

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr Wayne Hunt a resident at Staitheford House Approved Premises on 3 December 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*



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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 Wayne Hunt died at Staitheford House Approved Premises, Stafford on 3 December 2015 of combined heroin and alcohol toxicity. He was 32 years old. I offer my condolences to Mr Hunt's family and friends.

I am satisfied that Mr Hunt received some good support from staff at Staitheford House for substances misuse problems, particularly with alcohol, but I consider they should have tested him more frequently for drug use. While I recognise it would have been difficult for staff at Staitheford House to prevent his death, I am concerned that they did not check his welfare for over six hours after he had returned to the approved premises clearly intoxicated on 3 December.

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

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

**August 2016**

**Contents**

Summary ..... 1  
The Investigation Process ..... 2  
Background Information ..... 3  
Key Events ..... 4  
Findings..... 8

# Summary

## Events

1. On 25 September 2015, Mr Wayne Hunt was released from prison to Wenger House Approved Premises in Newcastle under Lyme. He had a history of drug and alcohol problems and had been warned of the dangers of reduced tolerance and overdose if he took drugs after his release. He tested positive for drugs within three weeks and asked to move from what he said were negative influences at Wenger House. His offender manager arranged a move to Staitheford House Approved Premises, Stafford on 4 November.
2. Mr Hunt engaged with a local drug and alcohol service but continued to drink, sometimes excessively. Staff at Staitheford House tested him regularly for alcohol but not for drugs.
3. On the afternoon of 3 December, Mr Hunt came back to Staitheford House drunk. He said he was going to go to his room to sleep it off. Shortly afterwards, he went to the communal toilet where other residents found him collapsed, over six hours later. There was a syringe close by.
4. Staff called an ambulance and assessed Mr Hunt who was very cold and had no pulse. They decided that resuscitation was not appropriate, as Mr Hunt was clearly dead. Paramedics arrived shortly after and confirmed Mr Hunt's death.

## Findings

5. We are satisfied that staff at Staitheford House generally gave Mr Hunt appropriate support but after he came back drunk on 3 December, no one checked his welfare, which we consider would have been prudent.
6. Although staff monitored Mr Hunt's alcohol use, they tested him for drugs only when he requested tests, when tests showed no evidence of drug use. This is the second recent death at Staitheford House where we have raised the issue of insufficient drug testing.

## Recommendations

- 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 manager of Staitheford House Approved Premises should ensure that staff monitor the welfare of residents by regular checks when residents appear to be significantly intoxicated by alcohol or other substances.

## The Investigation Process

7. The investigator issued notices to staff and prisoners at Staitheford House informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
8. The investigator obtained copies of relevant extracts from Mr Hunt's prison and probation records.
9. We informed HM Coroner for South Staffordshire District of the investigation who gave us the results of the post-mortem and toxicology tests. We have given the coroner a copy of this report.
10. One of the Ombudsman's family liaison officers contacted Mr Hunt's parents, to explain the investigation. They did not have any specific matters for the investigation to consider.
11. Mr Hunt's family received a copy of the initial report. The solicitor representing them wrote to us raising a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.
12. The probation service also considered our initial report and did not raise any factual inaccuracies. They submitted an action plan addressing our recommendations.

# Background Information

## Staitheford House Approved Premises

13. 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.
14. 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 for 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 premises' rules. Probation Service employees are on duty at Staitheford House 24 hours a day.

## One Recovery Staffordshire

15. One Recovery Staffordshire is a substance misuse partnership led by Addiction Dependency Solutions and supported by North Staffordshire NHS Combined Healthcare Trust, Changes, Brighter Futures and Arch Housing. One Recovery workers treat a client's primary addiction while considering their whole life holistically with particular emphasis on mental health and housing. Clients are subject to both alcohol and drug tests.

## Previous deaths at Staitheford House

16. Mr Hunt was the second person to die at Staitheford House since January 2015. We also raised the issue of insufficient drug testing in that investigation.

## Key Events

17. On 25 September 2015, Mr Wayne Hunt was released on licence from HMP Oakwood, after serving almost two years of a four and a half year sentence for burglary and assault. Mr Hunt had a history of substance misuse and had completed a methadone reduction programme at Oakwood. Two days before he was released, a drug worker at the prison warned him that he would have reduced tolerance to drugs and would be at greater risk of overdose if he used them in the community. He was given written information about this.
18. Before he was released, his offender manager (probation officer) checked he understood his licence conditions. As part of his licence conditions Mr Hunt was required to live at Wenger House. His probation officer met him when he arrived at Wenger House and reminded him of his licence conditions and the risks of reduced tolerance to drugs. Mr Hunt's licence conditions included that he should not spend the night elsewhere without permission, comply with curfew times and address his drug problems as stipulated by his probation officer. There was no licence condition about drinking alcohol.
19. Initially, Mr Hunt appeared motivated to make positive changes to his life and he engaged well with staff. However, after two weeks he said he was bored, depressed and felt too far away from his parents. He tested positive for heroin at a drug project meeting and his probation officer discussed this with him on 15 October. The probation officer gave him a verbal warning and said that he would not take further action if Mr Hunt continued to engage with drug services.
20. On 29 October, Mr Hunt told his probation officer that he would like to move from Wenger House because he felt he was exposed to negative influences there, including two other residents who were taking drugs. Mr Hunt said that he was tempted to take drugs and was drinking every day. The probation officer arranged for Mr Hunt to move to Staitheford House Approved Premises in Stafford, on 4 November.
21. When Mr Hunt arrived at Staitheford House, he signed the rules, which, among other things, said that he had to comply with room searches and drug and alcohol tests. He was not allowed to bring drugs or alcohol onto the premises. He also signed a substance misuse policy, which stipulated that he should see a doctor if he was on prescription drugs, warned that drug and alcohol consumption would not be tolerated on the premises and that no drug taking equipment should be brought in. He had to comply with room searches and access local drug and support services. Staff did not test him for drugs when he arrived, despite his recent history of drug taking.
22. On 4 November, the deputy manager updated Mr Hunt's risk and needs management plan, which staff had opened at Wenger House. The updated plan identified that Mr Hunt's risks included excessive use of substances, association with negative peers, lack of finances, loss of support and poor thinking skills. Staff were required to report any breaches of Mr Hunt's licence conditions to managers and he was to have alcohol tests on Saturdays and Tuesdays and additional random tests on suspicion. When staff suspected abuse, they were expected to refer Mr Hunt to alcohol and drugs services. The plan said that he

should have drug tests each Friday and at other times, if staff suspected any abuse.

23. On Wednesday 4 November, Mr Hunt tested positive for alcohol with a reading of 54 micrograms per 100 millilitres of breath. (As a comparator, 35mcg/100ml is the legal limit for driving.) Mr Hunt tested positive for alcohol almost every day with scores ranging from 11 to 102.
24. On 10 November, Mr Hunt had a meeting with this key worker at Staitheford House. He told him that he had registered with a GP and had seen him the day before but the doctor would not prescribe his medication, as he did not have up to date records. The key worker contacted the prison healthcare department to obtain this information for him. Mr Hunt also said he had sorted out his benefits.
25. On 12 November, Mr Hunt told a sessional supervisor that he had felt dismissed by the doctor, who had suggested he attend One Recovery. He asked her about getting diazepam and an alcohol blocker and she advised him to see his GP or clinic nurse. Mr Hunt said he had already made an appointment with a nurse at Stafford Health and Wellbeing Centre. A GP later prescribed his medication.
26. On Saturday 14 November and Wednesday 18 November, Mr Hunt asked staff to test him for drugs and the results were negative.
27. On 19 November, the probation officer and the key worker met Mr Hunt and they agreed a number of issues, including that Mr Hunt would attend One Recovery meetings, and would have random drug tests and daily alcohol tests. He would be liable to have bag and room searches, and staff would monitor his behaviour and relationships. They agreed to change Mr Hunt's curfew hours so that he only had to be in Staitheford House between 11.00pm and 6.00am (his curfew was originally from 7.00pm to 6.00am), but would impose more restrictive conditions if there were any concerns.
28. On Friday 20 November, Mr Hunt was allowed leave to his parents' home for the weekend. He returned on Monday 22 November and was irritated at being alcohol tested at 4.00pm instead of the usual time of 11.00pm. Staff reminded him that they could ask for tests at any time. The reading was 102.
29. On 23 November, the deputy manager spoke to Mr Hunt about his behaviour the night before. Mr Hunt accepted that staff would test him for alcohol at random times. He missed his appointment with the One Recovery service that day and told his key worker he felt they could not help him. The key worker advised him to make another appointment.
30. On 25 November, the deputy manager spoke to Mr Hunt about a positive alcohol test. Mr Hunt said he wanted medical help for his drinking and his probation officer advised him to stay engaged with drug and alcohol services. From 26 November, Mr Hunt occasionally tested negative for alcohol, but on some days, the score was very low.
31. On 1 December 2015, a medication check showed Mr Hunt had not taken any acamprosate, which he had been prescribed on 24 November. (Acamprosate is used in the treatment of alcohol dependence.) A supervisor at Staitheford House suspected he had taken more diazepam than prescribed and made a note of this.

32. On 2 December, Mr Hunt attended a One Recovery appointment. That day, he had an alcohol reading of four. On the morning of 3 December, Mr Hunt attended another One Recovery appointment and went into town in the afternoon. At 2.00pm, staff carried out a 'health and safety check' of the building, which included checking all the residents' rooms. They found nothing untoward in Mr Hunt's room.
33. When Mr Hunt returned to Staitheford House some time between 3.15pm and 3.30pm on 3 December, staff noted he was clearly under the influence of alcohol. The sessional supervisor decided not to test him for alcohol, as he was very argumentative when drunk and she felt it was more important to talk to him about his drinking. Mr Hunt agreed that he had been drinking and said he was going to his room to sleep it off. She did not consider he had taken drugs.
34. CCTV shows that at 3.40pm, Mr Hunt went into the communal toilet but staff did not know this. At 6.45pm, the sessional supervisor saw, on the CCTV, another resident go to Mr Hunt's door and knock on it but he got no response.
35. At approximately 10.00pm, another resident was looking for Mr Hunt but got no response when he knocked on his bedroom door. He noticed the toilet door had been shut and locked for some time, and was concerned that Mr Hunt was in there. He discussed this with two other residents and forced the door open. Mr Hunt was on the floor. He felt cold and was not breathing. There was a syringe on the windowsill.
36. The residents shouted to staff and staff attended immediately with a first aid bag. One noted Mr Hunt felt very cold and had no pulse. He called an ambulance and a sessional supervisor brought a defibrillator. However, they decided not to use the defibrillator or attempt to resuscitate Mr Hunt, as rigor mortis was present and it was clear that he had been dead for some time. Paramedics arrived shortly after and confirmed Mr Hunt's death.

### **Contact with Mr Hunt's family**

37. The manager of Staitheford House gave the police Mr Hunt's family details and, in the early hours of 4 December, the police informed Mr Hunt's family of his death. At 12.50pm on 4 December, a probation officer telephoned Mr Hunt's family to offer condolences and support. At 3.00pm, the manager also telephoned to add her condolences and support.
38. On 7 December, Mr Hunt's parents visited Staitheford House. In line with national policy, the probation service offered to contribute to funeral costs.

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

39. The manager posted notices to staff informing them of Mr Hunt's death and offering support. She also advised the staff involved in the emergency response of support available from the employee assistance programme. Staff spoke to the residents who had found Mr Hunt collapsed and offered support. All residents were informed of Mr Hunt's death the next day and the Samaritans attended a residents' meeting to offer support. Staff helped residents organise a memorial for Mr Hunt.

40. On 10 December, the manager held a staff briefing to talk them through events and the investigation process and offered further support. .

**Post-mortem**

41. The post-mortem and toxicology tests showed the cause of death as fatal combined heroin and alcohol toxicity.

# Findings

## Substance misuse

### *Alcohol*

42. Mr Hunt had a history of alcohol and opiate drug use. He continued to drink alcohol while he was a resident at Staitheford House, which was not in contravention of his licence conditions. Staff regularly tested him and encouraged him to engage with alcohol support services and he appeared to be doing this. We are satisfied that Mr Hunt received appropriate support for his alcohol misuse.

### *Drugs*

43. In prison, Mr Hunt had engaged with substance misuse services and had completed a methadone detoxification programme. However, opioid dependence is a chronic disorder with a high relapse rate, even after prolonged periods of abstinence. The risk of fatal overdose for opiate users just released from prison is high, because of reduced tolerance when they have not been using in prison.
44. 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. For this reason, 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.
45. Mr Hunt signed the rules when he arrived at Staitheford House on 4 November, yet staff did not screen him for drugs when he arrived, or in line with his risk and needs management plan. On 1 December, when a supervisor suspected that he had taken more diazepam than prescribed, she did not require him to have a drug test. Mr Hunt had no random drug tests at Staitheford House and the only time he was tested was at his request, when, unsurprisingly, the results were negative.
46. Apart from a routine health and safety check of resident's rooms on 3 December, we also note that there is no record that anyone ever searched Mr Hunt, his bags or his room for alcohol or drugs. On the day he died, it appears that Mr Hunt had brought drugs into the premises, which he took with fatal consequences.
47. We are satisfied that Mr Hunt was given appropriate information about the risks of using drugs before leaving prison and after he was released. We do not consider that staff at Staitheford House could have foreseen Mr Hunt's death. However, as he had used drugs while he was at Wenger House, we consider he should have had a baseline drug test as part of his induction at Staitheford House. Staff should also have tested him in line with his risk and needs management plan and considered searches and random testing at times when he appeared intoxicated. Positive tests might have encouraged him to seek further support from substance misuse services. We investigated the death in

July 2015 of another resident at Staitheford House and identified a similar need for drug tests for those at risk. We repeat our previous 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.**

### Welfare checks

48. When Mr Hunt came back to Staitheford House on 3 December, staff noted that he was very intoxicated. Mr Hunt said he was going back to his room to sleep it off. We are concerned that, despite his condition, no one checked his welfare for over six hours.
49. The Approved Premises Manual says that approved premises owe a duty of care to all residents, many of whom may be vulnerable for a range of different reasons. It says that additional welfare checks must be put in place at night to safeguard vulnerable individuals, including those with special health or mobility needs. We consider that Mr Hunt was vulnerable because of his dependency on alcohol and in particular because of his condition on 3 December. Although the manual refers particularly to welfare checks at night, we consider that there are also circumstances when they are necessary at other times.
50. We recognise that staff in approved premises have to use their judgment and discretion about how far to intrude in residents' lives but safety should always be paramount. We consider it would have been prudent for the staff to have satisfied themselves of Mr Hunt's safety on the afternoon and evening of 3 December by intermittent checks on his welfare. We make the following recommendation:

**The manager of Staitheford House Approved Premises should ensure that staff monitor the welfare of residents by regular checks when residents appear to be significantly intoxicated by alcohol or other substances.**

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