

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr John Quinn a resident at Howard House Approved Premises on 31 October 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.

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 John Quinn died on 31 October 2016, while a resident at Howard House Approved Premises. His cause of death was unascertained. Mr Quinn was 49 years old. I offer my condolences to Mr Quinn's family and friends.

Mr Quinn had a long history of alcohol misuse. Staff at Howard House appropriately supported him to address his alcohol misuse and followed correct processes when he was found to have consumed alcohol, and later when he absconded from the premises.

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

**Richard Pickering**  
**Deputy Prisons and Probation Ombudsman**

**February 2017**

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# Summary

## Events

1. On 13 June 2016, Mr John Quinn was released on licence from prison to Howard House Approved Premises in Leicester. He had a history of alcohol misuse, and associated offending behaviour. Mr Quinn was required to be in Howard House between 11pm and 6am, to abstain from alcohol and comply with daily alcohol tests.
2. In June, after the death of his mother, Mr Quinn failed to comply with his sentence plan by consuming alcohol. His offender manager gave him a formal warning.
3. In October 2016, when questioned by probation staff, Mr Quinn admitted to smoking cannabis in Howard House. His offender manager escalated this to the director of Leicestershire and Rutland Probation, as he was concerned about Mr Quinn's behaviour and risk of re-offending. Mr Quinn was given a director's warning for failing to comply with his sentence plan.
4. On 22 October, Mr Quinn tested positive for alcohol. He initially denied drinking as he believed this would result in his immediate recall to prison. When he admitted to staff that he had consumed some alcohol, they advised him to wait until he saw his Offender Manager and not to assume recall was imminent.
5. On 23 October, Mr Quinn left Howard House for the day. He did not return that evening by his curfew time. Staff attempted to make contact with him by phone. When they could not, in line with protocol, they started the emergency recall process.
6. Mr Quinn did not return and was found dead in a property in Leicester on 31 October 2016.

## Findings

7. Mr Quinn had a history of alcohol misuse associated with his offending behaviour. When released from prison, staff at Howard House Approved Premises ensured that he was aware of the conditions of his licence and made the relevant referrals to alcohol specialists to address his alcohol use. Mr Quinn was tested for alcohol on a daily basis.
8. When he breached the conditions of his sentence plan and licence, staff took the correct steps of issuing a formal warning in the first instance, and then a director's warning in the second. When Mr Quinn did not return to Howard House on 23 October, staff made attempts to contact him, before completing the process of recalling him to prison.
9. We are satisfied that probation staff fully supported Mr Quinn. Staff encouraged him to engage with the alcohol support services and appropriately monitored his alcohol use through regular testing.

## The Investigation Process

10. The investigator issued notices to staff and residents at Howard House Approved Premises informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
11. The investigator obtained copies of relevant extracts from Mr Quinn's Probation records, and spoke to relevant members of staff on the telephone for clarification.
12. We informed HM Coroner for Leicester City & South District of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
13. Mr Quinn's family received a copy of the initial report. They pointed out two factual inaccuracies. This report has been amended accordingly.
14. The initial report was shared with National Probation Service Midlands and NOMS (National Offender Management Service). They did not find any factual inaccuracies.

# Background Information

## Howard House Approved Premises

15. Approved premises (formerly known as probation and bail hostels) mostly accommodate offenders released from prison on licence and those directed there by the courts as a condition of bail. Their purpose is to provide a supportive and structured environment. Residents are responsible for their own healthcare and are expected to register with a GP.
16. Howard House is one of two approved premises in the Leicestershire area, managed by the National Probation Service. Howard House has eight shared rooms and five single rooms. Breakfast and evening meals are provided. There is a communal area for dining and socialising and areas set aside for group work. A key worker is allocated to each resident, with whom the resident discusses their progress and well-being. The key worker also ensures that residents adhere to their individual licence conditions and the rules of the approved premises. Howard House is staffed 24 hours a day by probation employees.

## Previous deaths at Howard House Approved Premises

17. There has been one previous death at Howard House, with which there are no significant similarities.

## Key Events

18. On 13 June 2016, Mr John Quinn was released on licence from HMP Hollesley Bay to Howard House Approved Premises (AP), after serving five years for arson and breaching a restraining order. He was allocated an Offender Manager. They met weekly at Leicester Probation Office.
19. After his arrival at Howard House on 13 June, a Probation Service Officer (PSO) went through Mr Quinn's licence conditions with him. After she had clarified that he understood what was required of him, Mr Quinn signed the licence. In addition to the standard licence conditions, Mr Quinn was required to comply with requirements set by his supervising officer to address his alcohol misuse. These requirements were implemented as part of his sentence plan (an assessment of an individual's offending needs and associated risks, and a plan, the primary purpose of which is to address the identified needs and risks).
20. At this appointment Mr Quinn signed the AP compact, which included the curfew rules. This document records that Mr Quinn had to reside at Howard House between the hours of 11.00pm and 6.00am. Mr Quinn completed his GP registration forms and signed a medication contract agreeing to take his medication under the supervision of probation staff. Mr Quinn was prescribed mertazapine (an antidepressant and anti anxiety medication), simvastatin (to manage high cholesterol) and omeprazole (to manage acid reflux).
21. Mr Quinn was required to sign for his medication, and his medicine checklist confirms that probation staff gave his medication to him daily.
22. As a requirement of his sentence plan, the PSO recorded in NDelius (the Probation case management system), that the consumption of alcohol was a trigger to Mr Quinn's offending behaviour, and that if he consumed alcohol, a recall to prison should be initiated. She further recorded that Mr Quinn should be tested for alcohol consumption on a daily basis.
23. The Offender Manager referred Mr Quinn to Turning Point (a social enterprise, providing specialist and integrated services which focus on improving lives and communities across mental health, learning disability, substance misuse, primary care, the criminal justice system and employment). On 15 June, Mr Quinn attended his first appointment with an alcohol worker at Turning Point.
24. The alcohol worker told the investigator that Mr Quinn saw him on a weekly basis and described him as very motivated to address his alcohol misuse.
25. On 27 June, a PSO tested Mr Quinn for alcohol. He tested positive. She gave this information to his Offender Manager. Mr Quinn told his Offender Manager that he had used alcohol to try and manage his emotions as his mother had died on 10 June, three days prior to his release. For this breach of his sentence plan, the Offender Manager gave him a formal warning.
26. On 13 July, the Offender Manager received call from Mr Quinn's previous offender supervisor at Hollesley bay. They advised him that they were listening into calls of a prisoner. On one occasion this prisoner spoke to Mr Quinn. During the call, Mr Quinn said that he had 'sussed out alcohol testing at Howard

- House, and that you can have a drink in the afternoon and it will be clear by the 10pm test'. The Offender Manager relayed this information to the AP staff, however it was agreed to not discuss this with Mr Quinn, as they considered that it could be bravado. To manage this potential risk, the AP manager requested that his alcohol tests were increased to two per day.
27. On 8 July, Mr Quinn asked the criminal justice drugs team at Turning Point to prescribe him antubuse (a drug that blocks an enzyme that is involved in metabolising alcohol intake. It produces unpleasant side effects when combined with alcohol in the body). He remained on antubuse for three months, and at his request, a joint decision was made with his GP that he was ready to stop taking it. The alcohol worker informed the investigator that it is normal to stop using antubuse between three and six months.
  28. Between July and October, Mr Quinn received no warnings, provided daily negative alcohol tests and attended weekly appointments with his Offender Manager and alcohol worker.
  29. On 4 October, Mr Quinn was challenged by probation staff as the smell of cannabis was coming from his bedroom. Mr Quinn denied any drug use, but days later when in supervision with his Offender Manager, he admitted to smoking cannabis. The Offender Manager recorded in NDelius that the use of alcohol and drugs concerned him and that Mr Quinn was at an increased risk of re-offending. He therefore escalated his concerns to the Director of Leicestershire and Rutland Probation, and on 17 October Mr Quinn was issued with a director's warning. Delius records indicate that Mr Quinn understood that he could be at risk of recall should he breach his licence conditions again.
  30. On 22 October, Mr Quinn went out for the day, and met his family at approximately 4.30pm. He returned to Howard House at 8:50pm and a Relief AP Officer tested him for alcohol consumption. Mr Quinn tested positive for alcohol with a reading of 20 micrograms per 100 millilitres of breath. (35mcg per 100ml is the legal limit for driving.)
  31. Mr Quinn denied having any alcohol to drink, so another test was completed, showing a reading of 0.19 micrograms of alcohol per 100 millilitres of breath. He continued to claim that he had not drunk anything, blaming fault on the test. A member of staff therefore agreed to take a test themselves, which showed a zero reading.
  32. An entry in Delius indicated that Mr Quinn repeatedly said that he would be recalled to prison, before leaving the main office and going to his room.
  33. In the early hours of 23 October, Mr Quinn came to the main office and told staff that he had consumed alcohol the day previously. He acknowledged that it was likely that he would be recalled to prison. The Relief AP Officer tried to explain to Mr Quinn that he should wait until seeing his Offender Manager on the Monday before concluding that recall was definite.
  34. Later that day, Mr Quinn left the hostel and failed to return for his 11pm curfew. The Relief AP Officer told us that she made all efforts to contact Mr Quinn directly, and contacted the local hospital. As she was unable to locate him, the

AP manager initiated an emergency recall. He informed the police and the Offender Manager, who needed to initiate a full recall when he returned to work.

35. On Monday 24, the Offender Manager completed the full recall processes. He told the investigator that later that day he received a call from Mr Quinn's sister. She told him that Mr Quinn had left the country and had arrived at their family's home in Southern Ireland. She said that her family were frightened by his erratic behaviour, so had called the police.
36. The Offender Manager contacted the local police department in Leicestershire. They confirmed that information was received from the Garda Síochána (Southern Irish Police) regarding a call from Mr Quinn's relatives. There was no further contact from the police, and Mr Quinn's location remained unknown.
37. On 31 October the Offender Manager received a call from the coroner's office informing him that Mr Quinn was found dead in a property in Leicester that day.

### **Contact with Mr Quinn's family**

38. Following Mr Quinn's death, the Leicestershire Police contacted Mr Quinn's son to inform him of his father's death. During the time that Mr Quinn was missing, the Offender Manager had established a relationship with Mr Quinn's family. He remained in contact with them after Mr Quinn's death.
39. Mr Quinn's funeral was held on 30 May, and the National Probation Service offered a contribution towards the costs in line with national policy.

### **Support for residents**

40. After Mr Quinn's death, the AP posted notices informing other residents of Mr Quinn's death, and advised them to speak to staff and management should they wish to access independent support.

### **Post-mortem report**

41. The doctor who completed the post-mortem concluded that there was no evidence to suggest that trauma or natural causes resulted in his death. Although three times over the legal limit to drive, the toxicology analysis did not reveal a high enough level of alcohol in Mr Quinn's body to conclude this as the cause of death. He states that it was possible that Mr Quinn was unconscious for a period of time before he died, and therefore the alcohol level in his system would be lower than when he initially became unwell. However, it is not possible to prove this pathologically. The cause of Mr Quinn's death therefore remains unascertained.

# Findings

## Alcohol and drug use

42. As part of his licence conditions, Mr Quinn was required to attend meetings with his alcohol support worker at Turning Point. He attended his appointments as required and his Offender Manager noted that he was in a positive frame of mind and wanted to engage with this service
43. Staff appropriately tested Mr Quinn's alcohol use. He tested positive for alcohol on two occasions, and on another admitted to smoking cannabis in Howard House. In all instances Mr Quinn was appropriately warned and made aware of the consequences should he breach his sentence plan and conditions of his licence again.
44. Mr Quinn had a significant amount of independence and autonomy at Howard House and although staff supported him in abstaining from alcohol and followed the relevant procedures, they could not monitor him all of the time. There is nothing that staff at Howard House could have done to prevent his death.

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