

**Circumstances surrounding the death of  
a resident at an Approved Premises, in  
Cheshire Probation Area, on 26 August 2005**

**Prisons and Probation Ombudsman for England and Wales**

**April 2006**

The man was 38 years old when he died on 26 August 2005, after apparently injecting himself with heroin shortly after arriving at the Approved Premises. He had been released from prison that morning, on parole licence, with a condition that he should reside at an Approved Premises situated in the Cheshire Probation Area.

The loss of any family member is distressing, but especially so in the circumstances described in this report. The man had a mild learning disability, and appears to have accidentally ended his own life. My colleagues and I offer our sincere condolences to his family and friends.

A member of my office carried out the investigation. I wish to thank the manager of the approved premises, for making the necessary facilities and information available to my investigator. Additionally, I thank a clinician from Cheshire and Wirral Partnership NHS Trust, for her invaluable assistance in providing comprehensive information regarding the man's learning disability.

In the course of the investigation, I asked for a clinical review to be carried out into the care and treatment received by the man. I am grateful to a doctor from Chorley and South Ribble Primary Care Trust, for her assistance.

My report contains information obtained from Cheshire County Council, made available to my investigator by the Probation Service. Their assessment clearly identifies the long term support needed by the man in order to live in the community, and confirms that he would have been eligible to receive the help. Sadly, the plans did not materialise as his life ended within hours of his release from prison.

**Stephen Shaw CBE**  
**Prisons and Probation Ombudsman**

**April 2006**

## **Contents**

Summary	4
Conduct of the investigation	5
The man	6
Secure unit	9
The Prison	10
The Approved Premises	11
Key Findings	12
Events Following Release From Prison	19
Clinical Review	23
Issues considered in the investigation	25
Issues raised by the man's family	27
Recommendations	28
Annexes	29

## Summary

1. On 25 August 2002, the man and his co-accused were charged with robbery following an incident at a petrol station in Cheshire in which an imitation firearm was used. He and his co-defendant were remanded in custody and taken to a prison in Merseyside.
2. Whilst in prison, the man underwent a mental health assessment. On 22 November 2003, he was transferred from prison under Section 38 of the Mental Health Act 1983 and placed in the care of Cheshire and Wirral Partnership NHS Trust. He remained in their care and lived as an in-patient at a secure unit.
3. The man was finally sentenced on 13 February 2004 at a Cheshire Crown Court to six years imprisonment, after pleading guilty to an offence of robbery with intent. His co-defendant received a sentence of eight years imprisonment. Following his conviction, the man returned to prison for assessment and allocation to a suitable prison. He was initially allocated to a prison in the Lancashire area and later in his sentence to another prison in the same area.
4. The man made good progress whilst in prison, gaining basic qualifications in literacy and numeracy skills and worked towards addressing his offending behaviour. Such was his improvement that his application to be released on parole licence was supported by prison and probation staff. On 26 August 2005, he was released from prison.
5. One of the conditions of his parole licence was that he should live at an Approved Premises, which is where he was taken by two staff employed by Cheshire and Wirral Partnership NHS Trust. He arrived in the early afternoon and, following a short induction meeting, he left the building with, a resident, who was apparently unknown to him. The resident said that the man asked him for a syringe, which he agreed to give him. The evidence suggests that both men went to a local canal, where the man apparently injected himself in the arm. He collapsed very soon afterwards and did not regain consciousness. The man died on the canal footpath.
6. My report covers a range of issues, including the response of the Probation Area to the man's death – about which I make a number of recommendations.

## Conduct of the Investigation

7. Once my office had been notified of the man's death, the investigation was allocated to a senior investigator from my office. He opened the investigation on 2 September by meeting a member of the Approved Premises staff who was temporarily in charge whilst the managers were away from the building. He gave my investigator an overview of what had occurred on 26 August. The investigator also met a resident of the Approved Premises. The resident co-operated with my investigation and gave his account of what had happened.
8. On 6 September, one of my Deputy Ombudsman, and the investigator visited the prison where the man had been prior to his release and spoke to a number of prison officers who had known him. Additionally, they talked to the prison chaplain, to a prison based probation officer, and to a prisoner who lived in a neighbouring cell to the man.
9. At the beginning of the following month, one of my family liaison officers (FLOs) and my investigator met the man's sister and brother in law at their home. They raised a number of questions and concerns, which the investigation has considered:
  - did the man obtain and use drugs in prison?
  - did he undergo a medical assessment prior to being released?
  - why was he allowed to leave the Approved Premises unaccompanied?
10. On the following day, 4 October, the investigator travelled to the Approved Premises to begin interviewing staff identified as able to contribute towards my investigation. In total, he interviewed five probation staff employed at the Approved Premises, together with the man's home probation officer and the resident. He completed all interviews on 17 October.
11. Additionally, having asked Chorley and South Ribble Primary Care Trust to carry out a clinical review of the man's medical care and treatment, his prison medical record was forwarded to them for their consideration.
12. Finally, on 12 January, my investigator met a consultant nurse from Cheshire and Wirral Partnership NHS Trust, at the secure unit. She gave an overview of the man's skills and learning disability. Also at that meeting was a community learning disability nurse from the Central Cheshire Community Health Team.

## **The Man**

13. The man was born in 1967, and was 38 years old when he died on 26 August. He grew up in Cheshire, along with his two brothers and one sister. Due to a learning disability, he was educated at schools for pupils with special needs rather than in mainstream schools. After leaving school, he was never fully employed.
14. He first began to get into trouble following the death of his mother 20 years ago, with the majority of his offending being carried out whilst under the influence of alcohol. His father died some time later, leaving him to be supported by his family and Social Services.
15. The man loved football, and was a keen supporter of both his local team and Manchester United. He had proudly worked as the club mascot of his local team, and was often seen running around the ground during match days wearing his mascot costume. Following his death, the football club paid tribute to him by making an announcement and placing a picture of him a match day programme. His family were allowed to spread his ashes on the football pitch. His other great love was his music collection.
16. Prior to being imprisoned, the man lived in an area of Cheshire, with help from the Social Services Department and some domiciliary care. This was provided by a care provider offering low level practical and social support. As an adult, the man lived for periods in staffed residential homes and at other times in his own rented accommodation with domiciliary care. He had previously been a resident at a homeless person's unit, but it had not been a good experience as other residents were known to have bullied him.

## **The Man's Learning Disability**

17. The man's family described him as someone whose behaviour was at times annoying, rather than harmful. He would get simple things wrong, such as calling for an ambulance when he really wanted a taxi.
18. He first came into contact with dedicated learning disability health services in about 1985. He was assessed as having a mild learning disability, which in his case meant he had a limited capacity to consider the consequences of his actions. He was unusually receptive to the suggestions of other people, and this would often lead him to behave in ways that were not in his best interest.
19. There are a range of definitions which apply to the term learning disability including diagnostic, legal and service eligibility definitions. Although the definitions vary, learning disability is usually categorised as being:
  - Profound
  - Severe
  - Moderate

➤ Mild

➤ Borderline

20. In his case, the learning disability was assessed as mild, which reduced his ability to cope independently as his social functioning was impaired. For example, although he could travel unaccompanied in areas that were familiar to him, he would not have been able to negotiate a journey to an unknown place on his own.
21. People with learning disabilities are entitled to the same services, including health and welfare services, as everyone else. However, it is also recognised that many people with learning disabilities require additional help to assist them with specific needs to access and benefit from mainstream services.
22. A range of dedicated services are available in most areas to meet the needs of people with learning disabilities. These include some services that are provided by statutory services and others that are provided by independent and voluntary sector organisations. People with learning disabilities are also entitled to access and receive the same range of primary and mental health services as everyone else.
23. In common with others, some people with learning disabilities have difficulties with their behaviour. This can include engaging in behaviour which may cause them harm. For example, self-injury, deliberate self harm, placing themselves at risk and behaviour that results in harm to others. Whenever the person has a profound or severe learning disability, this is usually referred to as 'challenging behaviour' and dealt with entirely by the services responsible for the person's care. When the person is more able i.e. with moderate, mild or borderline learning disabilities, the behaviour, particularly if there is a significant risk to others, may be viewed as offending behaviour that warrants involvement from the criminal justice agencies.
24. In order to meet the needs of people with learning disabilities, local authority social services departments provide some services directly and are also responsible for commissioning services from other providers. Direct services include assessment of need and risks and the development of care plans to address the needs and risks identified. Local authority social services departments may purchase various services provided by independent and voluntary sector organisations, for example, domiciliary care, housing support, day care and supported employment.
25. In Cheshire, local authority social services include adult learning disability teams based in East and Central Cheshire. Input from these teams, both in terms of direct provision and commissioning of other services, normally remains the responsibility of the team located in the area where the person comes from. Historically, the man had received services from East Cheshire Adults with a Learning Disability Team, and would have continued to do so, despite being accommodated in the central Cheshire area.

26. In the area where the man lived before going to prison, and the area he was to live on release, the specialist learning disability health services are provided by Cheshire and Wirral Partnership NHS Trust. The Trust's services for adults with learning disabilities include seven community health teams and four in patient assessment and treatment units. These services are arranged and provided in localities, and people normally access the team and/or unit serving the geographical area where they are residing. Prior to going to prison, the man received services from the East Cheshire Community Health Team, and in-patient services at the secure unit. On release from prison, arrangements were made for him to receive input from the Central Cheshire Community Health Team.

## **The Secure Unit**

27. The adult learning disability services provided by Cheshire and Wirral Partnership NHS Trust includes the secure unit. The unit provides 15 medium secure hospital beds. This service is regional and serves the population of Cheshire and Merseyside. The unit provides in-patient assessment and treatment services to adults with learning disabilities who pose a risk of harm to others and require hospital care in a secure environment.
28. All patients in the unit are detained subject to the provisions of the Mental Health Act 1983. They are held under the category of mental impairment, either for the purpose of assessment, or for treatment. In order to justify ongoing detention for treatment, the detaining hospital must be able to demonstrate that treatment will alleviate, or prevent deterioration in the patient's mental condition. In the man's case, treatment provided would have been focussed on assisting him to change his behaviour. Prior to sentence, the man's response to hospital treatment as an in-patient was assessed over a considerable period, with the conclusion that he would not benefit from the treatment available at the unit.
29. The services provided at the secure unit include a small Forensic Outreach Team. The team manages arrangements for admission to the secure unit and works with local services to facilitate discharge. The team also works closely with the Trust Learning Disability Community Health Team to assist them to respond effectively to referrals for people with learning disabilities, convicted of offences, or engage in offending behaviour.

## **The Prison**

30. The prison is a Category C training prison, located in Lancashire. Half the prison provides accommodation for vulnerable prisoners. Vulnerable prisoners are those who have asked to be kept separate from the normal accommodation areas of the prison, usually for their own safety and protection.
31. In December 2003, the prison was inspected by HM Chief Inspector of Prisons. The inspection found that 81 per cent of the prisoners surveyed felt safe, and that the relationships between prisoners and staff were respectful. The Chief Inspector described the prison as a good, well managed prison.

## The Approved Premises

32. Approved Premises, formally known as Probation and Bail Hostels, are approved by the Secretary of State within Section 9 of the Criminal Justice and Court Services Act 2000. Their purpose is to provide an enhanced level of residential supervision in the community, as well as a supportive and structured environment.
33. It is one of two Approved Premises available in the Cheshire area. Alternative premises are available however in the area. However, due to the nature of some of the man's offending history, the alternative was seen as unsuitable for him.
34. Both premises provide a resource to the Cheshire Courts and have the following aims:
  - protect the public
  - prevent re-offending
  - provide residents with an opportunity to address their problems in a safe, stable environment
  - enable residents to face up to their offending behaviour
  - complete the conditions of their order or licence
  - facilitate their resettlement into the community.
35. Outside agencies are available to provide support and advice regarding drug misuse and alcohol problems. A doctor and community psychiatric nurse visit and support the work of the premises.
36. All residents are expected to abide by the rules and regulations of the Approved Premises, including observing a strict overnight curfew. During the day, residents are free to go out of the premises unaccompanied and without stating where they are going.

## Key Findings

### *Events prior to 26 August 2005*

37. Prior to receiving his prison sentence, the man had been assessed by a psychiatrist on behalf of the sentencing Judge who had asked for a psychiatric report. The report noted that the man had been admitted on two occasions to the secure unit. It went on to say that the treatment had not brought about a positive change in his behaviour. The report concluded that he would probably benefit from some form of specialist input, but could not identify a suitable provider. The court dealt with the offence by imposing a six year prison sentence.
38. The combination of his suggestibility and underlying learning disability made the man vulnerable to exploitation and, whilst serving his prison sentence, he was treated as a Vulnerable Prisoner.
39. Having been identified and treated as a Vulnerable Prisoner, he coped well with his custodial sentence and appeared to thrive in a secure, structured and settled environment where the boundaries were clearly defined. However, because of the highly structured nature of the prison regime, those involved in his management came to the opinion that he was not developing the social and practical skills necessary for successful reintegration back into the community.
40. The man's home probation officer and the prison's probation officer completed a report for the Parole Board. The length of his sentence meant that he was eligible for consideration to be released on parole. In their report, they said that his interests, and that of the wider community, would be better served by him spending a longer period of time in the community under probation supervision. It was envisaged that he would then be able to develop the skills necessary for independent living, through using one-to-one supervision with his probation officer.
41. As part of the process for completing the man's parole report, on 8 March 2005, the probation officer faxed a copy of National Probation Service, Bail Referral Form, to the Approved Premises for their consideration. The reason for faxing the document was to give them the opportunity to comment on whether they considered the premises suitable for the man. The deputy manager at the Approved Premises supported the application and agreed to accept him if he was granted parole. The probation officer informed the Parole Board that, providing the man's application to be released on licence was successful; he would be accepted as a resident.
42. The Bail Referral Form contains a large amount of information relating to the man's offences and also a summary of the issues concerning his vulnerability. The probation officer made the following entries relating to specific headings:

**Any history of substance misuse:**

- *previous heavy drinking when not occupied and little support in the community.*

**Mental health/learning disability:**

- *The man has an IQ between 50 and 70 and very limited literacy skills. Has a mild learning disability with a moderate degree of functioning. He becomes more dysfunctional when under stress and is highly suggestible. Has been subject to in-patient treatment previously under MHA (Mental Health Act).*

**Vulnerable to abuse or bullying:**

- *The man could be vulnerable to abuse/bullying given the nature of his learning difficulties and suggestibility.*

**What is the defendant's view of Probation Hostel condition:**

- *The man is anxious about residing in a hostel and how he would cope. He would require increased support and supervision.*

43. In addition to the Bail Referral Form, the deputy manager received a copy of Cheshire County Council NHS Standard Assessment Document, which was faxed to her on 16 August 2005. The document gives a clear picture about the man's needs in relation to his ability to look after himself, particularly if living in tenancy accommodation. I have included a number of the entries here:

- *The man will require support to prepare for life in the community. To build and learn new skills in relation to maintaining independence, effective budgeting and understanding the responsibilities of becoming a tenant.*
- *Limited understanding of effective budgeting and is vulnerable to financial exploitation from others.*
- *Considered being very vulnerable, and open to suggestion from his peers. He has an extensive record of offences and does not appear to be able to make a link between "cause and effect".*
- *The man will need support to ensure that he does not give access to people who may exploit his vulnerability.*
- *His behaviour is described as not being able to empathise with others or foresee the consequences of his own behaviour. Easily influenced by his peers and does not seem to be able to differentiate between genuine interest in him and those who wish to exploit his vulnerability.*

- *Specialist support service will be required to work closely with his support staff to ensure that he is fully informed and enabled with information that he can comprehend.*

44. Under the heading of Self-Care, the document adds:

- *without ongoing support, the man would be at high risk of compromising his tenancy and significant risks to his well being.*

45. To become eligible for support in the community, the man's needs had to be considered. At page 11 of the document, under the heading of Summary of Needs to be Considered for Eligibility, there are six areas to be considered. In addition, under each of the sub headings the assessor is required to show the degree of risk, immediacy of need and description of need. The man was assessed and it was noted that there was a substantial degree of risk and immediate long term needs in all aspects of his life. The description of need for the six areas was:

#### **Accommodation**

- *The man needs support to ensure that risks to any tenancy he may secure in the future are minimised*

#### **Communication**

- *Support to ensure that the man understands information given to him*

#### **Social/relationships**

- *Support to minimise the risks of the man establishing inappropriate relationships and re-offending. Researching and facilitating access to activities and community resources appropriate to the man's needs and abilities*

#### **Self Care**

- *Support to ensure that he achieves as much independence as possible, to manage daily living tasks*

#### **Physical health**

- *Support to ensure that he is able to access medical/ specialist services if required*

#### **Mental health**

- *Support to ensure that he is able to access medical/ specialist services if required.*

46. The assessor concluded that the man was eligible to receive help and assistance to meet his needs. The report assessment was shared with the Probation Service and included with the documents passed to the Approved Premises for their consideration when deciding if it was suitable for him.
47. During her interview, the deputy manager said that, although the man had a learning disability, the premises were suitable for someone with his needs. She explained that, had it been identified that the man needed to be escorted by staff when leaving the premises, a place would not have been offered as that level of support was not available.
48. On 21 July 2005, the Parole Board approved the man's release on parole licence. The Parole Board decided that his licence should have three additional conditions:
  - to reside at the Approved Premises
  - to comply with any requirements imposed by the supervising officer for the purpose of ensuring addressing Alcohol and Offending Behaviour problems
  - not to enter a particular service station in Cheshire.
49. Having recognised his release needs at an early stage, the home probation officer liaised with the Social Services Department to plan support for the man in the community. A Community Learning Disabilities Nurse, from Central Cheshire Community Health Team was asked to assist and support the probation service to work effectively with the man. At a meeting held on 18 April 2005, it was agreed that the man should be placed at the Approved Premises. Following the meeting, it was confirmed that the man would be released on parole licence on 26 August.
50. After receiving confirmation that he was to be released on parole licence, Cheshire and Wirral Partnership Trust Staff, agreed that members of their staff should meet the man at the prison and accompany him to the Approved Premises. This arrangement was over and above anything that they were required to do for him, and not a normal service for the Trust to carry out. The decision was taken on the grounds that no other alternative arrangement could be made. The decision taken by Cheshire and Wirral Partnership NHS Trust was in the man's best interest, and reflects well on the care and treatment shown to him by the Trust.
51. My investigators met a number of staff and a prisoner at the prison on an informal basis, to discuss the man's general behaviour and attitude towards his pending release. Whilst the meetings were not recorded verbatim, a summary note of the conversations was taken.

### *Personal Officer*

52. Each prisoner is allocated a personal officer who is responsible for writing or contributing to any reports that are required. They act as first contact for prisoners and are able to offer support and advice, and assist in resolving any problems that a prisoner may be experiencing.
53. The personal officer had only known the man for a short period. He described him as someone who wanted to be liked and was always friendly. He said that the man enjoyed having banter with him and chatting, but that he also displayed signs of nervousness. It was his belief that this might have been due to his inability to read or write, but was aware that the man's reading and writing skills had improved since attending education classes. The man used to spend long periods of time with the officer in his office.
54. He said that the man was nervous about being released on parole, and would approach him daily for reassurance about his release. The man was concerned that his co-accused, whom he had given evidence against at the trial, would at some stage be allocated to the prison. However, this never occurred and his fears were unfounded.
55. The personal officer was surprised that the man had been involved with drugs, especially within a few hours of being discharged from prison. Although he added that he would not have been so surprised had it been after a few days, as the man was a follower and would easily get into the wrong crowd.
56. Finally, the personal officer said that the man's view of being released was quite shallow. He said the man had previously worked voluntarily at a sports club and assumed that he would be returning to that type of work. The man also believed that he would be offered accommodation from the Social Services. He ended by adding that he thought that the man would at some stage return to custody.

### *Prisoner*

57. The prisoner had known the man for just under 12 months and assisted him by writing and reading his letters. He said that the man was very excited at the prospect of being released and had no apprehensions. The man told him that he wanted to see his niece, as she had just become engaged. The prisoner said the man had made a jewellery box for his niece, and that he wanted her to have his stereo unit as an engagement present. He said that the man was looking forward to playing snooker with his brother.
58. The prisoner said the man liked a bit of heroin, but did not inject and was not a big user. He said the man had previous knowledge of drugs, but had no first hand knowledge of him using while in prison. He added the man mentioned that, approximately six weeks prior to release, he took heroin and said he had used a syringe. He was unaware that the man wanted to obtain drugs on his release.

### *Officer*

59. An officer took the man to the Reception Department in preparation for his release from prison. He said that the man was in good spirits, excited, and in a positive frame of mind. The man spoke to the officer about his family and his niece. He said the man wanted to show people what happens to someone when they go into prison.
60. He said the man would worry about the littlest of things, and would want to talk to someone for encouragement. He added that he could see the man as having the potential to self-harm, as he was not a strong character. Things would overwhelm him, which would lead to him requiring constant reassurance.
61. The man had not spoken about drugs in any great detail, but the officer said that when he did, he knew the terminology. The man spoke in greater detail about alcohol.

### *Prison Probation Officer*

62. The prison probation officer described the man as having a low IQ, a poor copier, and someone easily influenced by peers in the community. She said that he wanted to be liked by people, and regularly sought reassurance from her as he would worry constantly about things. She said he was always polite, respectful and interacted well. He was remorseful about his offence and worried about whether he would obtain parole or not. She confirmed that the man had no positive drug tests recorded against him whilst he was in prison.

### *Chaplain*

63. The chaplain said the man attended the chapel every week and also went to most of the extra activities which were available, including a video discussion group and listening to the prison band rehearsals. She said that he told her that he wanted to keep off drugs, but he had not said what type of drugs he had been involved with. She said that he was more concerned about alcohol than drugs.
64. On 23 August, the man had been to the chapel as usual. The chaplain said that he appeared fine, but was anxious about leaving prison. She stressed that in her opinion he was no more anxious than any other prisoner due to leave prison.

### *A Listener*

65. Listeners are prisoners trained by the Samaritans to respond to other prisoners who feel vulnerable or at risk of self-harm. Listeners see prisoners on a confidential basis, and do not discuss individuals with anyone other than the Samaritan staff. For this reason, I have not identified the Listener by name.

66. The Listener said that he had seen the man in this capacity and described him as an up and down lad. He added the man once told him that he had a drug problem.

### **26 August**

67. A principal officer (PO) was the Orderly Officer on the day the man was discharged from prison. The Orderly Officer is responsible for ensuring that the correct prisoners are released, sign for their property and are aware of any licence conditions that have been included.
68. The PO said that at some time between 9:00am and 9:30am, he met the man in the reception area and talked to him about what was going to happen, making certain that he was aware of his licence conditions. The PO said that it was necessary to go through the conditions slowly in order to ensure that the man understood what was required of him. The man moved to a waiting room, pending the arrival of the staff collecting him to take him to the Approved Premises. He described how the man had talked about his plans for the future and said that he wanted to return to gardening. The man also told him that he knew the area that he was going to. He said the man was positive and upbeat when he spoke to him. The PO completed the man's release from prison, ensuring he had all of his property and money totalling £163.82.
69. Unfortunately, the PO received a telephone call informing him that the two staff collecting the man had been delayed in traffic and would not arrive until 11:00am. He told the man that his release would be delayed slightly, and said the man was upset when told of the delay. At approximately 11:30am, the two staff arrived at the prison to meet the man and take him to the Approved Premises.

### *The journey between the prison and the Approved Premises*

70. My investigator asked one of the staff to describe the man's attitude and behaviour following his discharge from prison and during the journey to the Approved Premises. She said that he was in a good mood, laughing and joking with her and his colleague throughout. She recalled the man talking about wanting to work on a farm and returning to football.
71. During the journey, they stopped at a service station for lunch. The man purchased a meal, cigarettes and a newspaper and she confirmed that he spent less than ten pounds of his own money.
72. Whilst in the car, they checked that the man understood what was happening, and were satisfied that he did. The man asked if they knew if "XXX" was at the Approved Premises. They both believed that he was referring to a resident called XXX, but did not know anyone by that name.

### *The Approved Premises*

73. The Approved Premises is monitored by a number of video cameras which are sited throughout the building and record all movements, including those entering and leaving the building. The video recording provides an accurate timed log of the man's arrival and later movements.
74. At 1:30pm, the man arrived at the Approved Premises and met the deputy manager. She, along with the two staff accompanying the man explained the rules of the premises to him. One of the two staff is skilled in passing information to people with a learning disability in language that can be easily understood. He ensured that the man understood what was required of him.
75. After completing the initial induction meeting, an assistant warden, and the two staff showed the man to his room followed by a familiarisation tour of the building. They asked to accompany the assistant warden and the man around the building, as they had not been there previously.
76. As they accompanied the man around the building, the man met a resident and they both appeared to know each other. They thought that he was XXX. The resident told my investigator that he had not seen the man previously and that he did not know him until he arrived. My investigator has been unable to establish who the man was referring to when speaking of XXX.
77. Arrangements had been made for the man to be given a more in depth induction later that day, along with another new resident who was due to arrive that afternoon. The induction was to include an explanation about benefit claims and to complete any outstanding issues not covered by the earlier induction. However, the second, more in depth induction meeting was not scheduled to include the specialist assistance of one of the staff accompanying the man from prison. Given the level of support required to ensure that the man knew what was required of him, it is surprising that arrangements were not made to offer him the same level of support for the second induction.
78. After the two staff left the building at 2:18pm, the man was invited to move freely around the building, make use of the facilities and meet other residents. He went into the poolroom, where the previously mentioned resident was playing pool. The resident explained to my investigator that they began to talk, and during the conversation the man asked him where he could obtain a syringe. He told the man that he knew where they were "stashed" and said that he could obtain one for him. After 14 minutes, the both left the Approved Premises and did not return until 3:36pm. When they returned, the man went upstairs to his room, leaving the resident downstairs. The resident said that he did not know why the man had gone to his room.
79. When the two staff left the building they drove to a local petrol station and re-fuelled their car. They then drove back in the direction of the Approved Premises and saw the man and the resident talking and walking towards the

- town centre. One of the two staff said that, although she was surprised to see the man in the area so soon after his arrival, she was not concerned for him.
80. The video image taken by the camera located at the entrance to the Approved Premises show that, as the man and the resident left the building, the man handed something to the resident. Staff at the Approved Premises suspect the man handed money to the resident. It has not been possible for my investigator to substantiate this, as the quality of the video image is not good enough to identify the item clearly.
  81. Following the man's death, the money found in his pockets was £20 less than the money he was given on his release from prison. We know that he spent approximately £10 of his own money whilst at the service station. There is no evidence to show that he purchased anything whilst in the centre of the town. Given these facts, the speculation that the man handed the missing £10 to the resident, and that this was to buy drugs is hard to avoid. However, I have no direct evidence that this was the case.
  82. A relief assistant warden saw the man and the resident leave the building and asked the deputy manager whether it was appropriate for the man to leave the building with the resident. The deputy manager said that the man would be okay with the resident. At interview, the relief assistant warden could not recall how long they were away, but said that it was long enough for her to say to the deputy manager that they had been gone for a good while and ask if she thought they would be okay. At that point she saw them on the television monitor, walking back towards the building.
  83. My investigator asked the relief assistant warden why she was concerned about the man being with the resident. She said that whenever residents are discharged from prison, they are given money which makes them vulnerable to other residents, who suggest they spend the money together. She said that she had two concerns for the man. First, whether he was alright with the resident and whether he would get there and back safely. Her other concern was whether the man would consume alcohol, as she was aware of the relationship between his offending and drinking. However, she also added that she thought that it was nice that the man had found a friend so soon, as it would help him settle.
  84. The investigator discussed with staff whether it was appropriate for someone with a learning disability to be leaving the building unaccompanied. It was generally considered that the man was assessed as suitable to be there, and the investigator was told that staff are not permitted to prevent a resident leave the building.
  85. The resident told my investigator that, after leaving the premises, the man crossed the road and made a telephone call from a public pay phone. He said he did not know who it was that the man telephoned. The man's sister believes that his brother received a telephone call from the man during the early afternoon, which appears to substantiate the residents account.

86. After completing the telephone call, the man and the resident went into the town centre. The resident said the man met an unidentified woman and added that he did not know her. He said that he did not hear what the man and the woman talked about, as he was some distance away. After the meeting, he and the man walked around the town for a while and returned to the Approved Premises at 3:36pm.
87. On their return to the premises, the man collected his property from the office and the resident assisted him to carry it to his room. The resident returned to the poolroom, followed shortly after by the man. He said that the man asked him where he could go to get away from the premises and the resident suggested going to the local canal.
88. He and the man left the building a second time at 4:05pm, turning right and walking in the direction of the town centre. The video recording taken six minutes later shows the man and him walking past the front of the building in the opposite direction to the town centre. They can be seen heading in the direction of the railway station which is on the route to the canal. The video image is the last recorded picture of the man.
89. The resident states that he and the man went to a local canal for a walk and, whilst they walked along the canal bank, the man produced a syringe from his sock and injected himself in the left arm. He said that he was unaware of what the man was going to do, but from his observations believed that the man knew what he was doing.
90. After apparently injecting himself, the man sat down for approximately ten seconds, and then stood up to continue their walk. The resident saw that he was staggering and walking in a circle, before his legs gave way and he fell to the ground. In an attempt to obtain assistance, the resident ran to a nearby house and asked the owner to telephone for an ambulance. He said that the lady he spoke to declined to telephone the emergency services, preferring instead to telephone the Approved Premises. In an effort to ensure the man received medical assistance, he ran to the premises which is approximately half a mile from where the man had collapsed.
91. As the resident reached the premises, the lady he had spoken to was speaking on the telephone to a member of staff. The resident told the staff what had happened, and at 5:20pm the assistant warden telephoned for an ambulance. She asked the resident to return to the man and show the ambulance staff where he had collapsed. However, before doing so, he went to his own room and changed some of his clothing. My investigator has been unable to clarify why he did this, but is aware that a police officer later examined the residents room and was satisfied that no further investigation of his room or clothing was required.
92. My investigator asked if a member of staff accompanied the resident to where the man was. He was told that as only two people were on duty, they were not allowed to leave fewer than two members of staff in the building.

93. The resident said that when he returned to the man, he could see that he was still breathing but with some difficulty. He assisted paramedic staff to carry their emergency equipment to the man and remained there until the police arrived, as they had also been requested to respond to the emergency call. Soon after the police arrived, one officer took the resident back to the Approved Premises where he made a statement. In his statement, the resident told the officer that he had supplied a syringe to the man. The police told my investigator that, as it is not illegal to be in possession of a syringe or to hand one to someone else, no charges were brought against the resident.
94. At 6:30pm, police confirmed to staff at the Approved Premises that the man had died.
95. During the investigation, my investigator asked staff at the premises where the man had been found. Unexpectedly, no one had visited the canal bank to identify where the man had died, as it was not seen as necessary. The investigator established that no letter of condolence was sent to his family from the premises, or from Cheshire Probation Area. Additionally, no representative of Cheshire Probation Area or the premises attended his funeral. Clearly, he had not been with them for long and therefore was largely unknown. However, it is unfortunate that the lack of attention to decency has given an impression that Cheshire Probation Area did not care for a resident who died whilst in their care. I am aware that the man's property was returned to his family by the police and not as part of any procedure by the Approved Premises.
96. In interview, an assistant warden at the premises, said that he first knew of the man's death when he returned to work the following Sunday. He had met the man on the day of his arrival, but left the building at approximately 2:30pm, as his duty had finished. When he returned to work on Sunday, he asked how the man was settling in, and was shocked to learn of his death. He said that he thought that it would have been more appropriate for him to have been contacted at home and informed of the death, rather than be told of it as he arrived back to work.
97. He also explained that, before returning the man's clothing to his family, someone at the premises had arranged for it to be washed. He believes that, whilst it is the policy of the National Probation Service to wash the clothing of anyone who dies in their care, it would be better to ask the family how they would like it to be dealt with.

## Clinical Review

98. A doctor employed by Chorley and South Ribble Primary Care Trust, carried out a clinical review of the care and treatment received by the man during the time that he was in custody. Her report does not comment on the few hours following his release from prison and his death, as this is outside her own remit.
99. In her report, the doctor identified that there were over 100 entries in the man's medical records made between 13 February 2003 and 26 August 2005. The entries related for most part to minor aches and pains. However, her review does refer to a report written by a consultant psychiatrist, prepared for the purpose of the man's appearance at Crown Court. She quotes the following comments from the report written by the psychiatrist:
- *the psychological assessment placed the man in the category of having a mild mental retardation. His day to day functioning is that of someone with a moderate degree of learning disability due to his difficulties in processing information, and his lack of education. If he is under any pressure or distressed, his abilities deteriorate*
  - *he demonstrates poor memory and when he cannot remember facts he confabulates i.e. he makes them up and distorts them*
  - *his response to leading questions is to say yes to everything, which demonstrates that he has a very high level of suggestibility. His adaptive living skills are poor. He needs help with managing money, any task that involves reading, and could neglect his personal hygiene*
  - *there is no evidence that he has an underlying major mental illness. He has a mild learning disability with a moderate degree of functioning. He becomes more dysfunctional when he is under stress. He confabulates and is highly suggestible*
  - *his learning disability makes him likely to act impulsively without considering the consequences of his action, particularly to others. In the past his use of alcohol increased his risk of offending and threatening behaviour. He claims to have abused illicit drugs including heroin in the past. Without concrete evidence to support this claim it is difficult to be sure whether this is true.*
100. The doctor ends her report saying: *there is nothing in any of the prison healthcare records made by healthcare staff during his time in prison to suggest that he was suffering from a mental illness.* She concludes the report by saying that, in her opinion, the man's problems stemmed from his learning disability.

## **Issues considered in the investigation**

### ***The prison***

101. During the time that the man was at the prison, he improved his reading and writing skills by attending the prison education classes. Additionally, he attended regular group meetings in the chapel and participated in the majority of extra activities that the chaplain was able to provide.
102. Prison staff, including the support agencies, took the opportunity to help and support him during his frequent periods of anxiety, and would spend time in ensuring that his concerns were dealt with as sympathetically as possible. My investigator found no evidence to suggest that the man's often quite lengthy demands on their time were ever too much for them to cope with. This reflects well on the prison and its staff.

**I recommend a copy of this report is sent to the Governor of the prison in light of my comments in paras 101 and 102.**

### ***Cheshire and Wirral Partnership NHS Trust***

103. The man was well known to staff at the secure unit, and they agreed to assist the Probation Service by supplying a member of staff who could explain things to him in a way that he would understand.
104. At a meeting to discuss the man's needs, it soon became evident that he was unable to make his own way to the Approved Premises and a suggestion was made that he should be collected from the prison and accompanied to the premises. Although it was recognised that he required assistance, the Probation Service were unable to supply anyone to meet him from prison. In the absence of a suitable person, representatives from Cheshire and Wirral Partnership NHS Trust agreed to supply two staff to take him. This gesture was over and above anything that they are required to do and demonstrates a high level of care and commitment to working in partnership with other agencies. I very much welcome the level of care shown to the man by the Trust and commend their actions.

**I recommend that a copy of this report is sent to the Director of the secure unit in light of my comments in paras 103 and 104.**

### ***Cheshire County Council Social Services Department***

105. It is clear from the Cheshire County Council Standard Assessment Document that a member of the social services staff had identified the man's needs. It is also clear that his needs were such that he would have been eligible to receive help, which sadly he could not access due to his untimely death. From the available evidence, I am satisfied that Social Services would have ensured that his identified needs would have been met.

### ***The Approved Premises***

106. A great deal of information was passed to the management team at the Approved Premises regarding the man's needs and his learning disability. It is clear that the information was considered and, despite his learning disability, he was deemed suitable. I am therefore satisfied that releasing him to approved premises was correct.
107. It was agreed that he required specialist support in order for him to receive induction information in a way that he would be able to understand. Two staff collected the man from the prison and accompanied him to the Approved Premises, where they remained throughout the initial induction. A further, more in depth, induction programme, including information about benefit claims, had been arranged for the man that evening. However, for some reason, the assistance of the support worker had been overlooked and no arrangements made for him to be there. Given the level of complexity of the subject, I am not certain that the man would have understood the information without his help. I make no formal recommendation but the gap in the induction programme requires addressing to ensure that all the identified needs of residents are met.
108. As I have previously said, the man's needs and learning disability were substantially communicated to the Approved Premises. I am satisfied that it was considered by staff, as it is clear that they questioned the suitability of him leaving with the resident but concluded that they could not prevent him doing so.
109. Following his death, no one from the Approved Premises, or Cheshire Probation Area, contacted the man's family and no thought appears to have been given to sending a representative to his funeral. Additionally, no one at the Approved Premises could identify with any certainty where it was that the man had died. Subsequent to the publication of the draft report, I am pleased to note that Cheshire Probation Area regrets any perceived lack of sensitivity or decency in the way they dealt with the man's death and their dealings with his family.

**Cheshire Probation Area should review its policy for dealing with the death of a hostel resident, paying particular attention as to how they communicate with the bereaved family, and how the Area should be represented at the funeral.**

**Cheshire Probation Area should review the procedure for liaising with the family of the deceased person and consider identifying someone as Area Family Liaison Officer.**

110. The resident admitted supplying the man with a syringe, which he collected from a "stash" in the vicinity of the premises. Like the police, I have been unable to uncover any evidence to suggest that anyone other than the man injected the drugs. I also do not know how he came by them. The police

investigated the resident's actions and concluded that he had not broken the law, as it is not an offence to be in possession of a syringe.

111. An assistant warden said that he was shocked to learn of the man's death when he returned to work. He would have preferred to have been informed beforehand. I believe that he has made a valid point and suggest that Cheshire Probation Area reviews its arrangements for communicating such information to off duty staff.

**Cheshire Probation Area should review its arrangements for communicating important information to off duty staff.**

112. He also raised the question of the appropriateness of washing the man's clothing before asking his family what they would wish. I am satisfied that Probation Service instructions advise that clothing is washed prior to returning it to the family. In contrast, Prison Service guidance places emphasis upon first eliciting the family's wishes. I believe that the National Probation Service should review its policy and, if necessary, issue new instructions.

**The National Probation Service should review its policy on washing the clothing of a resident who dies in their care, and if necessary, issue new instructions.**

113. A senior clinical scientist at the Regional Laboratory for Toxicology, City Hospital Birmingham carried out tests on samples of the man's blood and urine. He said that he had detected morphine in the blood sample. In his report he said, as in all cases involving opiate drugs, the toxicological significance of these concentrates will depend upon the degree of tolerance possessed by the deceased. In this case, the deceased had recently been released from prison and therefore may have had reduced tolerance to the effects of opiate drugs. Therefore in the absence of any other pathological findings, fatal opiate poisoning is a strong possibility.
114. The evidence leads me to conclude that the man died as a result of an accidental overdose of heroin.

## **Issues raised by the man's family**

### ***Did he obtain and use drugs in prison?***

115. Prisons operate two methods of drug testing, "random" and "reasonable suspicion". Random tests are carried out on those prisoners whose names have been produced from a computer-generated list. Each month, a new list is printed identifying those prisoners who should be tested that month. Random drug testing is a well-established method although only a small proportion of prisoners are tested each month. If prison staff believe that a particular prisoner has recently been in contact with drugs, a special test can be carried out under the "reasonable suspicion" arrangements.
116. The man's sister told my investigator that, as far as she was aware, the man was not a drug user. Prisoners undergo regular drug testing when in prison and, whilst my investigator has been unable to identify when he first used drugs, he has not identified any record of him having failed a drug test whilst in prison custody.
117. The man's family were particularly concerned that, if he did die of a heroin overdose, it must have been administered by someone else as he could not have injected himself as he was afraid of needles. Neither the police enquiries nor my own investigation have found any evidence to suggest that anyone other than the man injected the drugs.

### ***Did he undergo a medical assessment prior to being released?***

118. The man's sister asked if he had undergone any type of medical assessment prior to being released from custody. My investigator told her that he would have seen a doctor at least 24 hours before being released, but that the reason for seeing the doctor would be to assess his general health, and not his learning disability.

### ***Why was he allowed to leave the Approved Premises unaccompanied?***

119. Concern was raised by the man's sister that he was allowed to leave the premises unaccompanied by anyone from the Probation Service. I believe that my report has addressed this issue. A multi-disciplinary assessment had decided that the premises would provide suitable support and accommodation for him, and that he did not need to live in a more restrictive environment. I have seen nothing in the course of my investigation to suggest that the assessment was incorrect, or to suggest that a more restrictive environment would have been lawful.

## **Recommendations**

### **National Probation Service**

1. The National Probation Service should review its policy on washing the clothing of a resident who dies in their care, and if necessary, issue new instructions.
2. I recommend a copy of this report is sent to the Governor at the prison in light of my comments in paras 101 and 102.
3. I recommend that a copy of this report is sent to the Director of the secure unit in light of my comments in paras 103 and 104.

### **Cheshire Probation Area**

4. Cheshire Probation Area should review the procedures for dealing with the death of a hostel resident, paying particular attention as to how they communicate with the bereaved family, and how the Area should be represented at the funeral.
5. Cheshire Probation Area should review the procedure for liaising with the family of the deceased person and consider identifying someone as Area Family Liaison Officer.
6. Cheshire Probation Area should review its arrangements for communicating important information to off duty staff.

## **Annexes**

1. Chorley and South Ribble PCT Clinical Review
2. Parole Notification
3. Parole Assessment Report (Home Probation Officer)
4. Parole Assessment (Prison Probation Officer)
5. Transcript
6. Transcript
7. Transcript
8. Transcript
9. Transcript
10. Transcript
11. Cheshire Area Approved Premises Condition of Acceptance