



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man
at Manor Lodge Approved Premises, Windsor,
in July 2013**

Our Vision

*'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision'*

This is the investigation report into the death of a man who was found dead in his room on 21 July 2013 at Manor Lodge Approved Premises, Windsor. He was 39 years old. I offer my condolences to the man's family and friends.

The investigation was led by an investigator. The staff and residents of Manor Lodge and Thames Valley Probation cooperated fully with this investigation.

The man was released on licence from HMP Bullingdon on 28 February 2013. As part of his licence conditions, he was required to live at Manor Lodge. It appears that during the evening of 20 July, he drank several cans of strong lager and injected himself with heroin. A member of staff doing a morning roll check did not see the man but thought he had responded verbally when she called through his door at 7.30am the next day. The man was found dead in his room at 1.30pm. As paramedics estimated that he had been dead for 12 hours, discovery at the morning check would not have changed the outcome. A post-mortem report concluded that The man died from undiagnosed heart disease.

At first it was considered that the man's death might have been drug related and managers at Manor Lodge issued new security guidance to staff to reinforce safety. I welcome this response, but I am satisfied that poor security did not have a bearing on the man's death and that he died unexpectedly of natural causes which staff at Manor Lodge could not have foreseen or prevented.

Nigel Newcomen CBE
Prisons and Probation Ombudsman

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CONTENTS

Summary	5
The investigation process	6
Manor Lodge	7
Key events	8
Issues	12

SUMMARY

1. The man was released from HMP Bullingdon on licence on 28 February 2013 and was required to live at Manor Lodge Approved Premises, Windsor. He spent his time there applying for housing and jobs. The man made friends with other residents and seemed to settle well. He was known to drink alcohol but was not regarded as a disciplinary problem. He took a number of medications daily for bi-polar disorder, anxiety and back pain.
2. On the evening of 20 July 2013, the man drank several cans of lager and some vodka, and injected heroin illicitly in his room. He was last seen alive at about 11.30pm when a member of staff removed another resident from his room. The same member of staff did a roll check at 7.30am on 21 July and thought that she had obtained a verbal response from the man. The man was later found dead in his room at 1.30pm and paramedics estimated that he had been dead for 12 hours. We are satisfied that if he had been discovered at morning roll check it would not have changed the outcome.
3. A post-mortem and toxicology report showed the man had died from undiagnosed heart disease. As a result of this investigation, new guidance was issued to staff about roll checks, room searches and using radios. We are satisfied that none of these issues had a bearing on the man's death and that he died unexpectedly of natural causes.

THE INVESTIGATION PROCESS

4. The investigator issued notices about the investigation to staff and residents at Manor Lodge inviting anyone with information to contact her. No one came forward.
5. The investigator spoke on the telephone to the Area Manager for Thames Valley Probation and was sent a copy of the man's Manor Lodge file. The investigator visited Manor Lodge on 7 August 2013 and met the Manager, and interviewed three staff and two residents.
6. The investigator spoke to a Detective Constable from Thames Valley Police, who confirmed the police had concluded their investigation. She also spoke to the Berkshire Coroner's Officer. Following information from the Area Manager and residents at interview that the man's had taken drugs the night before he died, the investigation was suspended pending the results of a toxicology report, which was received on 1 October. The investigator spoke to the toxicologist by telephone.
7. One of our family liaison officers wrote to the man's family and told them about the investigation.

MANOR LODGE APPROVED PREMISES

8. Approved premises (formerly known as probation hostels) mostly accommodate offenders released from prison on licence. Their purpose is to provide an enhanced level of residential supervision in the community as well as a supportive and structured environment.
9. Manor Lodge in Windsor is run by Thames Valley Probation. Every resident attends an induction session and signs to say that he understands the rules which include not to bring illicit drugs or alcohol into Manor Lodge. Each resident is allocated an offender supervisor as their keyworker.
10. At weekends, one offender supervisor and one residential assistant are on duty between 8.30am and 8.30pm and another offender supervisor and residential assistant are on duty over night. Residential assistants are employed by CORPS Security. Their role is to patrol the building and grounds, lock the building at night and accompany the offender supervisors on room checks. They also give the residents their medication.
11. Manor Lodge has a curfew between 11.00pm and 7.00am when every resident is required to be in. The offender supervisor and residential assistant are expected to check that each resident is in their room at night. Another roll check takes place at 7.30am. Staff are required to open the room doors and satisfy themselves, by either a verbal response or a visual check, that each resident is alive and well. Residents are not allowed in each others' rooms.
12. Residents are initially asked to hand in any medication to staff. The medication is labelled and stored in a locked cabinet in the duty office. Residential assistants issue medication and the resident must take it in front of them. A record of whether the medication has been taken or not is kept in the resident's record. If a resident decides to routinely stop taking their medication they are asked to sign a disclaimer. Staff are instructed not to give medication to residents if they suspect they are under the influence of drugs or alcohol. Breathalysers are available for staff to check residents' levels of alcohol.
13. There have been no previous deaths at Manor Lodge.

KEY EVENTS

14. On 8 May 2012 the man was sentenced to three years imprisonment. He was released on licence from HMP Bullingdon on 28 February 2013. At the time of his offence, the man had no fixed accommodation and his release conditions required him to stay at Manor Lodge Approved Premises, Windsor and find appropriate housing in the community.
15. The man said that he had a history of drug and alcohol abuse at an initial assessment interview. He said he was not happy to have been placed in a hostel but was pleased to have been released from prison. He reported taking an overdose in 2010 in response to stressful domestic circumstances but did not currently feel like harming himself. The man said that he suffered from bi-polar disorder, anxiety and depression and had nerve damage to his back which affected his mobility and ability to work. He was prescribed quetiapine (300ml at night) for bi-polar disorder and citalopram (40mg daily) for anxiety and depression. The man was also prescribed dihydrocodeine (120ml twice daily) and zopiclone (75ml at night) for his back pain. The man had been released from Bullingdon with a few days supply of each medication. At Manor Lodge he was registered with a local GP.
16. An offender supervisor was the man's key worker at Manor Lodge. The man was set targets to find work, apply for housing in the community and abide by the conditions of his licence. The offender supervisor said the man was originally unhappy about being at Manor Lodge, but after he settled in and made friends he became more talkative and engaging. The man was mostly compliant with his medication but often took less than his prescribed dose of quetiapine because it made him drowsy. He signed a disclaimer about this. The man appears to have stopped taking citalopram on 2 July. During May and June, the man was also prescribed co-codamol for back pain but his medication record shows he took this only three times in May and June.
17. The offender supervisor said that on a few occasions the man had returned to the hostel having obviously drunk alcohol. He said the man had been spoken to about his drinking but his behaviour had never caused sufficient concern for him to face disciplinary action. The offender supervisor said that there was nothing in the man's behaviour at Manor Lodge to suggest that he was taking illicit drugs. His view was that the man had been coping reasonably well with his situation and had a good relationship with staff and residents. Finding somewhere to live caused the man some anxiety and frustration but at the time of his death they were actively pursuing a referral to a project in High Wycombe.
18. The man's record shows that he had two warnings while at Manor Lodge. The first was on 20 March for going in to another resident's room and the second on 29 April for missing a session with his key worker.

The events of 20 and 21 July 2013

19. A resident at Manor Lodge, had known the man for three months there and had become friends with him. The resident said he used to have a drink with the man and knew that the man used illicit drugs in his room. He described the man's drug use as "occasionally when he felt like partying". On the evening of 20 July, the resident said it was obvious from how the man was walking and talking that he had been drinking. The resident said the man had told him that he was determined to get hold of some heroin and appeared in a celebratory mood.
20. Another resident was also a friend of the man. He said that in his room on the evening of 20 July, the man drank two cans of super-strength lager, a can of strong lager and some vodka. The resident said that this was not an unusual amount for the man to drink but he usually spaced it over the day. On 20 July, he said the man began drinking at about 8.00 or 9.00pm.
21. Another resident did not want to speak to the investigator but made a statement to staff and Thames Valley Police the following day, in which he said that he had injected heroin (obtained from another resident) with the man in his room at about 11.30pm on 20 July.
22. Another offender supervisor was the offender supervisor on night duty on 20 July. The offender supervisor told the investigator that she is not a permanent member of staff but works frequently at Manor Lodge and knew the man very well. She had covered one of his recent key work sessions and talked to him in some depth about his circumstances. She said the man did not always engage well with staff and had a tendency to drink alcohol. The offender supervisor said when the man drank he became argumentative and would repeat the same things over and over. That evening, she said he was more friendly and talkative than usual but she did not think he had been drinking because none of the usual signs were there.
23. The offender supervisor said that the man came to the duty office for his medication some time before 11.00pm that night. The residential assistant was not in the office so the man sat and chatted to her while he waited. He showed her an infected insect bite on his leg and she advised him how to treat it. They talked about the hot weather. The offender supervisor said he did not smell of alcohol. The residential assistant then gave the man his medication and the offender supervisor told him to go up to his room as by then it was 11.00pm.
24. The man's medication record shows that at 11.00pm on 20 July he took two zopiclone tablets, 150mg of quetiapine and 120mg of dihydrocodeine. The offender supervisor said the residential assistant told her that at 11.30pm, he had seen on the CCTV a resident go into the man's room. The offender supervisor said she told the residential assistant that they should both go up to the room but he did not go with her. The offender supervisor told the resident to go back to his room and the man to lock his door and not let anyone else in. She told him that she had found some ointment for his insect

bite which he could have in the morning. She said the man said he was fine and thanked her for her concern. The offender supervisor then made sure the resident was in his room and went back downstairs. CCTV footage shows that the resident later left his room and knocked on the man's door at 12.20am. He did not appear to get a reply and returned to his room.

25. The offender supervisor said that the man was not known as a drug user at Manor Lodge and she had no reason to search his room. In any event to do so she would have needed to go downstairs to get the residential assistant and that would have given the man and resident the opportunity to hide anything illicit.
26. The next morning, Sunday 21 July the offender supervisor and the residential assistant carried out a roll check between 7.00 and 7.30am. During a roll check, the offender supervisor goes into each room and the residential assistant stands in the corridor and checks the room number off a list. The offender supervisor told the investigator that due to the very hot weather several residents were sleeping naked, although this was contrary to hostel rules. That morning, she said she had already been "embarrassed" three times before she got to the man's room and therefore decided that she would be satisfied with a verbal response. The offender supervisor said she did not look into the man's room but was convinced that she had heard him acknowledge her. She also noticed his light was, on which gave her the impression that he was awake. The offender supervisor went off duty at 8.30am.
27. The offender supervisor came on duty just after 8.00am on 21 July. A resident said he knocked on the man's door several times during the morning but did not get a response. At about 1.30pm, the other resident came back from church and he and the resident decided to ask the offender supervisor to check if the man was OK. The offender supervisor unlocked the man's door and found him sitting on his bed slumped forward with his head almost touching the floor. The offender supervisor said the man was quite clearly dead. He went back downstairs and told the residential assistant he was calling an ambulance. When he returned to the man's room he found the residential assistant and two residents there. He asked the residential assistant to take the two residents downstairs.
28. After he made the initial emergency call, the emergency operator called the offender supervisor on his mobile. The offender supervisor said the operator asked him to put the man on the floor and begin cardio pulmonary resuscitation (CPR). The residential assistant went back to the room and moved the bed while the offender supervisor and the resident put the man on the floor. The resident began chest compressions. The offender supervisor said that rigor mortis has set in and it was not possible to lay the man flat. He told the emergency operator that it was too late for CPR. Paramedics then arrived and pronounced the man dead. They told staff that it appeared that The man had been dead for some 12 hours.

Family liaison

29. West Midlands Police informed the man's family of his death that day. The hostel manager, was on leave when the man died. The Thames Valley Probation Area Manager, spoke to the man's sister by telephone on Monday 22 July. Two members of staff and the two resident attended the man's funeral. Thames Valley Probation offered financial assistance towards the funeral costs and returned the man's property to his family.

Care for staff and residents

30. The two residents said they had been well supported since the man's death and the offender supervisor and the residential assistant were satisfied with the support they had been offered. The offender supervisor said the Area Manager and hostel manager had been very supportive to her but she was not satisfied with the formal support through the human resources department. Her comments have been fed back via the hostel manager.

Post-mortem examination

31. The toxicology report showed that the man had alcohol, morphine (consistent with using heroin), a therapeutic dose of dihydrocodeine and cocaine metabolites (consistent with using cocaine more than eight hours before death) in his system when he died. However, the post mortem examination showed that the man had undiagnosed heart disease and it was that which had caused his death and not drugs or alcohol. The cause of death was:
- 1a Acute left ventricular failure
 - b. Ischaemic heart disease
 - c. Occlusive coronary atheroma

ISSUES

Morning roll check 21 July

32. The man was almost certainly dead by the time of morning roll check on 21 July. Ambulance paramedics who attended told staff that, judging by the rigor mortis present, he had probably been dead for some 12 hours. The offender supervisor did not make a visual check of the man that morning but was convinced that she had heard him respond. It seems she was mistaken but we are satisfied that the man was already dead and discovery at the morning roll check would not have saved his life. We are satisfied that the man died unexpectedly of undiagnosed heart disease which staff at Manor Lodge could not have predicted or prevented.

Evening roll check, searches and medication

33. The investigation found that residents often took the opportunity to go into each others rooms in between staff returning to the office after the evening roll check and monitoring the CCTV. It also appears that the man received his medication on 20 July despite having consumed a significant amount of alcohol. The residential assistant did not accompany the offender supervisor to the man's room as he should have done once he had seen another resident go in. None of these matters contributed to the man's death which was sudden and from natural causes, however there are issues of safety. As a result the Manor Lodge operational manager issued new guidance to staff that they should not leave the corridors immediately after the evening roll check. Residential assistants were instructed to undertake further corridor checks . to accompany offender supervisors if there were concerns that residents were going in and out of one another's rooms. Staff were reminded that medication should not be dispensed if there is any suspicion that a resident is under the influence of alcohol or drugs. We are satisfied that appropriate action was taken.