsychotic medication, and citalopram, an antidepressant) until he was able to register with a GP. His police contact met him as arranged and took him to his probation appointment. They arrived at Wolverhampton probation office at 11.30am.
19. Mr Elsworthy's offender manager told the investigator that at the meeting she explained the terms of Mr Elsworthy's licence in some detail. They discussed drug use and relapse prevention, and Mr Elsworthy agreed that he should avoid associating with drug users and associates who might have a negative impact on him. He said that he was glad to be at Stonnall Road which was some distance from Wolverhampton, where he knew a number of such people. Mr Elsworthy had a possible offer of employment from a fellow prisoner who was due for release the following week. He said he had a prison discharge grant of £53, so the meeting helped him compile a list of tasks he needed to deal with as priorities, including registering with a local doctor, applying for benefits, confirming his bank account, and obtaining a mobile phone. His offender manager said in interview that Mr Elsworthy engaged well, and said that he felt like he had good support available to him.
20. After the meeting, his police contact and a colleague escorted Mr Elsworthy to Stonnall Road. CCTV footage shows that they arrived at Stonnall Road at 1.55pm and Mr Elsworthy signed himself into the hostel at 2.00pm.
21. Residents at Stonnall Road have a two-stage induction, usually conducted on each of their first two days. One of the hostel's residential workers, gave Mr Elsworthy the first stage of his induction and showed him around. Mr Elsworthy said that he had stayed in Approved Premises before and was comfortable with

the rules and the regime. He had not arrived with any possessions or toiletries and said he needed to see some friends and to buy a few things he needed. New residents must hand over any medication to staff to hold for distribution as their prescriptions specify. Mr Elsworthy gave his medication to one of the hostel's residential workers. As is standard practice for new arrivals, a hostel's residential worker, gave Mr Elsworthy drug and alcohol tests, both of which were negative.

22. While being shown around the hostel, Mr Elsworthy recognised another resident, who he had known in prison. The said resident told the investigator that Mr Elsworthy approached him and asked whether he had any mamba (a form of NPS) or if he knew who in the hostel would have some. He said that NPS was not allowed in the hostel, and he did not want to know whether anyone would have any. Mr Elsworthy said that he was shortly going into Wolverhampton to get some. He asked the resident to go with him, but the resident declined. CCTV footage shows Mr Elsworthy going into the hostel's garden at 2.22pm and speaking to another resident for a few minutes before going back inside. At 2.48pm, he signed himself out of the hostel, remaining at the office window while speaking briefly to one of the hostel's residential workers before leaving the building.
23. After Mr Elsworthy left the hostel, the resident went to the office window and told one of the hostel's residential workers, that another resident had asked him where he could buy mamba. He did not name the resident.
24. All residents are subject to curfews - times by when they are required to be in the hostel. Under the terms of his licence, Mr Elsworthy had to be in the hostel between 7.00pm and 7.00am. When 7.00pm passed and he had not returned, a hostel's residential workers telephoned to inform the police. One of the hostel's residential workers, telephoned and informed hostel manager. At 7.35pm, the police telephoned the hostel and said that a man who they believed was Mr Elsworthy had died of cardiac failure in a hospital.

Contact with Mr Elsworthy's family

25. The hostel manager, provided Mr Elsworthy's mother's details to allow them to contact her as next of kin. She subsequently contacted Mr Elsworthy's mother and she and Mr Elsworthy's offender manager visited her. In line with guidance, the Probation Service offered a contribution to the costs of Mr Elsworthy's funeral.

Support for residents and staff

26. The hostel manager spoke to staff who had had dealings with Mr Elsworthy and provided contact details for support organisations if they wanted further support. Hostel staff spoke to residents. They provided details of avenues of support if they wished to take them.

Post-mortem report

27. Post-mortem reports showed that Mr Elsworthy had taken some form of NPS prior to his death. The substance he was holding in his hand when found was also a form of NPS. The report showed that his death was due to drug toxicity from synthetic cannabinoid.

Inquest

28. The Coroner's inquest provided a verdict of death due to drug use.

Findings

Pre-release

29. The hostel only received confirmation that Mr Elsworthy would be resident in Stonnall Road two days before his arrival. As such there was no contact with the prison and minimal contact with his offender manager.
30. There was some misunderstanding within the Probation Service about arrangements for Mr Elsworthy's release. This seems to have been a simple misunderstanding, possibly exacerbated by happening during the summer when various participants had periods of leave. It all took place behind the scenes, without Mr Elsworthy's knowledge, and did not have any material input to his death. For that reason, we make no recommendation.
31. The Approved Premises Manual stipulates that referrals to hostels must be made with an up-to-date OASys assessment "well in advance of the expected release date of an offender from prison". The manual also states that, prior to the admission of a released prisoner, offender managers should provide the hostel with a full risk assessment, a supervision plan, and a risk management plan.
32. The stipulation "well in advance" is non-specific, but cannot reasonably be said to cover two days' notice. Mr Elsworthy's OASys offender assessment system was updated in July, so was current. It was available to the hostel, and did include risk management and planning information. The investigator asked the hostel manager if the short timescale made any difference to her preparations for Mr Elsworthy's arrival, and she said that it did not. She said that the hostel often had to respond adroitly to changes in offenders' risk, to changes in plans, and urgent requests to house offenders. They noted that Mr Elsworthy had a history of self-harm and rightly implemented procedures to monitor him during the night. The hostel manager was confident that there were no aspects of preparation that were not done or would have been done differently if the timescale had been longer.

Induction

33. Mr Elsworthy arrived at the hostel as planned, and one of the hostel's residential workers took him through the first phase of the induction process. There were no apparent problems. Mr Elsworthy had been resident in a hostel before and was aware of the regime. Once this procedure had been completed, Mr Elsworthy was free to leave the hostel. There were no further obligations on hostel staff at that stage, and there were no apparent reasons for staff to have any concerns about Mr Elsworthy.

New Psychoactive Substances (NPS)

34. In a Learning Lessons Bulletin, published in November 2017, after Mr Elsworthy's death, we raised concerns about the implications of NPS for the Approved Premises estate. We identified the need for testing methods to evolve and for the National Probation Service to review its drug testing policy to consider introducing testing for NPS. Further to this, in a report on the death of a resident in another Approved Premises that we published in January 2018, we

recommended that the National Probation Service implement a strategy that includes developing mechanisms to test for NPS use. The National Probation Service accepted this recommendation and said that a sub-group of the Approved Premises Continuous Improvement Governance Group had been commissioned to review all aspects of substance misuse in Approved Premises, including testing.

35. Mr Elsworthy had a history of drug use, and had had a previous hostel placement withdrawn after he was found with NPS. Mr Elsworthy's offender manager, knew him from previous supervision, had been in ongoing contact with his offender supervisor in prison and had good insight into his previous drug use. At the meeting on his day of release, they addressed issues around his drug usage, including relapse prevention. Mr Elsworthy's offender manager said in interview that Mr Elsworthy seemed genuine in his insistence that he wanted to try and abstain from drugs. He expressed satisfaction that he had been placed in a hostel away from his home area, where he would not come into contact with acquaintances from the drug culture. Although it later became apparent that Mr Elsworthy's intentions were different from those he expressed, we are content that the offender manager was aware of drug use as an issue for Mr Elsworthy and addressed it appropriately.
36. One of the hostel's residential workers gave Mr Elsworthy a drug test on arrival at the hostel, which was negative. The test would not detect NPS. Mr Elsworthy had been with police and probation staff since leaving prison so would have had limited opportunity to buy or take any drugs. Both the offender manager and a hostel's residential worker said that Mr Elsworthy did not appear to be under the influence of anything. Mr Elsworthy approached another resident and asked whether he had any NPS. When told not, Mr Elsworthy said that he was going into Wolverhampton to get some. The other resident did report this to hostel staff, although he did not name Mr Elsworthy and did not report it until after Mr Elsworthy had left the hostel. As Mr Elsworthy did not return to the hostel after this, staff had no opportunity to explore this with him. Staff had no reason to anticipate his actions when he left the hostel.

**Prisons &
Probation**

Ombudsman
Independent Investigations