

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ian Holmes a resident at Cardigan House Independent Approved Premises on 24 May 2018

A report by the Prisons and Probation Ombudsman

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 Ian Holmes died on 24 May 2018 while a resident at Cardigan House Independent Approved Premises. The post-mortem examination found that the most likely cause of his death was heroin toxicity. Mr Holmes was 47 years old. I offer my condolences to those who knew him.

Mr Holmes was released from prison the day before he died. He had a long history of offending behaviour, linked to substance misuse. He was allocated a place at Cardigan House before he was released from HMP Moorland as he was at high risk of reoffending.

Mr Holmes was at Cardigan House for less than a day. During that time, staff managed him appropriately. However, I am concerned that Cardigan House did not contribute towards his funeral costs in line with national instructions.

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

Sue McAllister CB
Prisons and Probation Ombudsman

March 2019

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Summary

Events

1. On 23 May 2018, Mr Ian Holmes was released from HMP Moorland to Cardigan House Independent Approved Premises.
2. He arrived at Cardigan House at 2.45pm, and had an induction with a case manager. Mr Holmes signed a document to say that he understood the rules of the approved premises, which included having to remain on site between 11.00pm and 6.00am.
3. Mr Holmes then met the manager of Cardigan House. She recorded that he had used crack cocaine before he arrived at the approved premises, and advised him to not use any more drugs that day due his lowered tolerance. Mr Holmes agreed not to.
4. At 4.30pm, Mr Holmes left Cardigan House. He did not return by the 11.00pm curfew, and staff initiated enforcement procedures.
5. At 1.40am on 24 May, police officers arrived at Cardigan House, and told a support worker that Mr Holmes had died in hospital after a drugs overdose. The post-mortem examination established that he had most likely died of heroin toxicity.

Findings

6. We found that staff had managed Mr Holmes appropriately during his very brief stay at Cardigan House: they had given him an induction and advice about how to reduce his risk of harm from drugs. Staff could not have prevented his death.
7. However, staff did not take steps to ensure that the National Probation Service contributed to the costs of Mr Holmes' funeral.

Recommendation

- The National Probation Service should ensure that staff at independent approved premises understand the procedures to follow after a death in custody to ensure that they contribute towards a resident's funeral costs in line with national instructions.

The Investigation Process

8. The investigator issued notices to staff and residents at Cardigan House informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
9. The investigator obtained copies of relevant extracts from Mr Holmes' prison and probation records.
10. We informed HM Coroner for West Yorkshire Eastern District of the investigation who gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
11. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

Cardigan House Independent Approved Premises

12. 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.
13. Cardigan House is one of two approved premises in the Leeds area, and is owned by Progress to Change, a charity, and works in close partnership with the Ministry of Justice, the National Probation Service and Community Rehabilitation Companies. It is contractually funded by the Ministry of Justice.
14. Cardigan House has 25 single rooms and one double room. A key worker is allocated to each resident to discuss their progress and wellbeing. The key worker also ensures that residents adhere to their individual licence conditions and the rules of the approved premises. Cardigan House is staffed 24 hours a day by employees of Progress to Change.

Previous deaths at Cardigan House

15. There was one previous death at Cardigan House in 2013 but there are no similarities between this case and that of Mr Holmes' death.

Key Events

16. On 22 September 2017, Mr Ian Holmes was sentenced to eight months in prison, with a four-month post-sentence supervision period for possession of a bladed article and breach of a sex offender notification requirement. He was sent to HMP Moorland, and remained there until 22 January 2018, when he was released on licence to Cardigan House Independent Approved Premises in Leeds. That day, Mr Holmes did not return in time for his curfew and was recalled to Moorland.
17. On 17 May, while a prisoner at Moorland, Mr Holmes met a drugs worker. They discussed that he was soon to be released, and she noted in Mr Holmes' contact record that she had advised him about harm reduction, that he was aware that his tolerance to drugs was lowered, and that he was therefore at risk of overdose if he used drugs on release. She told Mr Holmes that she had arranged an appointment for him on 24 May at a Drug Intervention Programme Team.
18. On 23 May 2018, Mr Holmes was released to Cardigan House. He arrived at 2.45pm and met a case manager who completed his induction. She discussed the post-sentence supervision requirements with Mr Holmes, and explained that although he was not on licence, he needed to comply with the rules of the approved premises, including that he should remain on site between 11.00pm and 6.00am.
19. Mr Holmes arrived at Cardigan House with two different medications to manage his epilepsy. As part of his induction, Mr Holmes completed his GP registration forms and agreed to take his medication under the supervision of probation staff.
20. Mr Holmes' offender manager was due to see him weekly at a probation office.
21. The case manager noted in NDelius, the probation case management system, that a member of staff who worked at Engage Leeds, a charitable organisation that supports those with complex needs, including substance misuse and offending behaviour, was scheduled to collect Mr Holmes on 24 May to prescribe him subutex at a drugs and alcohol service for adults.
22. The manager of Cardigan House met Mr Holmes at approximately 4.00pm on 23 May. During their conversation, Mr Holmes told her that he had celebrated his release by using crack cocaine. She recorded in NDelius that she had warned him about the risks of using more drugs that day, due to his lowered tolerance. He assured her that he understood.
23. At 4.30pm, Mr Holmes left Cardigan House and did not return in time for the 11.00pm curfew. A support worker noted in NDelius that staff had been contacted to start enforcement procedures as Mr Holmes had breached the requirements of his order.
24. At approximately 1.40am on 24 May, two police officers from the Leeds Police Service attended Cardigan House. They informed a support worker that Mr Holmes had been found in Leeds city centre, having overdosed on drugs, and that he was taken to hospital, where he had later died.

Contact with Mr Holmes' family

25. On 24 May, when the police told staff at Cardigan House of Mr Holmes' death, they looked through his belongings and records to locate his next of kin but found no details. The police and the Coroner's office subsequently tried to find details for Mr Holmes' next of kin but were unsuccessful.
26. Staff at Cardigan House had no further contact with the police. They confirmed that they did not contact the Head of Public Protection to arrange for the National Probation Service to contribute to the costs of Mr Holmes' funeral, which took place on 15 August 2018, and was paid for by the National Health Service (NHS).

Support for staff

27. Staff at Cardigan House discussed Mr Holmes' death in a team meeting on 29 May. Although most staff had not had contact with him, they were advised how to seek support if they were affected by his death.

Post-mortem report

28. The Coroner concluded that Mr Holmes most likely died of heroin toxicity. Toxicology results indicated that he also had gabapentin, cocaine, mirtazapine in his bloodstream at the time of his death, as well as low levels of amitriptyline and carbamazepine. The Coroner concluded that these other substances were less likely to have contributed to Mr Holmes' death.

Findings

Care at Cardigan House

29. When Mr Holmes arrived at Cardigan House on 23 May 2018, he reported immediately to a member of staff, who completed his induction.
30. Staff appropriately managed his risk of re-offending and harm, associated with substance misuse. Mr Holmes was required to sign an agreement to take his epilepsy medication in front of staff. Staff arranged an appointment for Mr Holmes to meet drug intervention services the following day. Before he left the approved premises, Mr Holmes was made aware of the risks of using drugs as his tolerance would have lowered.
31. Staff at Cardigan House did all they reasonably could to manage Mr Holmes, and could not have prevented his death.

Contribution towards funeral costs

32. Although not noted in Mr Holmes' records, staff told the investigator that approximately two months after his death, the person, who was responsible for patient affairs at the hospital's trust, contacted her to ask if Mr Holmes had any valuable belongings to offset his funeral costs, which the NHS had met. It was confirmed that he did not.
33. If a resident dies while under the care of an approved premises and has no next of kin, the National Probation Service is expected to offer a contribution towards funeral costs, regardless of whether or not the approved premises is independently managed.
24. As Cardigan House is an independent approved premises, they cannot directly offer a financial contribution towards funeral costs. However, they are managed on behalf of the National Probation Service, and we would have expected staff at Cardigan House to contact the Head of Public Protection and the local delivery unit after Mr Holmes' death to arrange for the National Probation Trust to contribute towards the funeral costs. We make the following recommendation:

The National Probation Service should ensure that staff at independent approved premises understand the procedures to follow after a death in custody to ensure that they contribute towards a resident's funeral costs in line with national instructions.

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