Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Patrick Whiting, a resident of Fleming House Approved Premises, on 26 July 2024

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 Patrick Whiting was found unresponsive in a public toilet on 26 July 2024, while a resident at Fleming House Approved Premises. A postmortem examination found that he died from cardiac hypertrophy (thickening of the left ventricle, which reduces the amount of blood supplied to the body). He was 66 years old. I offer my condolences to Mr Whiting's family and friends.

Mr Whiting was released on licence to live at Fleming House after 15 years in prison. There was no indication during that time that he had a heart condition. Although Mr Whiting was fitted with an electronic monitoring tag as part of his licence conditions, no one considered using its GPS capabilities to find his location when he was identified as missing.

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 **May 2025**

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Summary

Events

1. On 15 October 2009, Mr Patrick Whiting was sentenced to an imprisonment for public protection sentence (IPP) with a tariff of five years, for robbery. He had a long history of substance misuse. While in prison, Mr Whiting was frequently found under the influence of psychoactive substances (known as Spice). He was diabetic and prescribed pain relief for a knee injury. Mr Whiting did not have a recorded history of heart disease.

2. On 14 June 2024, Mr Whiting was released on licence and post-sentence supervision to Fleming House Approved Premises (AP).

3. On 26 July, Mr Whiting was present for the morning welfare check. At around 7.56am, he left the AP to attend the Chatham Hub and his lunchtime curfew was lifted. He did not arrive at the Chatham Hub. CCTV shows that he entered a local shopping centre at 9.17am.

4. By 5.00pm, Mr Whiting had not returned to Fleming House for his curfew. AP staff attempted to call him, but there was no answer. At 7.32pm, after further efforts to locate him, a senior probation manager authorised Mr Whiting's recall to prison.

5. On 30 July, a Kent Coroner's Officer contacted Fleming House and told staff that Mr Whiting had died. They confirmed that he had been discovered unresponsive in public toilets at the shopping centre on 26 July and pronounced life extinct at 10.02pm.

Findings

6. There was no indication that Mr Whiting had any underlying heart condition while at Fleming House, and he had no recorded history of heart disease. He had registered with a local GP soon after release and took his diabetic medication as prescribed.

7. Although he was fitted with an electronic monitoring tag, no one considered using its GPS feature to identify Mr Whiting's location.

Recommendation

- The Probation Service, together with Electronic Monitoring Services, should explore the feasibility of developing an Approved Premises protocol to quickly identify the whereabouts of a person living in AP who fails to report for curfew, to enable early identification of their location.

The Investigation Process

8. The National Approved Premises Team notified us of Mr Whiting's death on 31 July 2024.

9. The investigator issued notices to staff and residents at Fleming House AP informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

10. The investigator visited Fleming House on 7 August. She obtained copies of relevant extracts from Mr Whiting's probation, prison and medical records. During her visit she spoke to residents at Fleming House who knew Mr Whiting.

11. The investigator interviewed four members of staff from Fleming House, and two probation practitioners from North Kent Probation Delivery Unit (PDU), on 29 August. In addition, she interviewed a senior probation officer (SPO), Head of Service and the Deputy Head of Service for North Kent PDU, the acting SPO and the manager for the psychosocial substance misuse provider at HMP Rochester.

12. We suspended our investigation between 5 September and 10 December, pending the results of Mr Whiting's toxicology.

13. We informed HM Coroner for Kent and Medway of the investigation. The Coroner gave us the results of the post-mortem examination and toxicology report. We have sent the Coroner a copy of this report.

14. The Ombudsman's office contacted Mr Whiting's brothers to explain the investigation and to ask if they had any matters they wanted us to consider. Mr Whiting's brother, who he had nominated as his next of kin, asked about the events leading up to his death and said that communication with the AP had been poor.

15. Mr Whiting's brother received a copy of the initial report. He did not identify any factual inaccuracies.

16. The Probation Service also received a copy of the report. They did not identify any factual inaccuracies. We agreed a variation in the wording of the recommendation.

Background Information

Fleming House Approved Premises

17. Approved Premises (AP - formerly known as probation and bail hostels) mostly accommodate offenders released from prison on licence and those directed there by courts as a condition of bail. Their purpose is to provide a supportive and structured environment. Residents are responsible for their own healthcare and are expected to register with a GP.

18. Fleming House is in Maidstone, Kent and managed by the National Probation Service. It has 27 single rooms (and will soon have four shared rooms), including a ground floor accessible room. Breakfast and evening meals are provided and there is a communal area for eating and socialising. Each resident has a key worker to oversee their progress and wellbeing and see that they adhere to their individual licence conditions and the premises' rules. Staff are on duty at Fleming House 24 hours a day.

Previous deaths at Fleming House

19. Mr Whiting was the first resident at Fleming House to die since 2019. In 2017 and 2019, two residents of Fleming House died from natural causes. There are no significant similarities with Mr Whiting's death. There has been one self-inflicted death at Fleming House since Mr Whiting died.

Imprisonment for Public Protection Sentences (IPP)

20. Imprisonment for public protection sentences were abolished in 2012. They were intended to protect the public from offenders whose crimes were not serious enough to merit a normal life sentence, but who could only be released once they had served their minimum tariff and had demonstrated to the satisfaction of the Parole Board that they had sufficiently reduced their risk.

Recall

21. Recall refers to the process of returning to prison an individual who does not follow their licence conditions. It is the responsibility of the Probation Service to initiate recall of individuals on licensed supervision through the Public Protection Casework Section (PPCS).

22. The recall process is set out in the Recall, Review and Re-Release of Recalled Prisoners Policy Framework. In addition to breaching a licence condition, Probation practitioners must consider whether the recall threshold has been made based on an individual's behaviour or circumstances presented while on licence.

23. At the point of initiating recall, it is the responsibility of the police to attend a known address and arrest the individual.

Key Events

24. On 20 May 2009, Mr Patrick Whiting was remanded to prison charged with robbery and taken to HMP Elmley. On 15 October, he was sentenced to an imprisonment for Public Protection (IPP) sentence with a tariff of five years. Mr Whiting had been to prison before. He spent time at Elmley, HMP Swaleside and HMP The Mount before being transferred to HMP Rochester on 26 October 2021.

25. In December 2022, blood tests indicated Mr Whiting had Type 2 diabetes. A doctor prescribed metformin to help regulate his blood sugar and provided him with information on how to manage his condition. Healthcare staff completed a care plan. There was nothing in his medical record to indicate he had, or complained of, any heart related issues.

26. Mr Whiting had a long history of substance misuse and was frequently found under the influence of psychoactive substances (known as Spice). In 2024, before he was released, Mr Whiting was found under the influence on nine occasions, the last time being 23 May. Throughout his time in custody Mr Whiting was offered support by substance misuse services and although at times he was motivated to address this, at other times he declined to engage. He was not engaged with substance misuse services at the time of his release.

Pre-release

27. On 14 February 2024, as part of the parole process, his Community Offender Manager (COM – probation practitioner) completed Mr Whiting's AP referral, which included risk information regarding the impact of his substance misuse. She noted that the purpose of the AP placement was to assist Mr Whiting in adjusting to life outside of prison and provide drug/alcohol monitoring.

28. On 2 April, the Parole Board informed Mr Whiting that he was to be released to Fleming House AP.

Fleming House Approved Premises

29. On 14 June, Mr Whiting was released on licence to Fleming House. His licence conditions included a curfew between 8.00pm - 8.00am (with reporting instructions each day at 12.00pm and 5.00pm unless otherwise authorised) and a GPS monitoring tag for six months.

30. On arrival at Fleming House, a residential worker completed the first stage induction with Mr Whiting, which included completing a Support and Safety Plan (SaSP – a guided wellbeing assessment to identify any risks or areas for support). Mr Whiting disclosed that he had diabetes and said that he needed help to register with a GP. The residential worker drug tested Mr Whiting, which was sent for testing in a laboratory. Mr Whiting's key worker introduced himself.

31. Mr Whiting had a video call with his COM, who encouraged him to register with the local GP to ensure his diabetes was properly managed. Mr Whiting was allocated a room on the first floor.

32. On 17 June, the key worker completed Mr Whiting's second stage induction. He recorded that Mr Whiting had completed the necessary forms to register with the local GP.

33. During this meeting Mr Whiting spoke about his substance misuse and said that at times during his prison sentence he did not care about the outcome but had a more positive outlook now he had been released. Mr Whiting disclosed to his key worker that he had tampered with his urine sample on arrival at Fleming House because he thought it would indicate he had used Spice. The key worker noted that AP staff should continue to monitor Mr Whiting's general wellbeing and monitor and test to ensure he was not using illicit substances.

34. On 19 June, Mr Whiting said that he felt dizzy and had fallen in his room. An ambulance took him to A&E and paramedics suspected that his dizziness related to low blood sugar or a urine infection. Mr Whiting returned to Fleming House having discharged himself from hospital, without having any tests. Over the next few days staff completed welfare checks every two hours and no further issues were recorded.

35. On 21 June, electronic monitoring equipment was fitted and installed for Mr Whiting. Later, the testing laboratory confirmed Mr Whiting's reception drug test was positive for opiates. A residential worker noted that this may have been because Mr Whiting was prescribed co-codamol (for knee pain) and he classed the positive result as acceptable.

36. On 26 June, Mr Whiting moved to the accessible room on the ground floor as he struggled with the stairs due to pain in his knee.

Events on Friday 26 July 2024

37. Mr Whiting was present for the 6.00am welfare check and left Fleming House at 7.56am, four minutes before his curfew. The time that Mr Whiting left Fleming House was not recorded in the logbook as it should have been.

38. A residential worker authorised that Mr Whiting did not have to report for his 12.00pm curfew, so he could attend the Chatham Hub. Mr Whiting did not arrive at the Hub. CCTV viewed by Kent Police after his death confirmed that, at 9.17am, Mr Whiting entered a local shopping centre in Chatham.

39. At 1.20pm, when he had not returned, Fleming House staff attempted to call Mr Whiting, but there was no answer. He was not present for the 3.30pm welfare check and did not sign in for his curfew at 5.00pm. Fleming House staff called Mr Whiting again at 5.45pm and 6.00pm, but there was no answer. A residential worker informed the out of hours on-call manager that Mr Whiting had not returned for his curfew. The on-call manager initiated an 'out of hours' recall, which was endorsed by a senior manager. The recall paperwork detailed actions that staff had taken to contact Mr Whiting.

40. The curfew monitoring sheet for 26 July showed that Mr Whiting had been present during curfew times (12.00pm, 5.01pm and 7.55pm), endorsed by AP staff, which was evidently not correct.

41. The Public Protection Casework Section progressed Mr Whiting's recall paperwork and, at 7.32pm, Mr Whiting's licence was revoked. The police were notified.

42. At 9.51pm, a cleaner entered the toilets in the shopping centre and found Mr Whiting. They contacted the police and paramedics, who arrived at around 10.00pm. Mr Whiting was observed to have rigor mortis and blood pooling, signs that he had been dead for some time. Paramedics confirmed life extinct.

43. At 11.13pm Kent Police contacted Fleming House and spoke to a residential worker. They requested Mr Whiting's next of kin details, which were provided. However, Mr Whiting's next of kin details had not been updated when he arrived at Fleming House and so were inaccurate. Kent Police did not inform Fleming House that Mr Whiting had died. (The residential worker made an incorrect assumption that he had been arrested.)

44. On 30 July, a coroner's officer contacted Fleming House and told them that Mr Whiting had died.

Contact with Mr Whiting's family

45. As Mr Whiting died away from Fleming House, Kent Police initially assumed responsibility for informing his next of kin of his death. However, the police were provided with incorrect contact details. In prison, Mr Whiting had nominated his sister as his next of kin, but she had died some months before his release. The police initially used these out of date details which upset Mr Whiting's brother-in-law. AP staff had not updated their records with his brother's details, which Mr Whiting provided when he arrived at Fleming House.

46. On 30 July, the AP area manager telephoned Mr Whiting's brother-in-law asking to speak to his wife. Mr Whiting's brother-in-law was distressed at having received a second call asking for his wife. The area manager offered his apologies.

47. The AP area manager offered assistance with funeral costs, in line with national instructions.

Support for residents and staff

48. After Mr Whiting's death, the AP manager spoke to the staff on duty who had met Mr Whiting during his time at Fleming House and sent an email to all staff with the details of how to access further support if necessary. Residents were informed and offered support in case they had been affected by Mr Whiting's death.

49. The key worker was on leave at the time of Mr Whiting's death and only learned when he logged on and checked his email on his first day back at work. The AP manager said that he made a conscious decision not to contact the key worker during his leave but accepted that he should have shared the news before he read the news in an email.

50. A residential worker said that she discovered Mr Whiting had died as a member of staff from Fleming House had sent her a Teams message.

Post-mortem report

51. A post-mortem examination found that Mr Whiting died from cardiac hypertrophy. Toxicology results confirmed no illicit substances were detected. The pathologist commented that illicit drug use can accelerate cardiac hypertrophy.

Inquest

52. On 9 December 2024, the Coroner concluded her investigation into Mr Whiting's death. There was no inquest as the cause of death was established as natural causes.

Findings

53. Mr Whiting died from natural causes, and toxicology tests did not identify that he had used any illicit substances in the time before his death.

54. Once a prisoner is released to live at an AP, they are responsible for their own healthcare. Mr Whiting registered with a local GP soon after his release and he took his diabetic medication as prescribed. We do not know the cause of his dizzy spell on 19 June, for which he was appropriately referred to hospital by AP staff, but there were no other indicators in the time before his death that Mr Whiting was experiencing any significant underlying physical health issues, including heart disease.

Electronic Monitoring Services (EMS)

55. Mr Whiting was fitted with two separate electronic monitoring devices, including a GPS location tracker. When he did not return to Fleming House on 26 July, nobody considered contacting the EMS provider to ask them to locate him.

56. The investigator was told by all staff interviewed that contacting the EMS to ask for location details had never been considered, but that using the GPS tracker in this way could be beneficial. The investigator contacted the EMS to ask if such a request was possible. The EMS Service Manager responded and confirmed that data can be requested to check someone's location or trail data. He said an external agency request would need to be submitted with clear justification for data to be released, which could be quickly accessed depending on the urgency of the request.

57. In this case it is unlikely to have made a difference to the outcome for Mr Whiting. However, had his last known location been established it may have avoided a member of the public finding Mr Whiting, and in other circumstances locating a resident more quickly might be crucial. We make the following recommendation:

    The Probation Service, together with Electronic Monitoring Services, should explore the feasibility of developing an Approved Premises protocol to quickly identify the whereabouts of a person living in AP who fails to report for curfew, to enable early identification of their location.

Approved Premises manager to note

58. On 26 July, AP staff incorrectly endorsed that Mr Whiting had been present during curfew checks. The AP manager was unaware of this error until the investigator highlighted it during his interview.

59. The AP manager contacted the two members of staff to ascertain how this mistake had occurred. They responded that it was an error, and that the sheet had been completed on the wrong day and that the signatures recorded on 26 July should have been for 25 July.

60. Accurate recording of residents' whereabouts is critical. APs house those considered to be at high risk of harm should they commit further offences and

inaccurate recording of their whereabouts could potentially put members of the public at risk. While there is no suggestion that Mr Whiting committed a further offence, accurate recording must be a priority for Fleming House. The AP Area Manager will want to consider this.

Other learning

61. During the PPO investigation we identified several issues that, while not linked to Mr Whiting's cause of death, were significant; Mr Whiting was only drug tested on the day of release; he was never referred to community substance misuse services; he resided at Fleming House for 43 days, without a room search; and the drug test result from 14 June was not accurately recorded and therefore incorrect information was provided to the Multi-Agency Public Protection Panel.

62. On 19 December, the PPO investigator met with the AP area manager and the Head of Public Protection (Residential) to provide feedback. The AP area manager has since provided an action plan to address these issues.

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