PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man at Norfolk Park Approved Premises, Sheffield in August 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 died suddenly as a result of epilepsy, in August 2013, at Norfolk Park Approved Premises, Sheffield. He was 50 years old. I offer my condolences to his family and friends.

The staff at Norfolk Park cooperated fully with the investigation. The investigation was suspended until February 2014 until a cause of death was established. I am sorry for the subsequent delay in issuing the report.

The man had been released on licence from prison in May 2012. He was under probation supervision when he was arrested and bailed on a charge of criminal damage. He was not recalled to prison, but was required to live at Norfolk Park, from 16 August, for a short period of closer supervision. He attended all of his probation appointments and staff described him as compliant with no indication of alcohol or drug misuse. He had epilepsy, for which he received medication.

During the day on 26 August, the man attended a police station as part of his bail conditions and spent some time at a local fun fair. In the evening, he said he was going to a nearby shop and was out for an hour or so. All residents have to be in the hostel by 11.00pm and in their rooms by 12.30am. At about 12.40am a night care worker at the hostel saw him out on the corridor talking to another resident and asked them to go to their rooms. She had no concerns about him at the time. The next morning, during a routine check, he was found dead in his room.

A toxicology report found traces of alcohol, cannabis and prescribed medication in the man's system, but these were not the cause of his death which the pathologist gave as sudden unexpected death in epilepsy. I do not consider that there is anything that staff at Norfolk Park could have done to prevent his death and I am satisfied that he received appropriate care.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **January 2015**

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SUMMARY

1. The man was released on licence from HMP Lindholme on 8 May 2012. His sentence was due to expire on 18 November 2013. He had epilepsy and depression, for which he received medication and had a history of alcohol and drug misuse.

2. On 15 August 2013, the man was arrested and bailed for an offence of criminal damage. His offender manager decided that this incident did not warrant a recall to prison, but arranged for him to live at Norfolk Park Approved Premises from 16 August for a short period of more intensive supervision.

3. During his time at Norfolk Park, the man attended all of his probation and police appointments. He adhered to the premises' rules and abided by his curfew times.

4. During the day of 26 August, the man attended a police station as he was required to do under his bail conditions and also went to a local fair. At 9.21pm on 26 August, he signed out to go to a local garage shop. He returned just over an hour later and staff saw him in the dining area during the curfew check at about 11.00pm.

5. At 12.40am, a member of staff saw the man out in the corridor with another resident. She asked them to return to their rooms and watched as they did.

6. At about 7.40am, during a routine check, the same member of staff found the man lying on his bed, unresponsive. Other staff attended, but did not attempt resuscitation as rigor mortis was present and it was clear that he had been dead for some time. Paramedics arrived and, at 7.53am, confirmed that he had died.

7. A post-mortem and toxicology report found alcohol, cannabis, zopiclone in his system, as well as tramadol which he was prescribed. The pathologist noted that, while it was possible that the mixture of drugs could have caused the fit, the cause of death was sudden unexpected death in epilepsy.

8. We consider that the care the man received at Norfolk Park was appropriate and that his death could not have been prevented. We make no recommendations.

9. The man's family and the service were given the opportunity to see the draft report. The service responded with some minor factual inaccuracies which have been amended in this final report.

THE INVESTIGATION PROCESS

10. The investigator issued notices to staff and residents at Norfolk Park Approved Premises, inviting anyone with relevant information to contact her. No one responded.

11. The investigator obtained copies of relevant extracts of the man's probation records and clinical records. She interviewed two members of staff and his offender manager at Norfolk Park on 5 September 2013.

12. We informed HM Coroner South Yorkshire West District of the investigation who provided a copy of the post-mortem and toxicology reports. We have sent the Coroner a copy of this investigation report. This investigation was suspended pending confirmation of the man's cause of death, which we received on 3 February 2014. We regret the delay in issuing this report.

13. One of the Ombudsman's family liaison officers telephoned and wrote to the man's family to explain the investigation process, but received no response.

NORFOLK PARK APPROVED PREMISES, SHEFFIELD

14. 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.

15. Norfolk Park in Sheffield is the largest of three approved premises managed by the then South Yorkshire Probation Trust. It has accommodation for up to 33 men arranged over three separate areas. In the main building there is accommodation for up to 23 residents, communal areas for dining and socialising and areas set aside for group work. There are two further separate buildings, each of which houses up to five residents. Each resident is allocated a key worker responsible for discussing progress and well-being with the resident. The key worker also helps to ensure that residents adhere to their individual licence conditions and the rules of the approved premises. Norfolk Park is staffed 24 hours a day by probation employees.

KEY EVENTS

16. The man was convicted of abduction on 4 April 2011 and sentenced to 36 months in prison. He was sent to HMP Lindholme. He was released on licence on 8 May 2012 and lived at a private address. His sentence was due to expire on 18 November 2013.

17. The man suffered from epilepsy and depression. He was prescribed gabapentin and epilim (for epilepsy), tramadol (pain relief), paroxetine (antidepressant) and lanzoprazole (to reduce stomach acid). He had a history of alcohol and drug misuse.

18. On 15 August 2013, the man was arrested and bailed for an offence of criminal damage. The next day, his offender manager and her manager decided that he should be managed in the community at approved premises and that his licence should not be revoked.

19. On 16 August, the man moved to Norfolk Park Approved premises. This was initially for one week but then extended to two weeks. Norfolk Park staff retained his medication and issued it to him twice daily in line with his prescriptions.

20. The man attended all of his probation and police appointments while at Norfolk Park. He followed hostel rules, signed in and out of the premises and adhered to the 11.00pm curfew.

Events leading up to death

21. At 7.49am on Monday 26 August, the man was given his morning prescription of two paroxetine and one epilim tablet. He was also due tramadol and gabapentin. He told an approved premises worker that he had to sign in at a police station as part of his bail conditions that day and did not know whether he would be able to get back to the hostel for his next medication. She therefore issued him a double dose of tramadol (4 tablets) and gabapentin (4 tablets).

22. The man signed out of the premises to go to a local fair at 11.01am and returned at 3.56pm. He signed out again, four minutes later, to go back to the fair and came back again at 5.08pm. He told the approved premises worker that he had attended his appointment at the police station and that a friend had brought him back. He asked for a bus pass to attend his next appointment at the police station on Friday 30 August.

23. At 9.06pm, the man spoke briefly to a relief night care worker at reception and said he was going to the local garage shop, about a ten minute walk away. The night care worker told us that the man appeared fine. He did not see him when he signed back in at 10.22pm.

24. Another night care worker checked that all residents were in the building and locked the doors at 11.00pm. She said that the man had been in the dining room area at the time the checks were done.

25. At about 12.40am on 27 August, relief night care worker saw the man with another resident together on the first floor landing. She reminded them that they were expected to be in their own rooms by 12.30am. She saw them both go back to their rooms on the CCTV monitors. She told us that he appeared to be fine at this time. About half an hour later, she saw the other resident who had been with him, staggering along the corridor. He appeared to be under the influence of some substance, but she could not smell alcohol. She helped him back to his room. There were no other incidents or disturbances that night.

26. At around 7.30am she began the morning checks. She arrived at the man's room, knocked and unlocked the door and saw him lying face down on the bed, on top of the covers. She spoke to him but he did not respond, so she went over to try to wake him. She said he felt cold, looked blue and was stiff. She said it was clear he was dead so she did not attempt resuscitation.

27. She went to the office and informed her colleague. He called an ambulance and they both returned to the man's room with an emergency bag. On the advice of ambulance control, they placed him on the floor and tried to open his mouth to attempt resuscitation, but were unable to do this because rigor mortis was present. Paramedics arrived shortly afterwards and, at 7.53am, they confirmed that he had died.

Post-mortem

28. A post-mortem examination and toxicology tests identified ethanol (alcohol), cannabis, tramadol and zopiclone (medication for insomnia) in the man's system. Although he had previously been prescribed zopiclone, only the tramadol was currently prescribed. The toxicologist found no evidence of morphine.

29. The pathologist said that, while the toxicology results did not identify a specific drug or group of drugs definitely implicated in the cause of death, the mixture can have an unpredictable effect on individuals and might potentially have caused a fit.

30. The overall conclusion was that the man's cause of death was sudden unexpected death in epilepsy (SUDEP).

ISSUES

31. Although the toxicology report noted a number of drugs in the man's system, the pathologist was unable to say whether these were definitely implicated in his cause of death. The mixture of substances could have caused a fit, but there is no evidence of this and the cause of death is given as sudden unexpected death in epilepsy (when a person with epilepsy suddenly dies and the reason for the death is not known).

32. No illegal drugs were found in the man's room and he was compliant with the regime at Norfolk Park. The night care worker said that he appeared fine when she saw him at 12.40am and she did not suspect he had drunk alcohol or taken illegal drugs. We do not know when and where he used the cannabis and alcohol.

33. We note that the man was given a double dose of tramadol and gabapentin the day before his death. However, there is no indication that he misused these and the toxicology report noted that the levels in his system were therapeutic.

34. We are satisfied that the man's death was sudden and unexpected and could not have been prevented.