Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Daniel Smith, a resident of Ellison House Approved Premises, on 25 March 2015

A report by the Prisons and Probation Ombudsman
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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

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 Daniel Smith died of heart disease at Ellison House Approved Premises on 25 March 2015. He was 42 years old. I offer my condolences to Mr Smith's family and friends.

Mr Smith died suddenly and unexpectedly of natural causes. He never reported any serious concerns about his health and I am satisfied that there is nothing that staff at Ellison House could not have done to predict or prevent his death.

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

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

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Summary

Events

1. Mr Daniel Smith had lived at Ellison House Approved Premises, since 6 August 2014.

2. At about 11.20pm on 24 March 2015, Mr Smith went to another resident's room to ask for some tobacco. The other resident later claimed that he said he was going to smoke drugs. Mr Smith went back to his own room just before 11.30pm. The next morning, staff found Mr Smith dead in his room. It was apparent that he had been dead for some time and nothing could be done to help him.

3. A post-mortem examination concluded that Mr Smith died unexpectedly of heart disease.

Findings

4. Mr Smith died suddenly and unexpectedly of apparently previously undiagnosed heart disease. We are satisfied that staff at Ellision House could not have predicted or prevented his death. We make no recommendations.

The Investigation Process

5. The investigator issued notices to staff and residents at Ellison House Approved Premises informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

6. The investigator visited Ellison House on 27 March 2015, and obtained relevant copies of the man's records. He interviewed three members of staff at Ellison House on 15 April 2015.

7. We informed HM Coroner for Inner South London District of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

8. One of the Ombudsman's family liaison officers contacted Mr Smith's family to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They wanted to know more about the circumstances of Mr Smith's death.

9. Mr Smith's family received a copy of the draft report. They did not raise any further issues, or comment on the factual accuracy of the report.

Background Information

Ellison House

10. Approved premises (formerly knows 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 to reduce the likelihood of further offending.

11. Ellison House in Camberwell, London, can accommodate up to 30 men. Every resident attends an induction session and signs to say that they understand the rules, which include not to bring drugs or alcohol into Ellison House. Residents have a key worker, based at Ellison House, who meets them regularly to check their progress, but overall responsibility for their supervision remains with their offender manager (probation officer).

12. Ellison House operates a curfew between 11.00pm and 6.00am, when all residents are expected to be on the premises. As well as a curfew check, staff conduct wellbeing checks of residents four times a day at 8.00am, 10.30am, 3.00pm and 8.00pm. Residents are not allowed in each other's rooms. Residents who are considered to be at risk of drug or alcohol abuse are routinely tested.

13. Residents are responsible for their own health. The man was registered with a GP and was receiving treatment for a painful skin condition.

Previous deaths at Ellison House

14. We have investigated one previous death at Ellison House. There were no similarities with the circumstances of Mr Smith's death.

Key Events

15. On 20 June 2014, Mr Daniel Smith was released on licence from HMP Brixton. Initially, he lived in bed and breakfast accommodation in east London. From 6 August, he was required to live at Ellison House Approved Premises, Camberwell.

16. Mr Smith did not have a job and spent most of his time at Ellison House. He made friends with other residents and seemed to settle well. His key worker said he took part in a number of rehabilitation programmes and showed new residents around Ellison House. As part of his licence conditions, Mr Smith had to stop drinking alcohol. He always passed the approved premises' routine alcohol tests. Staff had no concerns that he used drugs.

17. A residential assistant said that Mr Smith was looking forward to moving on, in the near future and was waiting for a flat to become available. He had plans to become a courier.

18. A few days later, at 9.00pm, a night residential assistant passed Mr smith as she arrived for work. He was smoking outside Ellison House with other residents. She next saw him at 11.00pm when she started to check that residents were back by the curfew time. He was in the communal living area and she gave him a letter about an increase in service charges. She said he joked about the letter, saying that he would not pay the increase, as he would have moved on. This was the last time that Mr Smith was seen alive by a member of staff.

19. After the man's death, another resident told a residential assistant that at about 11.20pm, Mr Smith had gone to his room and asked him for some rolling tobacco. He said that Mr Smith told him he was going to use the tobacco to mix with some Spice (a synthetic cannabinoid otherwise known as a new psychoactive substance). He said he gave him tobacco, they had a brief chat and Mr Smith went back to his own room just before 11.30pm. He appears to have been the last person to see him alive.

20. The next morning, at 8.00am, the night residential assistant began a welfare check to ensure that all the residents who were present were okay. At around 8.07am she knocked on Mr Smith's door. There was no reply so she knocked again. She said she called out his name and said that she was going to open the door.

21. The night residential assistant looked into the room and saw Mr Smith sitting on the edge of his bed, slumped to his right. He was fully clothed and it looked as if he had not slept in his bed. She said she checked him and it was apparent that he had died and rigor mortis had set in. She therefore did not attempt to resuscitate him. She called an ambulance and paramedics arrived within two minutes, they said that Mr Smith had been dead for some time.

Contact with the man's family

22. The police informed Mr Smith's father of his death that day. The manager of Ellison House later contacted Mr Smith's sister. The National Probation Service contributed towards the cost of the funeral in line with national guidance.

Support for residents and staff

23. After Mr Smith's death, the manager debriefed the staff and offered support to those who needed it. Staff said they had been well supported after the death. Residents at Ellison House were also invited to attend a meeting and staff offered them group or individual support.

Post-mortem examination

24. The post-mortem examination concluded that Mr Smith died of natural causes, from a condition called cardiac sarcoidosis. (Sarcoidosis is a chronic disease, which causes nodules in the heart, lungs, liver, lymph and salivary glands. It can cause sudden cardiac arrest, as in his case.) A toxicology report found no that there were no evidence of drugs in Mr Smith's body at the time of his death, but there was no test available for new psychoactive substances.

Findings

25. Mr Smith had been dead for sometime when he was found. We are satisfied that Mr Smith died unexpectedly of undiagnosed heart disease which staff at Ellision House could not have predicted or prevented. There is no evidence that drugs played any part in the circumstances of his death.

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