

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Stewart Dimech a resident at Luton Approved Premises on 13 September 2016

**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 Stewart Dimech died of opiate poisoning on 13 September 2016, while a resident of Luton Approved Premises (AP). He was 52 years old. I offer my condolences to Mr Dimech's family and friends.

Despite the tragic outcome, I am satisfied that staff at Luton AP appropriately supported Dimech to address his drug use in the community. However, I note that approved premises', unlike prisons, are currently unable to test for new psychoactive substances (NPS), which - given its prevalence - is a weakness that merits national review.

I am also satisfied that Luton AP helped Mr Dimech to address his mental health needs and took appropriate steps when he failed to return on the day of 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

April 2017

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Summary

Events

1. On 26 May 2016, Mr Stewart Dimech was charged with threatening behaviour and remanded into HMP Bedford. On 9 August, he was sentenced to three months imprisonment but due to time served he was released on licence two days later.
2. Mr Dimech met his new offender manager on 23 August. She noted that he had a long history of drug and alcohol use and that he was hospitalised in June following a drugs overdose. He had previously threatened to cut his wrists and told her that when he was homeless he felt suicidal every day. She noted that he was already engaging with mental health services and drug and alcohol support services.
3. On 26 August, Mr Dimech was charged with new offences of assault and criminal damage. His offender manager did not consider the offences were serious enough to warrant a prison recall and arranged for him to reside at Luton Approved Premises (AP). He was required to attend weekly meetings with his offender manager, attend key work sessions, appointments with the mental health team and drug and alcohol counselling. He had a curfew between 9.00pm and 7.00am and had to sign in at 12.00pm and 5.00pm.
4. When he arrived at Luton AP, Mr Dimech completed a suicide assessment where a member of staff urged him to tell someone if he started to feel unwell. He had a prescription for migrleave pink, vitamin B and thiamine to assist drug and alcohol withdrawal, with a daily dose diazepam (to treat anxiety) and gabapentin (to treat seizures), which he took under the supervision of staff.
5. Staff conducted a routine search of Mr Dimech's room on 3 September. They did not find any drugs or alcohol. On 6 September, a member of staff found Mr Dimech trying to smoke in the dining room. He said he had had a nightmare, was hearing voices and was afraid he would hurt himself or someone else. He said he would visit his GP the next day to request an increase in diazepam.
6. The following morning, Mr Dimech's GP did not prescribe an increase in diazepam. Mr Dimech did not attend an appointment with his offender manager and signed in late at 5.55pm. He provided a positive test result for cocaine, opiates and alcohol.
7. On 8 September, Mr Dimech attended a mental health appointment at Charter House with his care-coordinator, an approved premises nurse and a psychiatrist who prescribed quetiapine to treat his psychosis. During the appointment, Mr Dimech mentioned that he used 'Spice' in prison, a new psychoactive substance (NPS – a range of drugs that have been designed to mimic established illicit drugs). He promised to modify his behaviour with regard to drugs and alcohol.
8. When he returned to Luton AP, Mr Dimech was unsteady on his feet but provided a negative result for drugs and alcohol. Staff suspected he had taken NPS but he denied it. The following day, he displayed the same behaviour. He tested positive for alcohol but again provided a negative result for drugs. Staff

conducted a search of his room on 10 September and did not find any drugs or alcohol.

9. On 12 September, Mr Dimech attended court and was bailed. He visited his drugs and alcohol support worker who reported that he was in good spirits. Mr Dimech returned to Luton and worked on his legal paperwork with a member of staff.
10. On 13 September, Mr Dimech planned to pay back some of his benefits payment to his mother and speak with his solicitor. That morning, he visited his mother and she told a member of staff that he stole 100 of her gabapentin tablets. He returned to Luton AP for lunch before going out again. Staff did not notice anything unusual about his behaviour.
11. Mr Dimech did not return to Luton AP to sign in at 5.00pm or for his 9.00pm curfew. A member of staff telephoned Mr Dimech's mobile at 7.00pm, 7.30pm and 8.20pm but the number was unreachable. The on call manager telephoned Luton Police Station at 8.40pm to see if he was in police custody but he was not. At his 9.00pm curfew, his location was still not known and the on call manager awaited an update. At 11.30pm, police told the on call manager that Mr Dimech had died in a nearby caravan.

Findings

12. We are satisfied that probation staff and an approved premises nurse at Luton AP fully supported Mr Dimech. Staff encouraged him to engage with the mental health team, and drug and alcohol support services, and they appropriately monitored his drug and alcohol use through regular testing and room searches.
13. However, while approved premises' staff thought that Mr Dimech was using NPS, they were unable to test for it. Although NPS have not been linked to his death, this omission in their knowledge meant that staff were unable to identify or address this possible drug misuse and refer him for appropriate support. Given the prevalence of NPS, we believe that the National Probation Service should review its drug testing arrangements in their approved premises.
14. We are also satisfied that probation staff made appropriate attempts to locate Mr Dimech and check on his welfare when he did not sign into the approved premises on 13 September.

Recommendation

- The National Probation Service should review its drug testing arrangements in approved premises and take steps to enable staff to identify NPS use.

The Investigation Process

15. The investigator issued notices to staff and residents at Luton Approved Premises informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
16. The investigator visited Luton Approved Premises on 19 September 2016 and obtained copies of relevant extracts from Mr Dimech's records.
17. The investigator conducted a telephone interview with Mr Dimech's offender manager on 2 December.
18. We informed HM Coroner for Bedfordshire and Luton of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
19. One of the Ombudsman's family liaison officers contacted Mr Dimech's mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She asked us to identify the prescription medication Mr Dimech was taking at the time of his death, and whether he was tested for drugs while at Luton Approved Premises.
20. Mr Dimech's mother received a copy of the initial report. She did not raise any further issues, or comment on the factual accuracy of the report.
21. The initial report was shared with the National Probation Service. The National Probation Service did not find any factual inaccuracies.

Background Information

Luton Approved Premises

22. Approved premises (formerly known as probation and bail hostels) 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 expected to register with a GP.
23. Luton AP is managed by the National Probation Service. It has 17 bedrooms. All meals are provided and there is a communal area for dining and socialising. Each resident is allocated a key worker and an offender manager to oversee their progress and well-being and that they adhere to licence conditions and the premises' rules. Probation service employees are on duty 24 hours a day.

Previous deaths at Luton

24. Mr Dimech is the first resident to have died at Luton AP since 2006.

New Psychoactive Substances (NPS)

25. New psychoactive substances, previously known as 'legal highs' are an increasing problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of NPS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.
26. In July 2015, we published a Learning Lessons Bulletin about the use of NPS and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of NPS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.
27. NOMS now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements. Testing has begun, and NOMS continue to analyse data about drug use in prison to ensure new versions of NPS are included in the testing process.

Key Events

28. On 26 May 2016, Mr Stewart Dimech was charged with threatening behaviour and remanded into HMP Bedford. On 9 August, he was sentenced to three months imprisonment but due to time served he was released on licence two days later.
29. On 15 August, Mr Dimech was allocated an offender manager and he met her on 23 August. She recorded that Mr Dimech had a long history of excessive drinking, and that he had taken drugs since he was 13 years old, which had escalated to use of heroin. She noted that his mental health was not well documented but that he had engaged with Charter House for mental health services and at Reconnect for drug and alcohol support services.
30. Mr Dimech told the offender manager that in June he had taken a drugs overdose and was hospitalised for four days. He also said that when he was homeless he felt suicidal every day. She noted that he had also threatened to cut his wrists in front of staff at Charter House.
31. On 26 August, Mr Dimech was charged with new offences of assault and criminal damage, committed while under the influence of alcohol. The offender manager considered that the offences were not serious enough to warrant a prison recall and liaised with the manager of Luton AP to accommodate Mr Dimech until his licence expired on 19 September 2016. As part of his move to Luton AP, Mr Dimech was required to attend weekly meetings with her, key work sessions at Luton and attend appointments at Reconnect and the mental health team at Charter House. He had a curfew between 9.00pm and 7.00am, and had to report to staff and sign in at 12.00pm and 5.00pm every day.
32. On 2 September, the offender manager told Mr Dimech that a room was available at Luton AP and he said he was very happy to stay there. During the meeting, he told her that he had taken heroin and crack cocaine in the last week.
33. Mr Dimech was already registered with a community GP, who prescribed a daily dose of diazepam to treat anxiety, gabapentin to treat seizures, vitamin B and thiamine to assist drug and alcohol withdrawal, and migrleave pink to treat migraines. His medication was to be taken under the supervision of staff at Luton AP.
34. When Mr Dimech arrived at Luton AP, he provided a negative test result for drugs and alcohol. He told staff that he had taken heroin and cocaine two days earlier and that he usually drank one can of lager a day.
35. Mr Dimech completed a suicide assessment and said he felt happy to be at Luton AP. He said that he tended to hear voices and that he took a drugs overdose in June. A member of staff told Mr Dimech to tell staff if he began to feel unwell. He signed the approved premises drugs policy that the use of drugs might result in his removal from the premises and a recall to prison.
36. Over the coming days, there were no issues concerning Mr Dimech and a routine search of his room on 3 September did not detect any drugs or alcohol. On 5 September, he visited his drug and alcohol support worker. He did not stay long

but he told a worker from Reconnect that he was happy to have a room at Luton AP.

37. During the evening of 6 September, a member of staff caught Mr Dimech trying to light a cigarette indoors. He said he had had a nightmare and that he would normally take more diazepam, but as he had taken his maximum dose, he decided to have a cigarette. He told her he had been hearing voices and he was worried that he would hurt himself or someone else. He said he would visit his GP the next day to request an increase in diazepam. He told her he was pleased that when he was offered drugs earlier in the day he turned them down.
38. The following morning, Mr Dimech's GP did not increase his diazepam prescription as he had hoped. He was due to meet his offender manager at 11.00am, but arrived at 9.30am and told reception staff that he could not attend his appointment. He said that he needed to go to his mother's for the day because he had had a difficult night.
39. The offender manager telephoned Mr Dimech's mother later that afternoon and she told the offender manager that she had not seen her son since 3 September. Mr Dimech did not sign in at Luton AP at 12.00pm or 5.00pm and returned at 5.55pm. He told the manager that he was late because he had drunk a couple of cans of beer and fallen asleep on a park bench. He tested positive for cocaine and opiates and produced an alcohol reading of 25mcg (micrograms per 100 millilitres of breath – 35mcg is the legal drink-driving limit). Due to his positive test result, a member of staff carried out healthcare checks at midnight and 3.00am. There were no concerns. The offender manager issued Mr Dimech with a warning for breaching the drugs policy.
40. The following morning, a member of staff noted that Mr Dimech appeared to be in very good spirits. He told her he had been an "idiot" the day before, pushed boundaries and did not intend to do it again. At 10.00am, he left Luton AP and attended a mental health appointment at Charter House with a care co-ordinator, a nurse who worked at Luton AP and a psychiatrist.
41. After the appointment, the nurse updated the offender manager and said that the psychiatrist prescribed Mr Dimech quetiapine to treat his psychosis. Mr Dimech told them that he was prescribed quetiapine while at HMP Peterborough and it had been unsuccessful because he had taken 'Spice', a new psychoactive substance (NPS – a range of drugs that have been designed to mimic established illicit drugs). The nurse told the offender manager that Mr Dimech appeared to be aware that drugs and alcohol impaired his well-being and that he agreed to try quetiapine while avoiding illicit substances. The care co-ordinator planned to create a care plan and provide him with a follow up appointment but Mr Dimech died before this could be implemented.
42. After his appointment at Charter House, Mr Dimech returned to Luton AP at 2.00pm. A member of staff noticed he was unsteady on his feet, had slurred speech and poor eye contact. He provided a negative test result for drugs and alcohol. Staff suspected he had taken NPS but he denied it. After approximately 40 minutes, he returned to normal.

43. On 9 September, the manager spoke with Mr Dimech about his presentation the day before and told him to stop taking illicit substances. Mr Dimech told her that he had been picking up cigarette butts, and may have been smoking substances without realising.
44. The following morning, Mr Dimech went out and returned before lunch. A member of staff could smell alcohol and noticed he was unsteady on his feet. She suspected he had taken NPS. He provided a negative test result for drugs and produced an alcohol reading of 16mcg. He said he had a few drags from other people's cigarettes that morning. Staff saw him eating a lot more than usual, which increased their suspicions that he had taken NPS. They continued to monitor him throughout the day. There were no further concerns. Staff conducted a search of his room the next day and did not find any drugs or alcohol.
45. On 12 September, Mr Dimech appeared at Magistrates Court and was bailed until 27 September. After his court appearance, Mr Dimech visited a worker at Reconnect. The worker told the investigator that Mr Dimech was in good spirits. Mr Dimech returned to Luton AP for lunch and remained there organising legal paperwork with a member of staff. He provided a negative test result for drugs and alcohol and no concerns were reported that evening.

Events of 13 September 2016

46. During the morning of 13 September, a member of staff overheard Mr Dimech on the telephone telling his mother that he was expecting to receive £235 in benefits that day. The member of staff noted that Mr Dimech planned to repay some money to his mother and speak with his solicitor that day. He visited his mother, and returned to Luton AP at 12.00pm. He went out after lunch. Staff did not record anything unusual about Mr Dimech and a senior manager confirmed that his interaction with staff on that day was normal.
47. Mr Dimech did not return to Luton AP to sign in at 5.00pm. A member of staff telephoned Mr Dimech's mobile at 7.00pm, 7.30pm and 8.20pm but the number was unreachable. The oncall manager telephoned Luton Police Station at 8.40pm to see if Mr Dimech was in police custody, but he was not. At his 9.00pm curfew, his location was still not known and she awaited an update.
48. At 11.30pm, police told the oncall manager that Mr Dimech had died in a nearby caravan. Paramedics called the police because they suspected Mr Dimech had taken a drugs overdose and had found him at approximately 7.30pm.
49. When informed of Mr Dimech's death, a resident told a member of staff that he knew Mr Dimech had been taking crack cocaine, heroin and 'Spice' and that Mr Dimech had told him he recently collapsed in the town centre after taking 'Spice'.
50. On 15 September, Mr Dimech's mother visited Luton AP and told the senior manager that when he visited her on 13 September he stole 100 gabapentin tablets from her.

Contact with Mr Dimech's family

51. After Mr Dimech's death, the police visited Mr Dimech's parents and informed them of his death. The following day, the senior manager spoke with Mr Dimech's mother and offered her condolences and ongoing support. Mr Dimech's mother visited the approved premises the next day.
52. Mr Dimech's funeral was held on 10 October 2016. The National Probation Service contributed to the costs in line with national policy.

Support for residents and staff

53. After Mr Dimech's death, the senior manager debriefed the staff to ensure they had the opportunity to discuss any issues arising, and to offer support.
54. The senior manager held a meeting with residents to tell them of Mr Dimech's death and offered the support of staff if they wished to discuss it.

Post-mortem report

55. The post-mortem concluded that Mr Dimech died of fatal opiate poisoning.

Findings

Drug use

56. As part of his licence conditions, Mr Dimech was required to attend meetings with his drug and alcohol support worker at Reconnect and attend mental health appointments at Charter House. Mr Dimech went to Reconnect on 5 and 12 September and, on 8 September, attended a comprehensive meeting at Charter House with the support of a nurse. His offender manager noted that he was in a positive frame of mind and wanted to engage with these services.
57. Mr Dimech admitted using crack cocaine and heroin days before he arrived at Luton AP. A few days later, he told a member of staff he had turned down the offer of drugs and expressed a desire to be drug free.
58. Staff appropriately tested Mr Dimech for drugs and alcohol, and searched his room on two occasions. He tested positive for heroin and cocaine in only one of five drug tests conducted over ten days, with the other tests negative. While these tests were negative, staff thought that he displayed signs of drug use and suspected that he had taken NPS, which the drug testing kits currently available at Luton cannot detect. When staff had these suspicions, they spoke to him about the risks and warned Mr Dimech against using illicit substances.
59. Prior to arriving at Luton AP, Mr Dimech had a long history of drug use. He had a significant amount of independence and autonomy at Luton AP and although staff told him to stop taking drugs and followed the relevant procedures, they could not monitor him all of the time. We are satisfied that staff at Luton took appropriate steps to stop Mr Dimech's drug use and to prevent his death.
60. During his time in Luton AP, staff suspected that Mr Dimech was using NPS although this could not be detected by the oral swab drug testing procedures currently in place. Since September 2016, drug testing kits in prisons have been able to detect NPS, albeit from urine samples, and technologies are evolving all the time. The prevalence of NPS makes their omission from testing in approved premises a serious impediment to identifying patterns of usage and providing appropriate support and interventions. We believe the National Probation Service needs to review its drug testing arrangements to address this gap. We make the following recommendation:

The National Probation Service should review its drug testing arrangements in approved premises and take steps to enable staff to identify NPS use.

Staff checks

61. When Mr Dimech did not return to the approved premises at 5.00pm on 13 September, a member of staff made three attempts to contact him and the oncall manager checked whether he was in police custody. We are satisfied that staff at Luton AP took appropriate steps to contact Mr Dimech and check on his welfare when he did not return to the premises.

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