Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Daniel Short, a resident of Glogan House Approved Premises, on 14 August 2019

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 Short died on 14 August 2019 at Glogan House Approved Premises as a result of heroin toxicity. Mr Short was 33 years old. I offer my condolences to Mr Short's family and friends.

The emergency response was poor. Approved premises staff showed poor judgment when they found Mr Short unresponsive and suspected he had taken drugs. They did not attempt first aid and struggled to follow the ambulance service's instructions.

We were also concerned that approved premises staff did not fully understand their responsibility to challenge Mr Short's substance misuse issues. We recommend that Glogan House's manager introduces a local substance misuse policy as a matter of urgency.

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

Sue McAllister, CB
Prisons and Probation Ombudsman **June 2020**

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Summary

Events

1. On 26 July 2019, Mr Short was released from HMP Parc on licence and went to Glogan House Approved Premises (AP) in Somerset. Initially, he settled well and staff raised no concerns about his behaviour.

2. On 4 August, a residential service worker found drug paraphernalia during a routine room search. She confiscated the items and told the Approved Premises manager, who issued him with a warning. On the same day, Mr Short tested positive for cannabis. The next day, he tested positive for cannabis again. Mr Short was not tested again before he died.

3. At 11.10pm on 13 August, a residential worker found Mr Short unresponsive on all fours in his room. She pressed her alarm key. Another residential worker responded and concluded that Mr Short had taken drugs. The residential workers decided to wait for Mr Short to recover.

4. When they went back to Mr Short's room at 11.45pm, they found him in the same position and still unresponsive. They went back to the office and called the duty manager, who told them to call an ambulance immediately. The residential workers called the ambulance at 12.04am, but did not follow their instructions immediately. They started resuscitation at 12.09am. At 12.14am, paramedics arrived at Mr Short's room, continued with resuscitation until 12.42am, when Mr Short was pronounced dead.

5. The post-mortem examination found that Mr Short died of acute toxicity of morphine (heroin).

Findings

6. The residential workers showed poor judgement during the emergency response. They did not act with any sense of urgency and did not call an ambulance when they thought that Mr Short had taken drugs on 13 August. They also failed to take their own mobile phones during the curfew checks and did not use the mobile phone in the first aid kit. Initially, they did not follow the ambulance service's instructions to find a mobile phone or start resuscitation.

7. We cannot say if the outcome might have been different for Mr Short if the residential workers had acted with greater urgency when they found him unresponsive at 11.10pm, but any delay in a medical emergency may be critical.

8. Approved premises staff should have challenged Mr Short's substance misuse more robustly. They did not search his room or test him for drugs after 5 August, although he had tested positive for cannabis and they had found drug paraphernalia in his room. We are concerned that Mr Short's offender manager and approved premises staff were not clear about their responsibility to manage offenders' substance misuse issues. There was no local substance misuse policy, contrary to national policy.

9. We are also concerned that the drug testing kits in use at Glogan House were unreliable. We found a similar concern at an AP in Manchester in a previous investigation. Given the prevalence of drug use among many AP residents, this unsatisfactory state of affairs needs to be resolved without delay.

10. Managers did not attend the AP for several hours after Mr Short's death. Approved premises staff and residents were very shocked and needed the support of managers without delay.

Recommendations

- The Approved Premises Manager should:
  - ensure that staff err on the side of caution and call an ambulance immediately when a resident is found unresponsive and may have taken drugs;
  - ensure that staff carry a mobile phone with them at all times;
  - ensure that newly appointed staff receive first aid and CPR training before they start work in the AP;
  - share this report with residential workers A and B and discuss the Ombudsman's findings with them.
- The National Probation Service should review the quality and reliability of the drug testing kits available in Glogan House and provide them with effective means to test for a wide range of substances including some prescription drugs and psychoactive substances.
- The Approved Premises Manager should develop a local substance misuse policy, in line with the requirements of the Approved Premises Manual. The policy should set out procedures for requesting substance misuse tests and room searches.
- The National Probation Service should review the position on the use of naloxone and make a decision about whether it should be made available for use by AP staff.
- The Approved Premises Manager should ensure that a manager attends the AP immediately when a resident dies, in line with best practice.

The Investigation Process

11. The investigator issued notices to staff and residents at Glogan House, informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

12. The investigator obtained copies of relevant extracts from Mr Short's records. The investigation was then suspended while we waited for the results of toxicology tests. The investigation was resumed on 30 September 2019. On 4 December 2019, the investigator interviewed seven members of staff.

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

14. The Ombudsman's family liaison officer contacted Mr Short's mother to explain the investigation and to ask whether he had any matters the family wanted the investigation to consider.

15. Mr Short's mother wanted to know whether Mr Short was taking drugs throughout his time at Glogan House or whether he died due to a single overdose. She also wanted to know how he was behaving in the weeks leading up to his death. We have addressed these questions in this report.

16. We sent a copy of the initial report to Mr Short's mother. She pointed out one factual inaccuracy which has been addressed in this report.

17. We also sent a copy of the initial report to the National Probation Service. They pointed out two factual inaccuracies which have been addressed in this report.

Background Information

Glogan House Approved Premises (AP)

18. 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. Each resident is allocated a key worker or offender supervisor to oversee his progress and well-being, and to ensure that he adheres to licence conditions and the premises' rules.

19. Glogan House Approved Premises is a house in Bridgwater, Somerset, providing accommodation for up to 16 men in two double and 12 single rooms. There are communal lounges, laundry facilities, a dining room and other areas used for group work. Staff are available at Glogan House 24-hours a day (with at least two members of staff on duty overnight). Residents are responsible for their own health and are expected to register with a local GP surgery. Prescribed medication is held by each resident in his room, subject to a risk assessment.

Previous deaths at Glogan House

20. Mr Short was the second death at Glogan House. The previous death was in 2011 and was due to natural causes.

Psychoactive substances (PS)

21. Psychoactive substances (formerly known as 'new psychoactive substances' or 'legal highs') are a serious problem across prisons and probation services. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Those under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

Key Events

22. On 12 October 2017, Mr Daniel Short was sentenced to two years and six months imprisonment for actual bodily harm. The victim of his offence was his partner. He was sent to HMP Exeter.

23. Mr Short had a history of drug and alcohol misuse, self-harm and suicide attempts in custody and was subject to suicide and self-harm monitoring (known as ACCT) on multiple occasions. In 2018, Mr Short tried to hang himself three times. On 17 January 2019, Mr Short transferred to Parc, where he was subject to ACCT monitoring from 14 February until 3 March. On 26 July 2019, Mr Short was released from HMP Parc on licence.

24. Mr Short's licence conditions required him to live at Glogan House Approved Premises, initially for two weeks. His placement was then extended to 20 August 2019. His licence also required him to be regularly tested for drugs, as specified by his offender manager (probation officer). He was subject to a curfew from 11.00pm to 6.00am.

25. Mr Short's offender manager at the time wrote in his release plan that he should be notified if there was any evidence that Mr Short was taking drugs. He wrote that Mr Short would be referred to a substance misuse agency in such circumstances and noted that Mr Short would be recalled if he failed to address his substance misuse issues.

26. The offender manager recorded in a national approved premises referral that Mr Short was at risk to himself, particularly in February, the month that his step-mother had died. He also recorded that Mr Short refused to engage with substance misuse services in custody and had lost his job while in custody because he was using psychoactive substances (PS).

27. When Mr Short arrived at Glogan House on the evening of 26 July, a residential service worker explained the AP rules, including the room search policy, drug and alcohol restrictions and what support was available from AP staff. She tested Mr Short for drugs and alcohol and it was negative. She gave Mr Short an information sheet about overdose prevention and recorded that Mr Short had suffered from depression for years, but did not want to take antidepressants.

28. The next day, another residential service worker assessed Mr Short's risk to himself. She recorded that Mr Short said that he had injected heroin in the past and had wanted to die, "but not now". Mr Short said that he had tried to overdose in the past, but did not currently feel suicidal. He said that he had depression, but was not taking any medication. She assessed that Mr Short was at low risk to himself. She tested Mr Short for drugs and alcohol and, again, it was negative.

29. On 29 July, Mr Short's new offender manager introduced herself over the phone. Mr Short's key worker was on the call. Mr Short told her that he had seen his father and daughter since his release. He was concerned that he could no longer live at the address he had hoped to go to after his placement at Glogan House. His offender manager told Mr Short that she would speak to the approved premises manager to secure an extension of his stay beyond the initial two weeks and check

other placements at approved premises in Bristol. She planned to meet Mr Short on 5 August to review his situation.

30. On 30 July, a residential worker tested Mr Short for drugs and alcohol. The test was negative. Mr Short joined the local gym and staff recorded that he engaged well with other residents and staff at Glogan House.

31. On 4 August, a residential service worker carried out a routine search in Mr Short's room. She found several syringes, needles and three bottles of testosterone (steroids), one empty. She confiscated the items and told the approved premises manager. The same day, she recorded that Mr Short had tested positive for cannabis. Mr Short said that he had not smoked cannabis in years, but he had been around friends who smoked it.

32. During an offender management meeting on 5 August, Mr Short told his offender manager that he had not taken drugs and he thought "passive smoking" had given the positive result. Mr Short denied using steroids and said the syringes were old. She reminded Mr Short that any drug paraphernalia breached the AP rules and told him that the approved premises manager was going to give him a warning, which she did two days later. (The approved premises manager gave a 'red warning' used for serious breaches of AP rules. Two such warnings could result in losing the AP place.) Mr Short said he had felt depressed in the past, which he linked to his drug misuse. He said he had been going to the gym to keep away from drugs. She told Mr Short that the approved premises manager had agreed to an extension to his placement until 20 August.

33. The same day, Mr Short asked a residential service worker to be drug tested again, and again, he tested positive for cannabis. She recorded that staff suspected that Mr Short was meeting old associates in the community who were dealing drugs. She recorded that staff should monitor him.

34. On 11 August, Mr Short had an alcohol test but was not tested for drugs. The test was negative. This was the last test that Mr Short had at Glogan House. Staff recorded no concerns.

Events of 13 August

35. On 13 August, Mr Short told staff that he was going to a Job Centre appointment and left the premises at 8.30am. The key worker said that Mr Short had agreed to meet him at 12.30pm, but Mr Short did not turn up for his key worker session that day.

36. At 8.00pm, a residential worker started work at Glogan House. Another residential worker briefed her about the residents and did not pass on any concerns about Mr Short.

37. At 9.06pm, Mr Short returned to Glogan House with a takeaway. At 9.15pm, Mr Short went to the main office and asked a residential worker to unlock the kitchen for him. She unlocked the kitchen and, shortly afterwards, Mr Short went to the dining room with his food.

38. At 9.45pm, residential worker A started her shift. At 10.00pm, she went to the kitchen and noticed Mr Short with three other residents smoking a cigarette outside. She said hello to the residents and went back to the office. She said that she had no concerns about any of them. Mr Short then went back to his room.

39. At 11.00pm, residential worker B started curfew checks. She had her first aid kit with her, containing a resuscitation shield (for mouth to mouth resuscitation) and a mobile phone. When she got to Mr Short's room at 11.10pm, she found him on all fours on the floor. She told the investigator that she did not notice any drug paraphernalia at the time, although on reflection, she thought there might have been a spoon. She said that she thought that Mr Short was asleep in that position, but she became concerned when he did not respond. She said that she could hear him breathing, but did not check his vital signs. She pressed her alarm, which triggered a general call to staff.

40. Residential worker A responded and got to Mr Short's room two minutes later. She thought that Mr Short was under the influence of drugs, possibly PS. She told the investigator that she was not overly concerned and assumed Mr Short would soon recover. Residential worker B said that she did not question her colleague's assessment because "she did not know how somebody would present under the influence of PS" and relied on her colleague's experience. They agreed to leave and check him later.

41. When they went back to Mr Short's room at 11.45pm, he had not moved. Residential worker B said that she could still hear Mr Short breathing and he was still a "normal colour", but he remained unresponsive. They went to the office to call the duty manager. Residential worker A said that she wanted "to ask his advice about what to do". She said that she had to call the duty manager two or three times before he answered, so it took five or ten minutes to speak to him.

42. The duty manager said that he received the call just after midnight on 14 December. He told residential worker A to call an ambulance immediately.

43. From 12.04am to 12:08am, residential worker A spoke to the ambulance service. In the recording of her telephone conversation with the ambulance controller, she told the ambulance controller that Mr Short was breathing but was not conscious. She told the controller that she suspected that Mr Short had taken PS. The ambulance controller asked her whether she could get closer to Mr Short with the phone, but she said that it was not possible.

44. Up to this point, neither residential workers had attempted first aid. The ambulance controller asked residential worker A to get a mobile phone so she could call her back and guide her through treating Mr Short. The residential worker eventually provided a number, terminated the call and went back to Mr Short's room with her colleague.

45. South West Ambulance Service (SWAS) allocated an ambulance after the call at 12.06am, but they stood it down a minute later. SWAS told the investigator that the call was initially categorized as a "cat-2" (a no priority call) because residential worker A said that she believed that Mr Short was breathing.

46. At 12.09am, the ambulance controller called residential worker A, who again tried unsuccessfully to get a response from Mr Short. At this point, she told the ambulance controller that "they could not hear him breathing". SWAS told the investigator that after this second call the ambulance was prioritised for dispatch.

47. The ambulance controller instructed residential worker A to put Mr Short on his back, but she said that there was not enough room. Another resident in the next room helped to clear the area of furniture. They tried to put Mr Short on his back, but they could not move him as he was too heavy. The ambulance controller insisted that Mr Short needed to be on his back for resuscitation.

48. At 00.12am, residential worker A confirmed that Mr Short was on his back and told the ambulance controller that he looked blue. She repeated that she could not hear him breathing. The ambulance service controller asked her to give mouth to mouth breaths to Mr Short, but she said that she could not. She told the investigator that she panicked. She passed the phone to residential worker B, who also said that she could not do mouth to mouth because she had not been trained. The ambulance controller instructed her to start chest compressions.

49. Paramedics got to Mr Short's room at 12.14am, after residential worker A let them in to the building. Paramedics continued with resuscitation procedures until 12.42am, when Mr Short was pronounced dead.

50. After Mr Short's death, police found a quantity of powder, a spoon and unidentified pills on him.

Contact with Mr Short's family

51. On 14 August, in line with National Probation Service guidance, the police visited Mr Short's father at his home address and informed him of his son's death.

52. On 16 August, the area manager contacted Mr Short's mother by telephone and offered her condolences and support. In the days that followed, he maintained contact with Mr Short's family. On 6 September, Mr Short's family visited Glogan House.

53. On 18 September, Mr Short's funeral took place. In line with national guidance, the Probation Service offered a contribution to the costs of the funeral.

Support for residents and staff

54. The Approved Premises Manual requires that the duty manager notifies his line manager if a resident dies, and the line manager should decide whether the duty manager should go to the AP. The duty manager called his line manager to tell her about Mr Short's death. The line manager said that he should call the AP Manager to alert her, but he did not have to go to the AP because he lived three hours away. The duty manager sent the approved premises manager a text message at 1.00am, which she did not read until 7.15am in the morning.

55. At 7.30am, the approved premises manager telephoned residential worker A and asked her to stay at the premises until she arrived. No manager had attended the premises up to this point.

56. At 8.00am, the approved premises manager arrived at the premises and debriefed both residential workers. They had the opportunity to discuss any issues arising, and she offered support.

Post-mortem report

57. The post-mortem examination found that Mr Short died of acute toxicity of morphine (a heroin overdose).

58. The pathologist said that the concentration of morphine was at a level consistent with a recent heroin injection. Toxicology tests also indicated that Mr Short had recently used cocaine.

Findings

Emergency response

59. The Approved Premises Manual, issued in 2014, provides guidance for AP staff on what to do in the event of emergencies. It stipulates that in cases of suspected overdose, where a resident is unconscious or has breathing difficulties, resuscitation should be attempted by someone who is first-aid trained. The manual also requires that all staff must receive training in first aid, including CPR, appropriate to their grade. At all times at least one member of staff on duty must have up-to-date first aid training.

60. We are concerned that both residential workers showed poor judgement when they found Mr Short unresponsive at 11.10pm and failed to respond effectively. They did not check Mr Short for vital signs or call an ambulance for 54 minutes.

61. Both residential workers did not consider taking the defibrillator to Mr Short's room. They told the investigator that they knew it was in the office, but did not think about using one. They did not consider using the mobile phone which was in the emergency bag nor did they take their own mobile phones during the curfew checks. (Residential worker A said that this is a regular occurrence at Glogan House.) When they spoke to the ambulance controller, they struggled to follow her instructions, further delaying emergency resuscitation efforts.

62. The approved premises manager confirmed that residential worker A had received substance misuse awareness training and knew to call an ambulance immediately if a resident appears to be under the influence of drugs and was not responsive. We accept that both residential workers (who were not first aid trained at the time of the incident) panicked. However, we are concerned that the initial failure to act, combined with the subsequent lack of urgency and effectiveness, meant that there was a delay in Mr Short receiving urgent medical assistance. We cannot say if this affected the outcome for Mr Short, but any delay in these circumstances can be critical.

63. We make the following recommendation:

The Approved Premises Manager should:

- **ensure that staff err on the side of caution and call an ambulance immediately when a resident is found unresponsive and may have taken drugs;**
- **ensure that staff carry a mobile phone with them at all times;**
- **ensure that newly appointed staff receive first aid and CPR training before they start work in the AP;**
- **share this report with both residential workers and discuss the Ombudsman's findings with them.**

Substance misuse

64. The Approved Premises Manual says that residents should be tested for drugs or alcohol if they have a history of substance misuse or staff have reasonable suspicion that they are using drugs. Even where there is no direct suspicion, room searches should be carried out regularly.

65. The approved premises manager told the investigator that she expected a resident's offender manager to specify the frequency of drug testing. She would expect AP staff to carry out additional tests if there was any suspicion that the resident was misusing drugs or alcohol. Mr Short's offender manager told the investigator that it is not her responsibility to set the frequency of testing, but she thought residents were tested at least weekly at Glogan House.

66. We are concerned that there was no clarity about who should oversee Mr Short's drug testing. We consider that, as testing is intelligence-led, the responsibility must be shared between the offender manager and staff at the AP.

67. The approved premises manager told the investigator that, on 9 August, staff discovered that their drug testing kits were showing falsely positive results. On 12 August, she suspended the use of drug testing kits at Glogan House. The Approved Premises Manual sets out the expectation that APs are to be well equipped for drug and alcohol testing. In light of Mr Short's history of substance misuse and the discovery of drugs paraphernalia in his room, we are surprised that Mr Short was not tested again after 5 August, and that his room was not searched.

68. We are also concerned that the drug testing kits used at Glogan House were unreliable. In our investigation into the death of a resident in an Approved Premises in Manchester in June 2019, we were also told that the drug testing kits in use at that AP were unreliable and gave inaccurate results. In common with other APs, many residents at Glogan House have substance misuse issues and abstinence from illicit substances is a standard condition of their probation licence and their residence in the AP. APs do not have the same powers as prison staff to search residents and are limited to searching rooms and asking residents to empty their pockets. It is therefore crucial that staff in APs are provided with the means to ensure effective drug testing.

69. We have been told that the National Approved Premises Team are undertaking a review of drug tests in APs with a focus on quality and reliability. We welcome this initiative and support it with the following recommendation:

    The National Probation Service should review the quality and reliability of the drug testing kits available in Glogan House and provide them with effective means to test for a wide range of substances including some prescription drugs and psychoactive substances.

70. The Approved Premises Manual stipulates that APs should have a local substance misuse policy. The policy should include instructions about managing residents in possession of or using substances, or those found unconscious or with breathing difficulties. It should also cover when room searches are required and how they should be carried out. The manual says that staff should be familiar with the policy.

71. Glogan House AP did not have such a policy at the time of Mr Short's death and there were no plans to develop one. Residential workers A and B and the key worker told the investigator that drugs are available at Glogan House and they all said that it was not rare to see offenders under the influence of drugs.

72. Glogan House should develop a substance misuse local policy, in line with national requirements. We make the following recommendation:

The Approved Premises Manager should develop a local substance misuse policy, in line with the requirements of the Approved Premises Manual. The policy should set out procedures for requesting substance misuse tests and room searches.

Naloxone

73. Naloxone is the emergency antidote for overdoses caused by heroin and other opiates or opioids (such as methadone, morphine and fentanyl). The main life-threatening effect of heroin and other opiates is to slow down and stop breathing. Naloxone blocks this effect and reverses the breathing difficulties. It can be administered by injection or nasal spray.

74. Naloxone is a prescription-only medicine, so pharmacies cannot sell it over the counter. But drug services can supply it without a prescription and anyone can use it to save a life in an emergency. For example, drug services can supply naloxone for use in an emergency to a family member or friend of a person using heroin, or to an outreach worker or a hostel manager whose clients include people who use heroin.

75. The National Probation Service's current position, set out in May 2018, is that naloxone should not be administered by AP staff to residents who are suspected of having overdosed. We cannot say whether the use of naloxone might have changed the outcome for Mr Short, but we consider there is a strong case for making it available in APs for use by AP staff. We make the following recommendation:

The National Probation Service should review the position on the use of naloxone and make a decision about whether it should be made available for use by AP staff

Incident management and support to staff

76. The National Probation Service's out of hours protocol sets out AP managers' responsibilities from 5.00pm until 9.00am, Monday to Thursday, and from 5.00pm on Friday until 9.00am the following Monday. The protocol says that it is good practice for the duty manager to attend the AP if a resident dies out of hours, to offer support to staff and provide initial cover if a staff member is unable to continue with their shift.

77. Mr Short was pronounced dead at 12.42am. We are concerned that no manager attended the approved premises until 8.00am to support staff and other AP

residents. The key worker said that residential workers A and B were in a state of shock when he arrived at the premises the next day.

78. We do not consider that AP managers acted with sufficient urgency, given the gravity of the situation.

The Approved Premises Manager should ensure that a manager attends the AP immediately when a resident dies, in line with best practice.

Inquest

79. The inquest into Mr Short's death concluded on 8 December 2025. The jury recorded that measures taken to address his risk of drug use at Glogan House were ineffective and possibly contributed to his death. They found that there was a significant delay in staff seeking emergency medical treatment for Mr Short when he was found under the influence of drugs at 11.01pm on 13 August 2019, and that this delay would not have occurred had staff acted in accordance with their training. The jury found that this delay probably contributed to Mr Short's death.

80. The jury concluded that measures taken by Glogan House staff in the lead up to Mr Short's death were ineffective and possibly contributed to his death. They found that there was a significant delay in staff seeking emergency medical treatment and that there was neglect by the senior member of staff on the night of 13-14 August 2019.

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