

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Neil Jones a resident at Staitheford House Approved Premises on 31 July 2015

**A report by the Prisons and Probation Ombudsman  
Nigel Newcomen CBE**

## 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*



© Crown copyright 2015

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit [nationalarchives.gov.uk/doc/open-government-licence/version/3](http://nationalarchives.gov.uk/doc/open-government-licence/version/3) or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: [psi@nationalarchives.gsi.gov.uk](mailto:psi@nationalarchives.gsi.gov.uk).

Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

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 Neil Jones died on 31 July 2015 of respiratory arrest, due to alcohol and opiate consumption, and inhalation of gastric contents, while a resident at Staitheford House Approved Premises in Stafford. He was 31 years old. I offer my condolences to Mr Jones' family and friends.

Mr Jones had been released from prison earlier in July. Although Staitheford House was not Mr Jones' preferred location, as it was not near his family and friends, I am satisfied that staff at Staitheford House gave him good support, particularly for his alcohol misuse. While I am surprised that Mr Jones, who had a history of opiate misuse, was never tested for drug use, I do not consider that there was anything that staff at Staitheford House could have done to prevent his death.

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

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

**May 2016**

**Contents**

Summary .....  
The Investigation Process .....  
Background Information .....  
Key Events .....  
Findings.....

# Summary

## Events

1. On 3 July 2015, Mr Neil Jones left HMP Hewell after a short prison sentence. He should have gone straight to Staitheford House Approved Premises in Stafford after reporting to his probation office, but stayed at his brother's house for one night and appears to have slept on the streets in Worcester on other nights. He was arrested for assaulting his partner and attended Magistrates Court on 8 July, from where he was bailed and required to live at Staitheford House.
2. Mr Jones was not happy at having to live in Stafford and wanted to be in Hereford, closer to his friends and family. However, this was not possible at the time.
3. Mr Jones had a history of substance misuse, including alcohol and opiate drugs, although his major problem appeared to be with alcohol. Staff at Staitheford House tested his alcohol use frequently but never tested him for drugs, which Mr Jones denied using. He was supported by the community drug and alcohol team.
4. On 26 July, Mr Jones left Staitheford House and did not come back that night. He telephoned staff the next day and said he had tried to commit suicide by cutting his wrists and had thought about jumping off a bridge. He came back to Staitheford House at 10.50pm the next night, 27 July. Staff noted he had superficial lacerations to his wrists and monitored him frequently during the night to check his safety.
5. On 31 July, Mr Jones went out and did not come back. One of the night supervisors checked the local hospitals and police throughout the night, but could not find Mr Jones. The next afternoon, on 1 August, the police informed staff at Staitheford House that Mr Jones had been found dead in a public park the previous evening.

## Findings

6. Mr Jones was unhappy at having to live in Stafford and wanted to move to approved premises closer to his family and friends. This was not possible due to a lack of available beds, but probation staff told Mr Jones they would review this with the intention of moving him closer to home. We are satisfied that Mr Jones' location was suitable at the time and that staff at Staitheford House provided appropriate support.
7. We consider that, when Mr Jones returned to Staitheford House on 27 July, after making cuts to his wrists, staff monitored him appropriately through the night and met him the next day to ensure he was well supported.
8. Mr Jones had a history of substance misuse problems. As he reported mainly alcohol problems, this was the focus of the support he received. However, Mr Jones was never tested for drug use at Staitheford House. While this is unlikely to have changed the outcome for Mr Jones who was already being supported by drug and alcohol services, a positive test might have led to greater focus on that

aspect of his problems. We are satisfied that Mr Jones had been warned of the risks of using opiates again, particularly after a period of abstinence.

## **Recommendation**

- The manager of Staitheford House Approved Premises should ensure that high-risk residents with a history of drug misuse are screened for drugs as part of their induction and promptly tested and referred for help if drug use is suspected.

## The Investigation Process

9. The investigator issued notices to staff and residents at Staitheford House informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
10. The investigator visited Staitheford House on 25 August. She obtained copies of relevant extracts from Mr Jones' prison and probation records.
11. The investigator interviewed five members of staff by telephone in January and February.
12. NHS England commissioned a clinical reviewer to review Mr Jones' clinical care at HMP Hewell and Staitheford House.
13. We informed HM Coroner for Worcestershire of the investigation. The investigation was suspended until 12 November, until the coroner was able to give us the results of the post-mortem examination. We regret the consequent delay. We have sent the coroner a copy of this report.
14. One of the Ombudsman's family liaison officers contacted Mr Jones' mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Jones' mother wanted to know the following:
  - Details of the conditions of Mr Jones' release on licence.
  - Whether Mr Jones had known where he was expected to live after his release, before he left prison.
  - The monitoring measures Staitheford House had put in place after Mr Jones' apparent suicide attempt.
15. The initial report was shared with the National Probation Service. The National Probation Service did not find any factual inaccuracies and their action plan is annexed to this report.
16. Mr Jones' mother received a copy of the initial report. She pointed out some factual inaccuracies and/or omissions. This report has been amended accordingly. Mr Jones' mother also raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

## Background Information

### Staitheford House Approved Premises

17. Approved premises (formerly known as probation and bail hostels) mostly accommodate offenders released from prison on licence and those directed 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. Residents are responsible for their own healthcare and are expected to register with a GP.
18. Staitheford House is one of three Approved Premises in Stoke and Stafford. It has 12 double and one single room and is managed by the Midlands Area of the National Probation Service. Each resident is allocated a key worker/offender supervisor to oversee their progress and well-being and that they adhere to licence conditions and the premises' rules. Probation Service employees are on duty at Staitheford House 24 hours a day.

### Post-sentence Supervision Period (PSSP)

19. On 1 February 2015, the Offender Rehabilitation Act (ORA) came into effect. The Act provides that all those released from short prison sentences of up to 24 months will now be subject to a licence period and an additional period of statutory supervision in the community. This post-sentence supervision period tops up the licence period to make a total of 12 months supervision after release. The purpose of the PSSP is rehabilitative.
20. A decision on whether an offender has failed to comply with a supervision requirement, and what, if any, sanction there should be for that breach will fall to the court. This is in contrast to enforcement of the licence period, which is enforced through the recall process via the National Offender Management Service on behalf of the Secretary of State. Where there is a proven breach of a supervision requirement the courts may take no action, amend or remove supervision requirements, fine the offender or commit them to prison for 14 days. Courts can also impose a Supervision Default Order. This can be either unpaid work or an electronically monitored curfew (with a minimum of 20 days and no longer than the end of the Post-Sentence Supervision period).

### Previous deaths at Staitheford House

21. Mr Jones was the second resident of Staitheford House to die since 2007. There was another death five months after Mr Jones died. Each of the deaths involved opiate use.

## Key Events

22. On 3 July 2015, Mr Neil Jones was released from HMP Hewell, after a twelve-week prison sentence. Before his release, his offender manager (probation officer) arranged for him to live at Staitheford House Approved Premises, Stafford. The prison resettlement officer informed Mr Jones that this was a requirement.
23. Mr Jones had a history of substance misuse, involving alcohol, cannabis, and heroin. He had hepatitis C and he was waiting for treatment.
24. On 1 July, the manager of Staitheford House and his offender manager discussed the arrangements for Mr Jones to live at Staitheford House. They agreed that Mr Jones would be a temporary resident, with the aim of resettling in Hereford, his hometown. The requirements of his supervision were rehabilitative, and were intended to help address his substance misuse problems. The manager agreed that he would be drug tested periodically. Mr Jones had completed a drug detoxification programme in Hewell and before he left prison, nurses had warned him that he would have reduced tolerance levels to opiates and would be at greater risk of overdose if he used drugs again in the community.
25. On 3 July, Mr Jones left Hewell on a 24-hour licence. The conditions of Mr Jones' licence included not committing an offence, keeping in contact with his offender manager and that he should permanently reside at Staitheford House, as approved by his offender manager.
26. Mr Jones' licence said to report to the Hereford probation office and did not instruct him to go to Staitheford House. Mr Jones went to the probation office in Worcester, although it is not clear why. Staff at Worcester reported that he was clearly under the influence of alcohol; he was agitated and his behaviour was challenging. Probation staff gave Mr Jones a travel warrant so he could report to the Hereford probation office. However, he did not report to the Hereford probation office that day and did not go to Staitheford House.
27. Mr Jones' initial short licence period ended on 4 July and he moved into a post-sentence supervision period (PSSP). Mr Jones' supervision requirements included that he should be of good behaviour, not commit an offence, keep in contact with his offender manager to address his drug misuse, give an oral fluid or urine sample for testing to ensure he was not using illicit substances, and to live at Staitheford House.
28. On 8 July, Mr Jones appeared at Magistrates Court after police arrested him for allegedly assaulting his partner. He stayed with his brother for one night, before sleeping on the streets in Worcester at the time. The court released Mr Jones on bail to Staitheford House.
29. Mr Jones arrived at Staitheford House later on 8 July. His keyworker completed his induction, which included explaining the supervision requirements, Staitheford House rules, and the substance misuse policy. He told Mr Jones that if he did not comply with his supervision requirements he could be returned to court. Mr Jones had an alcohol breath test, which showed a reading of 15mg (for comparison, the drink drive limit is 35mg per 100ml of breath). He did not have a

drug test during induction, although his keyworker reminded him of the increased risks of drug overdose after release from prison.

30. On 9 July, Mr Jones registered with the local GP surgery. That evening, an alcohol breath test reading at Staitheford House was 100mg.
31. On 10 July, Mr Jones went to an appointment with his GP. Later that day, he spoke to the person who was standing in for his offender manager while she was on leave. Mr Jones said he did not want to live in Stafford, as it made him unhappy to be away from his friends and family in Hereford. He said he was drinking about two cans of beer a day, but was not using drugs. Mr Jones said he wanted help with his alcohol misuse, but did not want to engage with support services in Stafford, as he wanted to be involved with services closer to Hereford.
32. The deputy manager of Staitheford House gave Mr Jones a 'letter of concern' that day. The letter stated that Mr Jones had returned to Staitheford House late the previous night with an alcohol reading of 100mg. This was a concern, as alcohol was a link to his offending behaviour. He made an appointment for Mr Jones to see a One Recovery (a substance misuse partnership) worker on 17 July to discuss his alcohol use and the support available. He instructed staff to monitor Mr Jones and report any issues or concerns about substance misuse to managers.
33. On 12 July, a night support worker noted that Mr Jones appeared to be under the influence of some other substance as well as alcohol. She recorded that his behaviour was strange, but could not recall in what way when the investigator asked. She did not discuss this with managers at the time and Mr Jones did not have a drug test as a result of her suspicions.
34. Over the next five days, Mr Jones gave alcohol readings of 75mg, 53mg, 61mg, 47mg, and nil respectively. Mr Jones saw a One Recovery worker at Staitheford House on 17 July. He said he felt in control of his alcohol consumption and did not crave alcohol every morning. Over the next ten days, Mr Jones gave one nil alcohol reading. The rest ranged between 11mg and 89mg.
35. On 20 July, the replacement for the offender manager spoke to Mr Jones again. He said he felt better than he had the week before but again said he did not want to be in Stafford, although he realised that we would not be at Staitheford House in the long term. He said he was not using drugs and his alcohol use was 'okay'. She told him that it was important to have alcohol free days and Mr Jones said he had had three that week. Mr Jones said he was bored and unmotivated, but was seeing someone from Pathways (an alcohol treatment programme) in Worcester that day.
36. There were no significant entries in Mr Jones' record for the next five days.
37. At 11.21am on 26 July, Mr Jones signed out of Staitheford House and his mother collected him. He did not come back to Staitheford House that night and did not answer his mobile phone.
38. At 4.42pm on 27 July, Mr Jones telephoned Staitheford House and spoke to his keyworker. He said he was in a bad way emotionally and had attempted suicide the night before. He said he had cut his wrists and had considered jumping from

a bridge. He said he was worried that he would be recalled to prison. The keyworker explained that he would not be recalled but, as he had breached his supervision requirements, he might have to go to court to explain his actions. Mr Jones agreed to return to Staitheford House that evening.

39. The keyworker informed the offender manager of what had happened and spoke to Mr Jones' mother at length. His mother was worried about his wellbeing and that he might try to harm himself again. The keyworker said that staff would monitor and support Mr Jones and would try to get him an appointment with a GP, who might refer him to the local mental health services.
40. Mr Jones returned to Staitheford House at 10.50pm that evening and staff noted that the cuts to his wrists were superficial. His alcohol reading was 67mg. A night support worker gave him something to eat. The deputy manager and the keyworker discussed how best to monitor Mr Jones. They agreed that, depending on Mr Jones' wellbeing when he arrived back at Staitheford House, they would monitor him on a regular basis either in his room or in the observation room. They did not consider that formal monitoring through the care-planning system used to support prisoners at risk of suicide or self-harm was necessary and Mr Jones was reluctant to engage.
41. Staff checked Mr Jones during the night at 12.25am, 1.45am, 3.10am, 4.12am, 5.20am and at the 6.00am curfew check. This involved two members of staff going into his room to check on his welfare.
42. The next day, 28 July, the deputy manager and the keyworker reviewed the welfare checks with Mr Jones. He said he did not want to be checked any longer and did not want or need any support through the formal care-planning system. They were satisfied that welfare checks were no longer needed.
43. Later that day, the keyworker met Mr Jones to discuss how he was feeling. Mr Jones said he was feeling unwell from hepatitis C and his keyworker noted he looked weak and jaundiced. Mr Jones was expecting the results of blood tests taken by the GP. Mr Jones said he had asked the GP for help with his alcohol problems and the GP had advised him to attend the One Recovery meetings. Mr Jones said he was suffering alcohol withdrawal symptoms and because he was worried about having seizures, (a symptom of alcohol withdrawal) he had decided to continue drinking. The keyworker advised him to attend the recovery meetings and he agreed he would. Mr Jones said he had also referred himself to an alcohol intervention organisation in Worcester and had already attended a meeting.
44. Mr Jones said that he had hurt himself the day before because of the thought of leaving his friends and family and having to return to Staitheford House. He said he wanted to leave Stafford, as staff could not offer him the emotional support he needed and he wanted to be nearer to his family and friends. The keyworker reiterated that staff were always there to support him. He informed the offender manager of his discussion with Mr Jones.
45. On 30 July, Mr Jones missed his 11.00pm curfew. He said he had fallen asleep on the train and missed his stop. He got back at 12.09am on 31 July.

46. On the afternoon of 31 July, the offender manager telephoned Mr Jones, who said he had received his blood test results and would need a follow-up appointment with the GP, as they were not good. She encouraged him to attend the appointment so he could start hepatitis C treatment. She told Mr Jones that she had seen that he was determined to change and that she was not willing to give up on his rehabilitation, regardless of his current behaviour. Mr Jones said that he would work towards his rehabilitation.
47. That evening, Mr Jones was not back at Staitheford House by his curfew time of 11.00pm and did not return at all that night, a supervisor informed the duty probation manager and contacted local hospitals and the police, but there was no trace of Mr Jones. He kept in contact with the police and the duty manager throughout the night.
48. The supervisor tried to call Mr Jones' mother but there was no reply and he left a message. Mr Jones' mother called back around 7.00am the next morning and he explained that Mr Jones had not returned to Staitheford House. His mother said she would try to contact him and let them know if she managed to get in touch with him.
49. At 1.46pm that afternoon, the police informed staff at Staitheford House that a member of the public had found Mr Jones unresponsive in a local park at about 8.30pm the previous day (31 July). Paramedics had attended and had pronounced Mr Jones dead.

#### **Contact with Mr Jones' family**

50. On 1 August, the police informed Mr Jones' mother of his death. The offender manager and the manager then contacted her and offered their condolences and support. Mr Jones' funeral was on 12 August. The Probation Service offered a contribution to the costs in line with national policy.

#### **Support for residents and staff**

51. The manager posted notices informing staff and residents of Mr Jones' death, and offering support. She also debriefed staff and offered support.

#### **Post-mortem report**

52. The post-mortem report indicated that Mr Jones died of respiratory arrest due to alcohol and opiate consumption, and inhalation of gastric contents.

# Findings

## Substance misuse

### *Alcohol*

53. Mr Jones had a long-term history of alcohol and opiate drug use. He said his main issue was alcohol, and he started to drink again when he left prison. The staff at Staitheford House encouraged Mr Jones to engage with alcohol support services and he appeared to be doing this. We are satisfied that Mr Jones received appropriate support for his alcohol misuse, which appeared to be his main problem at the time.

### *Drugs*

54. Opioid dependence is a chronic disorder with a high relapse rate, even after prolonged periods of abstinence. The risk of fatal overdose is also high, as opiate users are particularly vulnerable due to reduced tolerance, especially in the immediate period after release from prison. While in prison, Mr Jones engaged with substance misuse services and completed a methadone detoxification programme. Prison nurses warned Mr Jones before his release, of the dangers of using drugs in the community and the higher risk of overdose due to reduced tolerance levels after a period of abstinence. During his induction, Mr Jones' keyworker also warned him of the risks.
55. The AP manual states that screening known drug users on arrival, or when they are suspected of renewed drug use, is a targeted and prudent use of resources. There may be occasions when an offender's drug use is not known, is denied, or has just started. It is important therefore that the AP rules provide for the screening of any resident, on reasonable suspicion and at the discretion of staff, and that this is explained to the offender when he signs the rules. Signing the rules gives automatic consent for testing.
56. Mr Jones denied taking drugs and staff focused on his alcohol use. He was not screened for drug use while at Staitheford House. The night support worker recorded her concerns that Mr Jones was under the influence of 'something other than alcohol', yet did not report this to managers and this did not trigger a drug test. There was no other recorded suspicion or indication of drug use while he was at Staitheford House.
57. As part of the approved premises induction process, residents should be screened for drug use if there is any concern they are using drugs or have a history of drug use. Mr Jones' supervision conditions included periodic screening for drug use and the manager had agreed to this before his arrival.
58. We are satisfied that Mr Jones was given appropriate information about using drugs before leaving prison and when he arrived at Staitheford House. We consider that staff at Staitheford House could not have foreseen Mr Jones' death. However, although Mr Jones did not disclose any current drug use, we consider that he should have had a baseline drug test at induction and a test on grounds of suspicion on 12 July when he appeared to be under the influence of drugs. If this indicated he had used drugs then he could have been encouraged

to seek further support from the substance misuse services from which he was already receiving help. We make the following recommendation:

**The manager of Staitheford House Approved Premises should ensure that high-risk residents with a history of drug misuse are screened for drugs as part of their induction and promptly tested and referred for help, if drug use is suspected.**

### Suicide and self-harm monitoring

59. When Mr Jones returned to Staitheford House on 27 July, he said he had attempted suicide the night before. Staff noted that he had superficial cuts on his wrists but he also said he had thought about jumping off a bridge. The deputy manager and Mr Jones' keyworker discussed how best to support Mr Jones and decided not to implement formal monitoring procedures. However, staff checked Mr Jones frequently through the night and met him to offer support the next day. Mr Jones was free to come and go from Staitheford House for much of the time. As he was reluctant to engage in formal monitoring, we accept that formal procedures would not have resulted in additional support. The staff made it clear that he could speak to them at any time and he did not give them any further concern about his risk of suicide after 27 July. We are satisfied that staff supported Mr Jones appropriately.

### Breaches of post-sentence supervision requirements

60. Probation Instruction (PI) 24/2014, 'Enforcement of the post-sentence supervision requirements' outlines the national policy on enforcing supervision requirements for offenders on post-sentence supervision. The PSI noted that the focus is on rehabilitation and an offender manager should only consider taking action for breach of supervision requirements if the offender displays a serious or wilful failure to comply or there is a significant rise in the risk of self-harm.
61. The offender manager was clearly committed to helping Mr Jones' rehabilitation and prioritised this, rather than taking any action for breach of supervision requirements and she did not consider that his risk of suicide or self-harm had significantly increased. She considered that Mr Jones was genuine about changing his behaviour and was determined to help him. We are satisfied that she acted in Mr Jones' best interest in prioritising efforts to rehabilitate Mr Jones and that it would have been premature to pursue any action for breach of his supervision requirements.

### Location

62. Mr Jones was unhappy about being at Staitheford House in Stafford, away from his family and friends in Hereford. The staff at Staitheford house told him his residency at was temporary and would be reviewed. However, the approved premise in Hereford, where he wanted to be, did not have any available beds. A senior probation officer told us that being at Staitheford House distanced Mr Jones from triggers and bad influences and it was appropriate for him to have a temporary placement there, with a view to him moving back to Hereford later. We are satisfied that Mr Jones was accommodated appropriately and staff supported him well.

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations