Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Joseph Hall, a resident at Carpenter House Approved Premises, on 27 April 2022

A report by the Prisons and Probation Ombudsman

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OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO

WHAT WE VALUE

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 Joseph Hall died on 27 April 2022 from a heroin overdose at Carpenter House Approved Premises (AP). He was 35 years old. I offer my condolences to Mr Hall's family and friends.

Mr Hall had a history of drug misuse but during his first six weeks at Carpenter House, he gave staff no indication that he was using drugs. However, on 20 April, a staff member suspected that Mr Hall was under the influence of drugs. I am concerned that AP staff failed to record this on the probation case management system, so Mr Hall's probation practitioner was unaware. I am also concerned that AP staff did not test Mr Hall or carry out a room search when they suspected that he had taken drugs.

There was some confusion about how often Mr Hall was tested for drugs at Carpenter House. Despite his key worker saying in his statement that Mr Hall was tested twice a week, it transpired that he was tested only once, on 7 March, the day he arrived. He was then expected to be tested only if staff had suspicions that he had taken drugs. We are concerned that Mr Hall's probation practitioner had assumed, wrongly, that Mr Hall was being tested regularly at Carpenter House. We would have expected her to know the drug testing arrangements and to have arranged more regular testing if deemed appropriate.

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

Kimberley Bingham
Acting Prisons and Probation Ombudsman **January 2023**

Contents

Summary

Events

1. On 7 March 2022, Mr Joseph Hall was released on licence to Carpenter House Approved Premises (AP) in Birmingham.

2. Mr Hall had a history of substance misuse but during his first six weeks at Carpenter House, he gave staff no indication that he was using drugs. On 23 March and 8 April, he tested positive for alcohol, but he gave no other cause for concern.

3. On 20 April, a member of AP staff suspected that Mr Hall was under the influence of drugs. She noted the AP handover log but took no further action.

4. On 26 April, Mr Hall spent the day with his family and returned to the AP at 9.00pm. Staff had no concerns about him that evening or during the night.

5. At 6.00am on 27 April, a staff member completed the morning check for residents, including Mr Hall. The staff member said Mr Hall was in bed and grunted in response when he called 'good morning'. At approximately 9.00am, staff carrying out the later checks found Mr Hall collapsed on his bathroom floor. One member of staff went to call an ambulance while the other checked Mr Hall for signs of life. Mr Hall was cold and stiff. Staff did not start CPR. When paramedics arrived at approximately 9.30am, they pronounced that Mr Hall was dead.

Findings

6. When AP staff suspected that Mr Hall was under the influence of drugs on 20 April, they failed to record this on nDelius (the probation case management system) so his probation practitioner was unaware. AP staff also failed to carry out a drug test on Mr Hall or carry out a room search.

7. There was some confusion about when Mr Hall was tested for drugs at the AP. In his original statement, Mr Hall's key worker said Mr Hall was tested for drugs twice a week, but this was incorrect. The AP Manager told us that he was only tested on arrival and then was only due to be tested if staff had suspicions that he had taken drugs. Mr Hall's probation practitioner had assumed, wrongly, that Mr Hall was being tested regularly at the AP and did not pick up from the records that he was not being tested for drugs.

Recommendations

- The Manager of Carpenter House AP should ensure that when staff suspect that a resident has used drugs, they:

    - make a record on nDelius so that the probation practitioner is aware;
    - carry out a drug test as soon as practicable; and
    - carry out a room search.

- The Head of the Birmingham Probation Delivery Unit should ensure that probation practitioners are aware of the drug testing arrangements for AP residents and arrange more frequent drug testing, if appropriate.

The Investigation Process

8. The investigator issued notices to staff and residents at Carpenter House Approved Premises informing them of the investigation and asking anyone with relevant information to contact her.

9. The investigator obtained copies of relevant extracts from Mr Hall's probation records and interviewed five members of staff.

10. We informed HM Coroner for Solihull and Birmingham of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

11. The Ombudsman's family liaison officer contacted Mr Hall's partner to explain the investigation and to ask if they had any matters, they wanted us to consider. Mr Hall's partner raised some queries about the bundle of documents sent to her by the Coroner, which we have responded to in separate correspondence.

12. Mr Hall's partner received a copy of the initial report. She did not raise any further issues, or comment on the factual accuracy of the report.

13. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

14. An inquest was concluded on 17 November 2022 and found Mr Hall's death to be drug related.

Background Information

Carpenter House Approved Premises

15. Approved premises (formerly known as probation and bail hostels) accommodate offenders released from prison on licence and those directed to live there by the courts as a condition of bail. Their purpose is to provide an enhanced level of residential supervision in the community, as well as a supportive and structured environment. Residents are responsible for their own health and are expected to register with a GP.

16. Carpenter House, in Birmingham, is managed by HM Prison and Probation Service (HMPPS). Each resident is allocated a keyworker to oversee their progress and wellbeing and to ensure they adhere to licence conditions and the AP's rules. HMPPS employees are on duty at Carpenter House 24 hours a day.

Previous deaths at Carpenter House

17. Mr Hall was the first resident to die at Carpenter House.

Key Events

18. In February 2018, Mr Joseph Hall was sentenced to six years in prison for theft and possessing a firearm. He was released on licence in January 2021 but was recalled in March after using drugs. On 7 March 2022, Mr Hall was released on licence from HMP Birmingham. He was required to live at Carpenter House Approved Premises (AP).

19. Mr Hall had a history of substance misuse and had a standard licence condition that he must provide a sample for drug testing on request. The AP's testing regime was that Mr Hall would be tested on arrival, on departure and whenever there was a suspicion that he had used drugs. The only drug test he had at Carpenter House was when he arrived. This was positive for opiates but was attributed to his medication. Mr Hall was tested for alcohol twice a week.

20. A residential worker delivered one key working session a week. He also spoke to Mr Hall informally most days.

21. On 22 March, staff were due to search Mr Hall's room but there is no record that this took place.

22. On 23 March, Mr Hall tested positive for alcohol. He said he had had one lager. Staff noted nDelius (the probation case management system) so that his probation practitioner was aware. She cleared the 'alert flag' raised on nDelius indicating she was not concerned. (Although Mr Hall signed an induction agreement to say he would not be under the influence of alcohol at the AP, alcohol abstinence was not one of his licence conditions.)

23. On 28 March, Mr Hall contacted the AP to say he was running late as he and his family had found a handbag full of cash and they had been waiting for the police. Staff noted nDelius that they had referred the matter to Ms Dulay.

24. On 5 April, staff searched Mr Hall's room but found nothing of concern.

25. On 8 April, Mr Hall returned to the AP very upset. He said he had had two cans of lager. The AP Manager opened a Care and Keep Safe Plan and staff checked Mr Hall hourly during the night. She closed the plan on 11 April, after Mr Hall said he had a good support network and was not considering harming himself.

26. On 15 April, Mr Hall signed out of Carpenter House at 8.05am to go to the gym. According to the post-mortem report, it has since come to light that Mr Hall had an altercation in a pub car park between 6.00pm and 7.00pm that day. He was hit on the side of his head and knocked out for a few seconds. An old scar on his face opened up and started bleeding.

27. Mr Hall got back to the AP at 9.04pm (just after his curfew time of 9.00pm) and told staff the traffic had made him late. (The AP manager told the investigator he had told another member of staff he fell off his bike.) Staff alerted his probation practitioner.

28. On 19 April, staff searched Mr Hall's room and found nothing of concern.

29. On 20 April, a residential worker had a key working meeting with Mr Hall. He recorded that Mr Hall was stressed and anxious about a parking fine his partner had received and asked when he could go and live with his family. He reassured Mr Hall who said he was determined to stay out of prison and away from drugs.

30. That evening, an unknown member of staff made an entry in the AP handover log about a conversation they had with Mr Hall that night at approximately 10.00pm. They noted that he seemed sluggish and possibly under the influence of drugs.

31. On 24 April, an unknown member of staff noted that Mr Hall said he would be moving on from the AP the next day. It is unclear why he said this as there were no plans for him to move until the family assessments had been completed and approval given.

32. On 25 April, Mr Hall visited his probation office, but his probation practitioner was on leave. He expressed dissatisfaction to staff there about problems the AP was having with hot water and heating.

33. On 26 April, Mr Hall left Carpenter House at 7.03am and spent the day with his partner. That day, staff prepared a letter to Mr Hall about his rent arrears which totalled £171.00.

34. At 9.00pm, Mr Hall returned to Carpenter House when his partner dropped him off. A residential worker signed him in, and another gave him the letter about his rent arrears, which included an appointment to discuss the issue with staff.

35. Mr Hall spent the remainder of the evening socialising in the dining room and the pool room. At approximately 11.00pm, a supervisor reminded Mr Hall to take his medication. Mr Hall went to the office and took some of his medication. He then went to bed. According to staff, he seemed fine.

36. At 11.00pm, night staff carried out checks to ensure that all residents were in their room. There were no concerns. Staff also carried out hourly patrols of the building but did not identify any issues.

27 April

37. At 6.00am on 27 April, a residential worker started checks to ensure all residents were present. He said he opened Mr Hall's door and thought he saw the outline of him in bed. He said he called 'good morning' and Mr Hall grunted in response. At 8.00am, the residential worker gave the day staff a handover and left the premises.

38. Shortly after 9.00am, two residential workers started the wellbeing checks together. Mr Hall's bed was made but he was not in it. They found him on the floor of his bathroom, on his left-hand side with his eyes closed. Dried blood was on the floor by his head which looked as if it had run from his nose.

39. One residential worker told the other to go to the office and tell the staff to call an ambulance. He also radioed them himself. He shook Mr Hall's leg and checked his wrist for a pulse but could not find one. He described Mr Hall as cold and stiff and thought he was dead.

40. Paramedics arrived at approximately 9.30am and pronounced that Mr Hall was dead.

Contact with Mr Hall's family

41. Following Mr Hall's death, a residential manager contacted Mr Hall's family to tell them that he had died. The Probation Service offered a contribution to the costs in line with national policy.

Support for residents and staff

42. After Mr Hall's death, senior managers spoke to the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support.

43. The AP manager also held a meeting with the residents to tell them Mr Hall had died and to offer them support.

Post-mortem report

44. The post-mortem report concluded that Mr Hall died of a heroin overdose. It said that the heroin was probably taken between 30 minutes and four hours before death. A foil wrap was found in Mr Hall's sock.

Findings

Response to suspected drug use on 20 April

45. Mr Hall died of a heroin overdose. He had a history of substance misuse but up to 20 April, gave staff no indication that he was using drugs. He tested positive for alcohol on 23 March and 8 April, but his offender manager was content that he was otherwise broadly compliant with the AP rules. While there were some minor infringements of AP rules, we accept that up to 20 April, Mr Hall's behaviour would not have warranted any action being taken against him.

46. On 20 April, a member of AP staff suspected that Mr Hall might be under the influence of drugs. However, the staff member did not record this on nDelius, and so Mr Hall's probation practitioner was unaware. (She was also on leave from 14 to 26 April inclusive.) Staff also failed to drug test Mr Hall or search his room.

47. The Approved Premises Room, Resident and Vehicle Searches Guidance Document states that staff should search residents' rooms on a random or intelligence led basis if they suspect alcohol or drugs are present in the AP. Staff should also drug test residents if they suspect they have taken drugs. The AP manager told us that in April 2022, residents could be selected for drug testing if there was reasonable suspicion that they had taken drugs and that Mr Hall should have been tested in response to the events of 20 April. We recommend:

    The Manager of Carpenter House should ensure that when staff suspect a resident has used drugs, they:

    - **make a record on nDelius so that the probation practitioner is aware;**
    - **carry out a drug test as soon as practicable; and**
    - **carry out a room search.**

Drug testing

48. We are concerned that there appeared to be some confusion about when Mr Hall was tested for drugs. In his initial statement, a residential worker said that Mr Hall was tested for drugs twice a week at Carpenter House. However, the records show that he was tested for drugs only once, on 7 March 2022, the day he arrived. The AP Manager told us that Mr Hall was only due to be tested for drugs on arrival, departure and when drug use was suspected. (The residential worker has since corrected his statement.) Mr Hall's probation practitioner said at interview that she had assumed that Mr Hall was regularly tested for drugs at Carpenter House but realised after his death that he had not been.

49. Given Mr Hall's history of substance misuse, we are surprised that his probation practitioner did not require him to be tested for drugs more frequently. It appears that she assumed, wrongly, that he was being tested regularly at the AP, though it is unclear why she did not realise from nDelius that this was not being done. We are aware that since Mr Hall's death, the Probation Service has introduced mandatory drug testing for all AP residents which means that all residents,

regardless of their history, will be tested for drugs at least twice during their stay at the AP. However, the instruction makes it clear that this does not replace drug testing as part of a licence condition. We consider that it is the probation practitioner's responsibility to identify if a resident requires more frequent drug testing and to ensure that this is done. We recommend:

The Head of the Birmingham Probation Delivery Unit should ensure that probation practitioners are aware of the drug testing arrangements for AP residents and arrange more frequent drug testing, if appropriate.

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