Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Louis Maniatt, a resident at Ty Newydd Approved Premises, on 22 April 2023

A report by the Prisons and Probation Ombudsman

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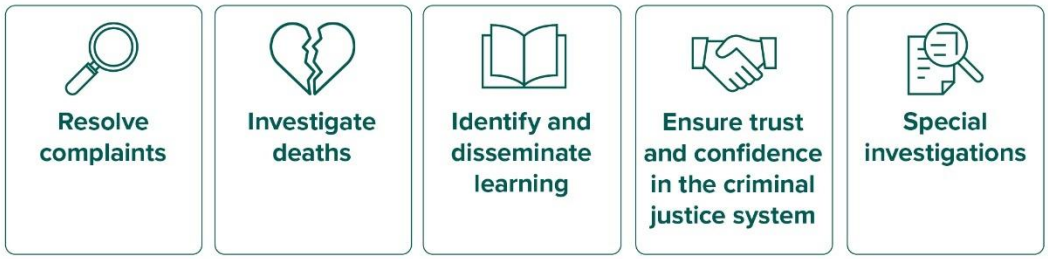
OUR VISION

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.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Louis Maniatt died of butane toxicity on 22 April 2023 at Ty Newydd Approved Premises. He was 43 years old. I offer my condolences to Mr Maniatt's family and friends.

Mr Maniatt was the second resident to die at Ty Newydd in three years.

Mr Maniatt had been released from prison slightly less than a month before his death. He had a history of substance misuse and mental health issues. Generally, staff provided reasonable care and he presented minimal concerns. However, on the morning that Mr Maniatt died, a residential worker did not carry out a thorough welfare check.

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

Adrian Usher
Prisons and Probation Ombudsman **February 2025**

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Summary

Events

1. Mr Louis Maniatt was sentenced to 90 months in prison for robbery. He was released from HMP Oakwood to Ty Newydd Approved Premises on 27 March 2023.

2. Mr Maniatt had a history of substance misuse and mental health issues. As part of his induction, staff explained his licence conditions and the AP rules.

3. Mr Maniatt made contact with community mental health services and registered with a GP. He was mostly compliant with his conditions and presented staff with no concerns. Mr Maniatt admitted to smoking cannabis on one occasion on an unspecified date before the 18 April, but he was engaging with substance misuse services and the Probation Practitioner was not concerned.

4. In the week leading up to his death, Mr Maniatt ran out of his medication, Olanzapine, for several days.

5. On 21 April, Mr Maniatt returned to the AP in the afternoon. He played pool with other residents that evening before going to bed around midnight.

6. At 9.00am the next morning, a residential worker did not obtain a roused response from Mr Maniatt as they were supposed to, but was not concerned about him, believing he was asleep. At 11.00am, another residential worker found Mr Maniatt unresponsive and further investigation revealed that he had died.

7. The post-mortem report examination and toxicology report confirmed Mr Maniatt died from butane toxicity.

Findings

8. A residential worker did not carry out a welfare check to the required standard on the morning of 22 April, but we are satisfied that the AP pursued appropriate avenues to discipline the member of staff.

9. Mr Maniatt ran out of medication, but the AP now uses a different GP surgery which prescribes more than just one week's supply of medication at a time. We have also asked the Head of Residential Public Protection for Probation Wales to ensure staff understand the system for ordering more medication when necessary.

10. AP staff did not check Mr Maniatt's next of kin's contact details to ensure they had the correct address. As a result, their letter of condolence was sent to the wrong address.

The Investigation Process

11. HMPPS notified us of Mr Maniatt's death on 22 April 2023.

12. The investigator issued notices to staff and residents at Ty Newydd Approved Premises informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

13. The investigator obtained copies of relevant extracts from Mr Maniatt's probation records.

14. The investigator interviewed the Head of Residential Public Protection for Probation in Wales in November 2023.

15. We informed HM Coroner for North Wales of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

16. The Ombudsman's family liaison officer contacted Mr Maniatt's daughter to explain the investigation and to ask if she had any matters she wanted us to consider. She wanted to know:

    - how Mr Maniatt had died,
    - why staff from the Approved Premises did not contact her mother to inform her of the death; and
    - what happened during staff's morning checks on Mr Maniatt the day he died.

    We have answered these questions in this report.

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

18. Mr Maniatt's family received a copy of the initial report. They raised a number of issues which did not impact on the factual accuracy of the report and have been addressed in separate correspondence.

Background Information

Ty Newydd Approved Premises

19. Approved Premises (formerly known as probation or 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 healthcare and are expected to register with a GP.

20. Ty Newydd AP in Wales is managed by the National Probation Service. It holds up to 17 men in single rooms. Each resident is allocated a key worker/offender supervisor to oversee their progress and wellbeing and to ensure that residents adhere to their licence conditions and the premises rules.

21. Residents are subject to AP rules in addition to any licence conditions they have been given. They are not allowed to leave the building between 11.00pm and 6.00am. Ty Newydd is staffed 24-hours a day.

Previous deaths at Ty Newydd AP

22. Mr Maniatt's death was the second at Ty Newydd in three years. The last death was in November 2022. In that case, the AP also delayed contacting the family.

Key Events

23. On 28 September 2018, Mr Louis Maniatt was sentenced to 90 months in prison for robbery. Mr Maniatt was released on licence from HMP Oakwood on 27 March 2023. He had a history of substance misuse (including alcohol, crack, cocaine and cannabis) and mental health issues. There were no reports of recent drug use or suspicion of it in Mr Maniatt's prison record (the last recorded suspicion in his prison record was early 2020). He had engaged with the prison's drug in-reach service at the time and later with Alcoholics Anonymous.

24. Among other conditions, his licence said he should reside at Ty Newydd Approved Premises, attend for drug testing and attend appointments, as directed, to address his dependency on, or propensity to misuse, drugs.

25. When Mr Maniatt arrived at Ty Newydd on 27 March, a keyworker (also a Probation Service Officer), a Probation Practitioner and another member of Ty Newydd staff completed his induction. They told him he would be fitted with an alco-tag soon and in fact this happened the same day. (An alco-tag is an electronic tag which monitors alcohol consumption through the skin.) Staff told him naloxone kits were available on site (naloxone can reverse the effects of an opiate overdose).

26. Mr Maniatt tested negative for substances. Residents would usually be tested again sometime in the latter stages of their expected stay, unless there were suspicions a resident was using drugs. There were no suspicions about Mr Maniatt and he was not tested again, and his room was not searched during his stay at the AP.

27. Ms Elfryn completed a Support and Safety Plan and made a mental health referral to the Hergest Unit. The keyworker also referred Mr Maniatt to Dechrau Newydd – a project which supports drug and alcohol users in the criminal justice system to improve their lives. She set a review date for 19 April and planned to visit Mr Maniatt again in a couple of days.

28. On 28 March, Mr Maniatt registered with a GP.

29. On 29 March, the keyworker saw Mr Maniatt and noted on his Support and Safety Plan that he had said it was important his mental health was controlled by medication because he felt there was a strong link between his mental health and substance misuse. He had previously spent time in a psychiatric facility following episodes of self-harm.

30. On 4 April, the group facilitator from Dechrau Newydd told the keyworker that Mr Maniatt had not engaged properly. It was agreed that one to one sessions would probably work for him better. He attended one to one appointments on 11 and 18 April, and Dechrau Newydd raised no concerns.

31. On 11 April, the Probation Practitioner agreed that the condition requiring Mr Maniatt to comply with a 12.00pm AP sign in could be removed. Middle of the day sign ins help staff monitor how new residents are coping with increased freedom. There were no concerns about Mr Maniatt abiding by his curfew conditions, he did not appear under the influence at any point, he did not leave the AP often or raise any suspicions which would have triggered a room search.

32. On 12 April, Mr Maniatt attended his appointment at The Hergest Unit. He felt the appointment had gone well, and he had been given a week's supply of Olanzapine with the expectation this would be available to him as a repeat prescription.

33. On 18 April, during a video-link meeting, Mr Maniatt told the Probation Practitioner he had smoked a 'spliff' on an undisclosed date (but during the period his GP arrangements were being finalised). The rest of the meeting concentrated on family contact matters. By this point, the Probation Practitioner had officially taken on another role, and Mr Maniatt's supervision was incrementally transferring over to another Probation Practitioner. She was at the meeting too.

34. On the same day, Mr Maniatt ran out of Olanzapine but there is no record that AP staff reordered more. The AP's usual process is that staff reorder more medication when a resident is running low rather than waiting until they run out.

35. On 19 April, the keyworker reviewed Mr Maniatt and noted he had another appointment scheduled at the Hergest Unit in May. (He had no Olanzapine on this date either.)

36. On 20 April, a duty officer told Mr Maniatt he was running out of Olanzapine, but in fact she later realised he had none left at all. She made arrangements to pick up some more for him, which would be available the next day. He seemed well and was not concerned. The AP's medication log indicated that the medication was available the next day.

37. On the afternoon of 21 April, Mr Maniatt signed out of the AP and said he was going to town. He returned at 3.29pm and played pool with other residents. A residential worker said he seemed happy and relaxed. Mr Maniatt went to bed around midnight.

Events of 22 April

38. At 6.00am of 22 April, Residential Worker A carried out a routine morning check on Mr Maniatt and received a response. (Residential workers are expected to get a response which indicates the person is awake and it does not necessarily need to be verbal).

39. At 9.00am, Residential Worker B carried out a further check on Mr Maniatt, He did not reply when she knocked on the door. She unlocked the door and found he was in bed, face up with his foot sticking out the end. She thought he was asleep and locked his door and left. She did not attempt to get a response or check for any signs of life.

40. At 11.00am, Residential Worker C carried out a check. He knocked on Mr Maniatt's door and called his name but got no response. He opened the door and found Mr Maniatt lying on his bed with his legs hanging over the left side of the bed and his arm across his chest holding a remote control. Mr Maniatt's eyes and mouth were open. He went into the room and touched his arm which was cold and stiff.

41. Residential Worker C pressed the panic alarm twice and waited for a colleague to attend. No one came, so he went downstairs to get Residential Worker B. They both went back to Mr Maniatt's room. Residential Worker B felt for a pulse in Mr

Maniatt's neck and wrist, but there was nothing, and they considered he had died. They went downstairs. Residential Worker B phoned for an ambulance and Residential Worker C contacted the AP managers. Paramedics arrived and confirmed that Mr Maniatt had died.

Contact with Mr Maniatt's family

42. At 5.40pm that day, the police notified Mr Maniatt's family of his death. It is standard practice for the police to do this for AP deaths. The AP manager contacted the family by phone the next day.

43. The Wales Approved Area Premises Manager was appointed as the single point of contact for Mr Maniatt's next of kin. She sent a letter of condolence to Mr Maniatt's next of kin on 26 April, offering support and in line with national instructions offered to contribute to the costs of the funeral.

44. However, the Wales Approved Area Premises Manager sent the letter to the first address the police had visited to break the news, which was the wrong address. The Probation Service did not know the police had subsequently located the next of kin living at a different address. On 4 May, Mr Maniatt's sister contacted the AP manager to make him aware of the correct contact details.

Support for residents and staff

45. The AP manager spoke to staff and residents who had had interactions with Mr Maniatt and gave them information about how to access support if they needed it.

Post-mortem report

46. A post-mortem examination and toxicology tests gave Mr Maniatt's cause of death as butane (liquefied gas) toxicity.

Findings

47. Staff at Ty Newydd AP made reasonable efforts to help Mr Maniatt and ensure he got the help he needed during his stay at the AP.

Mr Maniatt's substance misuse

48. Staff appropriately referred Mr Maniatt to Dechrau Newydd, a North Wales substance misuse service. Mr Maniatt had not engaged well in a group setting and arrangements were made for him to have one to one sessions instead. His last appointment with them was on 18 April and they did not flag any further concerns with the AP or Probation Practitioners.

49. Mr Maniatt died of butane toxicity, but he did not exhibit any obvious signs he was abusing this substance. Butane cannisters are used to refill lighters and as Mr Maniatt smoked, any discovery of a small amount of cannisters is unlikely to have caused concern had he been searched. (Two canisters were found in his room after his death.)

50. Although two residents told police that they knew Mr Maniatt abused butane, they were not prepared to give any further information about this, so we cannot say whether it was something staff should have detected. A residential worker confirmed it was a relatively unusual substance for Approved Premises residents to abuse.

51. Both Probation Practitioners were aware that Mr Maniatt had smoked cannabis at an unspecified point since his release. Mr Maniatt was engaging with substance misuse services and one instance of minor drug use did not initiate recall to prison. The first Probation Practitioner could not retrospectively remember a great deal about Mr Maniatt's disclosure, but he was content Mr Maniatt was engaging with Dechrau Newydd.

Welfare checks

52. On the morning of 22 April, Residential Worker B did not carry out the 9.00am welfare check as thoroughly as is expected – notably failing to get a roused response from Mr Maniatt. A disciplinary hearing concluded a 12 month final written warning was appropriate. The warning was to be kept on her personal record for 12 months, effective from 7 August 2023. It was to be taken into account if any further acts of misconduct occurred within this period.

53. The Wales Approved Area Premises Manager made us aware of a further incident which resulted in Residential Worker B's dismissal.

Head of Residential Public Protection for Probation Wales to note

Missed medication

54. The investigator asked the Wales Approved Area Premises Manager about Mr Maniatt's missed medication. The medication sheets implied he had missed some doses in the week leading up to his death and on other occasions. Mr Maniatt had

told staff that it was important his mental health was controlled by medication because he felt there was a strong link between his mental health and substance misuse.

55. The Wales Approved Area Premises Manager confirmed that standard practice at the AP is that medication is ordered when a resident is low and not when it has run out. The daily handover notes on Delius (Probation record) should advise if it has been ordered and if the order had been followed up by duty officers – in Mr Maniatt's case this had been missed. Combined with the GP's practice of only prescribing Mr Maniatt's medication one week at a time, this led to gaps in him receiving his medication.

56. The AP now uses a different GP surgery and has not encountered any similar issues. As a result, we make no recommendation. However, it is important that staff keep track of medication stocks and understand the system in place for preventing residents running out. The Wales Approved Area Premises Manager will wish to consider this.

Contact with Mr Maniatt's family

57. The police delivered the news of Mr Maniatt's death to his sister after they discovered she had moved address. AP staff did not check the family's contact details and their letter of condolence was sent to the wrong address. The Wales Approved Area Premises Manager will wish to note the importance of checking the address to ensure subsequent correspondence is sent to the correct place.

Inquest

58. At the inquest, held on 17 September 2025, the medical cause of death was determined to be butane toxicity and the jury's narrative verdict came to a conclusion of 'misadventure'.

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