Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Carl Sheldon, a resident of Wharflane House Approved Premises, on 8 March 2021

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 Carl Sheldon died on 8 March 2021, while a resident at Wharflane House Approved Premises. His cause of death is currently unknown pending the results of the post-mortem examinations. He was 33 years old. I offer my condolences to Mr Sheldon's family and friends.

The COVID-19 pandemic has presented approved premises with enormous challenges. The safety of staff and residents has, naturally, been prioritised and numerous measures have been instigated to reduce the risk of transmission of the virus. Keyworkers now work from home, residential staff are advised to remain in their offices, wherever possible, and staff interaction with residents has reduced significantly as a result. At the same time, communal areas within premises have been closed to preserve social distancing and it is not unusual for residents to spend most of the day in their rooms. While I appreciate that these measures are important, I am concerned that residents of approved premises are no longer receiving appropriate supervision and support on site.

I am concerned that appropriate priority was not given on his arrival to informing Mr Sheldon about his reduced tolerance to drugs and the increased risk of overdose. I am also concerned that he was not challenged when staff identified that he had likely been smoking cannabis in his room, and no one considered searching his room for illicit drugs.

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

Elizabeth Moody
Deputy Prisons and Probation Ombudsman **November 2021**

Contents

Summary

Events

1. On 2 March 2021, Mr Carl Sheldon was released from prison to live at Wharflane House Approved Premises. On the afternoon of his arrival, he received an induction from his keyworker which was conducted through a video conferencing platform due to restrictions in place during the COVID-19 pandemic.

2. At around 2.00am on 7 March, a residential worker identified a very strong smell of cannabis coming from Mr Sheldon's room. No one spoke to Mr Sheldon about this in the following days and it was listed to be discussed at a pre-arranged meeting with his offender manager and keyworker later in the week.

3. On 8 March, Mr Sheldon briefly left the premises late in the morning. At 12.55pm, he returned to his room having spent ten minutes smoking outside. This is the last time he was seen. At a whole premises' curfew check at 11.00pm, a residential worker found that he had died.

Findings

Substance misuse

4. We found that the likelihood of reduced drug tolerance and increased risk of overdose were not discussed sufficiently with Mr Sheldon on his first day at Wharflane House, as national instructions specify. We also found that his suspected cannabis use was not appropriately challenged and that no one considered searching his room for illicit drugs.

COVID-19

5. The COVID-19 pandemic has had a significant impact on the work of approved premises. Keywork is conducted remotely and residential workers at Wharflane House told us that their relationships with residents have suffered because of measures introduced to reduce face-to-face interaction. There is no evidence that anyone had any significant face-to-face contact with Mr Sheldon during his time at Wharflane House. The safety of staff and residents must, of course, be a priority, but we are concerned that residents are not receiving proper supervision and support during the pandemic.

Curfew checks

6. During Mr Sheldon's time at Wharflane House, residents were no longer required to sign for their individual curfews (Mr Sheldon's was at 7.00pm) as they had been judged 'non-essential' during the pandemic. Since his death, the Approved Premises Manager has reinstated this requirement.

Recommendations

- The National Approved Premises Team should ensure that all new residents are told about their reduced drug tolerance and increased overdose on arrival at the AP, in line with the expectations of the Approved Premises' Manual.

- The National Approved Premises Team should ensure that residents suspected of using illicit drugs in the premises are appropriately challenged and that staff search their room in line with current guidelines.

- The National Approved Premises Team should ensure that residents receive appropriate supervision and support during the COVID-19 pandemic.

The Investigation Process

7. The investigator issued notices to staff and residents at Wharflane House informing them of the investigation and asking anyone with relevant information to contact him. No one responded. He obtained relevant extracts from Mr Sheldon's probation records.

8. The investigator interviewed six members of staff at Wharflane House in April 2021. All the interviews were conducted by video because of the COVID-19 restrictions.

9. We informed HM Coroner for Stoke-on-Trent of the investigation. He gave us the results of the toxicology examination. We have sent the Coroner a copy of this report.

10. The Ombudsman's family liaison officer contacted Mr Sheldon's parents and sister to explain the investigation and to ask if they had any matters they wanted us to consider. Mr Sheldon's family asked why he was not seen for ten hours before his death and whether he was checked by Approved Premises staff in line with requirements.

11. We shared the initial report with the National Approved Premises Team. They did not identify any factual inaccuracies.

12. We also shared the initial report with Mr Sheldon's family. They raised some additional points which we have addressed in separate correspondence.

Background Information

Wharflane House Approved Premises (AP)

13. 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.

14. Wharflane House, in Stoke-on-Trent, is managed by HM Prison and Probation Service (HMPPS). Each resident is allocated a keyworker to oversee his progress and wellbeing, and to ensure that they adhere to licence conditions and the AP's rules. HMPPS employees are on duty at Wharflane House 24 hours a day.

15. During the COVID-19 pandemic, the testing of residents of approved premises for the use of illicit drugs was suspended. This was because of the increased risk of transmission of the virus when collecting samples for testing.

Previous deaths at Wharflane House

16. Mr Sheldon is the first resident to die at Wharflane House since 2011. There are no significant similarities between his death and that of the previous resident.

Key Events

17. On 1 June 2017, Mr Carl Sheldon was remanded in prison to HMP Dovegate. He was later sentenced to seven and a half years in prison for robbery.

18. During his time in prison, staff frequently recorded that he was under the influence of drugs or was suspected of using illicit substances. There were also periods when he abstained from drugs. In his last months in prison, staff recorded that he often used psychoactive substances (PS). Mr Sheldon was also diagnosed with a personality disorder (which affects how an individual thinks, feels, behaves and relates to others).

19. On 17 February 2021, an offender manager met Mr Sheldon ahead of his upcoming release to Wharflane House Approved Premises. She recorded that he said that he had "no issues" with drugs. Mr Sheldon also said that he may struggle to abstain from cannabis in the community but would "try his best".

20. On 18 February, a probation service officer who was to be Mr Sheldon's keyworker at Wharflane House, completed a risk management plan. She recorded that Mr Sheldon had used drugs both in the community and in prison, and that approved premises staff should observe him for signs of substance misuse.

21. On 25 February, a substance misuse service practitioner at Dovegate referred Mr Sheldon to the Stoke-on-Trent Community Drug and Alcohol Service (CDAS) so that they could provide support following his release from prison. The substance misuse practitioner recorded that Mr Sheldon was happy to engage with their services.

22. On 2 March, Mr Sheldon was released on licence from Dovegate. His licence conditions required him to live at Wharflane House and to present himself at a probation office for drug testing, if required. Mr Sheldon was subject to a curfew which required him to be in Wharflane House from 7.00pm every night. The only medication he was prescribed were antihistamines for a dust allergy and an inhaler for asthma.

Wharflane House Approved Premises

23. On the afternoon of his arrival, Mr Sheldon had a pre-arranged telephone conversation with his offender manager. Mr Sheldon said that he felt nervous and overwhelmed due to his release from prison. They discussed the pathway to Mr Sheldon seeing his children, via a social care risk assessment, which he said he understood. Mr Sheldon's offender manager also told him that she had referred him to the local Criminal Justice Mental Health Team.

24. On the same day, Mr Sheldon's keyworker completed an AP induction with Mr Sheldon. During the COVID-19 pandemic, probation service officers have worked from home rather than in approved premises. Mr Sheldon's induction was therefore completed by means of a video conferencing service rather than in person. Residents are given an induction pack to keep in their room that explains various aspects of living in, and the rules of, the approved premises. The pack highlights that using or bringing illegal drugs into the approved premises is against the rules

and that “action will be taken” when staff know it is happening. The pack also includes a warning about the risks of reduced tolerance for drugs and alcohol in people released from prison, and states that overdose, sometimes leading to death, is common. Mr Sheldon signed the induction pack.

25. Mr Sheldon’s keyworker told us that Mr Sheldon appeared to “play down” his mental ill health and that she thought she would have to explore this further in future key work sessions. She said that she could not remember discussing substance misuse with Mr Sheldon, although she thought that she would have done as it was her practice to read over the sections of the induction form that the resident must sign. The keyworker said that she did not think they went into any depth on the matter because of the substantial amount of material that needed to be covered in the session.

26. On 3 March, Mr Sheldon met his offender manager at the local probation office. She recorded that Mr Sheldon said that he had felt anxious and overwhelmed on release but was doing okay.

27. On 6 March, Mr Sheldon’s keyworker spoke to him by telephone to check how he had settled into Wharflane House. She recorded that Mr Sheldon said he was okay at the approved premises. The keyworker told us that he was not as talkative as when she spoke to him earlier in the week and that he did not appear to want to have a conversation. She said that she did not have any concerns about Mr Sheldon’s wellbeing.

28. At around 2.00am on 7 March, a residential worker recorded that she had identified a very strong smell of cannabis coming from Mr Sheldon’s room. She went into the room and noted that Mr Sheldon appeared asleep and that the smell of cannabis was evident. The approved premises manager told us that Mr Sheldon’s offender manager and keyworker had planned to discuss this event with Mr Sheldon at a meeting scheduled for 10 March.

8 March 2021

29. Two residential workers were on duty from 8.00am to 8.00pm on 8 March. The approved premises manager was also present for some of the day.

30. At 11.37am, Mr Sheldon left Wharflane House. The approved premises manager signed him out of the premises and recorded that he said that he was going to a cashpoint. At 11.50am, Mr Sheldon returned to the premises. A residential worker signed him in. She told us that Mr Sheldon was pleasant and chatty at the time, and that she had no concerns for his welfare.

31. At 12.45pm, Mr Sheldon left his room to go to the premises’ smoking shelter. He returned to his room at 12.55pm. This was the last time that Mr Sheldon left his room or was seen by anyone.

32. Staff at Wharflane House are required to complete a check of residents every two hours during the day (from 9.00am to 9.00pm) to identify which residents are in the premises. The approved premises manager told us that before the COVID-19 pandemic, these checks were completed by seeing the resident. (This could be done by watching CCTV footage rather than directly in person.) During the

pandemic, seeing the resident is not required and their presence can be ascertained by checking the signing out sheet and identifying whether their keys have been handed in. (Residents are required to hand in their room key when they leave the premises.) One of the residential workers told us that he completed most of the entries to confirm Mr Sheldon's presence during his shift on 8 March.

33. Mr Sheldon's individual curfew was at 7.00pm. Until January 2021, residents were required to come to the staff office to sign to confirm their presence at their individual curfew times. The approved premises manager told us that from January 2021, practice had "drifted" because of concerns of transmissibility of the new COVID-19 variant and residents no longer signed for their individual curfew. Instead, staff checked for their presence using the same methods as at other times.

34. Wharflane House also has a general curfew for all residents from 11.00pm to 6.00am. At these times, staff complete a full check of residents and account for everyone's presence by sight.

35. Two residential workers worked overnight from 8.00pm. At 11.03pm, residential worker A went to Mr Sheldon's room to complete the curfew check. He told us that he found Mr Sheldon sitting against the radiator, with mucus coming from his nose and vomit on the carpet next to him. He said that there were no signs of life from Mr Sheldon. The residential worker summoned his colleague, who told us that his view was that Mr Sheldon had died.

36. At 11.04pm, residential worker B telephoned for an ambulance. At 11.09pm, paramedics arrived at Wharflane House and confirmed that Mr Sheldon had died.

37. Staffordshire Police subsequently arrested two residents on suspicion of supplying drugs to Mr Sheldon. They were released pending investigation and recalled to prison custody.

Contact with Mr Sheldon's family

38. On 9 March, officers from Staffordshire Police visited Mr Sheldon's sister and told her of his death. The approved premises manager contacted Mr Sheldon's sister and offered assistance with funeral expenses, in line with national guidelines.

Support for residents and staff

39. After Mr Sheldon's death, the approved premises manager spoke to the staff involved and offered them support. Residents were informed of Mr Sheldon's death and offered support.

Post-mortem report

40. The post-mortem report and cause of death was not available when we issued our initial report. The toxicology examination did not detect any drugs, including psychoactive substances.

Findings

Substance misuse

Induction

41. Probation Instruction (PI) 32/2014, *Approved Premises' Manual*, says that one of the main causes of deaths among residents of approved premises is drug overdose, often due to reduced tolerance after release from prison. The Manual instructs that, on the day of release, the offender manager should make the resident aware of the risks of overdose should they return to using drugs at the same level as before they went into custody. Mr Sheldon's offender manager told us that she discussed engaging with CDAS with Mr Sheldon before his release from prison. She said that her understanding was that harm reduction work (following release) would be completed by his drug and alcohol support worker.

42. The Approved Premises' Manual also instructs that the risks of overdose should always be covered at induction and advice given to all approved premises residents on reduced drug tolerance following release from custody. Mr Sheldon's keyworker told us that she thought that she read the appropriate section of the induction pack to Mr Sheldon but that she did not discuss the subject further due to time constraints in the induction session. She told us that the induction session covers a lot of different subjects and residents often "switch off" during the session. The keyworker said that conducting these sessions remotely during the COVID-19 pandemic made it more difficult still to cover the induction material appropriately. She told us that a learning point for her from Mr Sheldon's death was to concentrate more on highlighting the dangers of reduced tolerance, particularly for residents with a history of substance misuse.

Suspected cannabis use

43. The Approved Premises' Manual says that staff must always challenge illegal substance misuse. It says that signs of substance misuse on the premises should lead to appropriate enforcement action, and that room searches should be carried out when it is suspected that illicit drugs are present in the premises.

44. Standard Operating Procedures for Approved Premises' during the COVID-19 pandemic say that room searches (for residents who are not self-isolating) must only be completed when social distancing can be achieved and where there is direct suspicion that contraband is being concealed in rooms.

45. Early in the morning of 7 March, Wharflane House staff strongly suspected that Mr Sheldon had used cannabis in his room. While the matter was due to be discussed with Mr Sheldon at a pre-arranged meeting with his offender manager and keyworker later in the week, no one considered speaking to or challenging him at the first opportunity the next day and there was no consideration to searching his room for illicit drugs. We make the following recommendations:

    The National Approved Premises Team should ensure that all new residents are told about their reduced drug tolerance and increased overdose on arrival at the AP, in line with the expectations of the Approved Premises' Manual.

The National Approved Premises Team should ensure that residents suspected of using illicit drugs in the premises are appropriately challenged and that staff search their room in line with current guidelines.

COVID-19

46. The COVID-19 pandemic has had a significant impact on the work of approved premises. Probation Service Officers and keyworkers now work remotely. As well as meaning that their interactions with residents are completed virtually rather than in person, Mr Sheldon's keyworker also told us that not working on site meant that she relied on staff highlighting risk issues to her rather than making her own observations as she had done when based in the premises.

47. Staff at Wharflane House told us that procedures designed to reduce the risk of transmission of the virus meant that they could not build relationships with residents as they had done previously. For instance, staff remain in their office whenever possible and only go into the residential areas when they have a specific reason to do so. As we will discuss later, some presence and curfew checks at Wharflane House no longer require the resident to be observed. At the same time, communal areas (such as lounges and games rooms) have been closed to help maintain social distancing. We were told that it was not unusual for residents to spend nearly all day in their rooms. During his time at Wharflane House, there is no evidence that anyone had a significant face-to-face conversation with Mr Sheldon, and no one identified that he had not been seen for around ten hours when he died.

48. Measures such as these are obviously important. There have been several residents at Wharflane House who have tested positive for COVID-19 and the safety of staff and residents should clearly be a priority. However, this does put staff and residents in a very difficult position. We are concerned that residents are not receiving proper support and communication from and interaction with staff, while at the same time, staff do not have the same opportunity to carry out proper supervision or identify important risk issues and other matters. We make the following recommendation:

The National Approved Premises Team should ensure that residents receive appropriate supervision and support during the COVID-19 pandemic.

Curfew checks

49. When Mr Sheldon lived at Wharflane House, checks on residents were not conducted in the same way as before the COVID-19 pandemic. Whole premises' curfew checks (at 6.00am and 11.00pm) were still conducted as previously, by seeing a resident. Individual curfews (such as Mr Sheldon's at 7.00pm) previously required the resident to sign at the staff office but were now completed by checking whether they had signed out of the premises or handed in their keys (and did not therefore require the resident to be seen). Two-hourly presence checks were completed using the same methods, whereas previously they had required the resident to be observed. As noted, these changes meant that Mr Sheldon was not seen for around ten hours before staff found that he had died when they conducted the whole premises' curfew check.

50. The approved premises manager told us that COVID-19 guidance suspended 'non-essential' checks of residents, but that this raised the question of which checks were essential. He told us that whole premises' curfew checks were essential but two-hourly presence checks were not. We agree that this is a reasonable interpretation of the guidance. The approved premises manager told us that he also viewed individual curfews as essential checks but that the practice at Wharflane House had "drifted" during the pandemic so that they were now completed using the same methods as non-essential checks. Since Mr Sheldon's death, the approved premises manager has reinstated the requirement for residents to sign in at their individual curfew times. We do not therefore make a recommendation.

Inquest

51. The inquest into Mr Sheldon's death concluded on 7 January 2025, and returned a verdict of natural causes.

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