Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Scott Carton at Westgate Approved Premises on 10 January 2017

A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141

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.

We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Scott Carton died on 10 January 2017 of mixed drug poisoning in his room at Westgate Approved Premises. He was 38 years old. I offer my condolences to his family and friends.

Mr Carton had a history of mental health issues and substance misuse. Mr Carton was a challenging resident for the five days he spent at Westgate, he self-harmed, had psychiatric assessments, threatened to kill himself, threatened staff and was arrested twice.

However, I am concerned that staff did not advise him of the risk of methadone toxicity, test for illicit drug use and identify and monitor his increasing risk of suicide and self-harm. I am also concerned that current National Probation Service policy does not address the risk of residents misusing prescribed medication and still does not sufficiently address the issue of the use of new psychoactive substances (NPS) in approved premises despite accepting previous recommendations from me to do so.

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 **February 2018**

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Summary

Events

1. On 5 January 2017, Mr Scott Carton was released from HMP Wealstun on licence to Westgate Approved Premises. Mr Carton had a history of substance misuse, including new psychoactive substances (NPS), and his offender manager agreed that he would be tested for alcohol and drugs at Westgate, as required. On the day of his release, Mr Carton's temporary offender manager did not discuss his substance misuse with him.

2. The next day, Westgate staff suspected Mr Carton was under the influence of "spice", a type of NPS, and due to the unpredictable effects, staff started suicide and self-harm prevention procedures to monitor his welfare. Mr Carton self-harmed, and was taken to hospital.

3. At hospital, a doctor gave Mr Carton diazepam for anxiety. The next day, he said he felt better and had no thoughts of self-harm. He later appeared again to be under the influence of drugs but was not tested and his room was not searched.

4. On the morning of 9 January, Mr Carton threatened to kill himself and, in a meeting with his offender manager, he again appeared to be under the influence of drugs. She told Mr Carton she would see him the next day, to which he responded, "If I make it". She emailed details of the meeting to staff at Westgate, but did not include this comment or that she suspected he had taken drugs.

5. Despite staff assessing Mr Carton as not suitable to have medication in possession, he went to a GP who prescribed him 14 pregabalin tablets for anxiety. Although he had signed a standard resident's contract agreeing to hand in medication, he immediately swallowed all of the pregabalin.

6. At 6.30pm, police arrested Mr Carton under Mental Health Act powers. He was released from hospital a few hours later and returned to Westgate. He showed a resident a knife and told the night officer that he would stab anyone who came into his room.

7. Paramedics examined Mr Carton but he refused to return to hospital. The duty manager told Mr Carton she would consider having him recalled to prison for breaching his licence conditions and/or Westgate's rules unless he complied with staff checks. He agreed to comply but then continued to threaten staff.

10 January

8. Mr Carton was checked at 7.00am, 8.00am and 9.10am and was "seen asleep". No one tried to get a response from Mr Carton despite his significant risk of suicide and self-harm. At 11.30am, he was recorded as "on his side asleep". At 1.30pm, a different member of staff checked him and thought it unusual that he was in the same position. They returned to his room and realised that he did not have a pulse, was cold and had signs of rigor mortis. They called an ambulance at 1.40pm. A paramedic arrived at 2.15pm and checked for signs of life but pronounced Mr Carton dead.

Findings

Assessment of Mr Carton's risk of suicide and self-harm

9. Mr Carton had a number of significant risk factors which increased in the days before he died. Staff failed adequately to identify, monitor and review his risk of suicide and self-harm. Despite this, we cannot conclude whether or not Mr Carton intended to take his life.

Welfare checks

10. There was no care management plan in place to check on Mr Carton's wellbeing, needs and risks on the morning of 10 January. While we cannot say whether it would have changed the outcome for him if staff had tried to get a response from him, they might have identified that he needed urgent medical attention.

Mixed drug toxicity

11. We are concerned that no one at Westgate advised Mr Carton of the risk of mixed drug toxicity despite a requirement to do so.

Medication

12. We are concerned that the current national policy on collecting prescribed medication is unclear and contradictory. It does not cover the risk that residents, who are assessed as not suitable to have medication in their possession, might themselves obtain a prescription from any number of services in the community and that they might collect it from any pharmacy.

Substance misuse

13. Mr Carton was suspected of being under the influence of illicit substances a number of times, including NPS. We are concerned that staff at Westgate never tested Mr Carton for substance misuse or searched his room, as required by his licence conditions.

NPS

14. We are concerned, in light of the prevalence of NPS, that the National Probation Service has still not developed a strategy to deal with suspected NPS use in approved premises.

Sharing intelligence about risk and substance misuse

15. Mr Carton's offender manager failed to tell staff at Westgate when she suspected he was under the influence of drugs and had threatened to take his own life, as she should have done.

Recommendations

- The manager of Westgate Approved Premises should ensure that all staff understand the procedure for identifying, managing and supporting residents at risk of suicide and self-harm. In particular, they should ensure that staff:
    - Review the risk of suicide and self-harm based on all available information and known risks factors; and
    - Clearly record the appropriate frequency of monitoring.
- The manager of Westgate Approved Premises should ensure that staff conducting welfare checks assure themselves of the safety of residents and that they have a care management plan in place for residents known to have taken an overdose.
- The manager of Westgate Approved Premises should ensure that residents suspected of substance misuse understand the risks of mixed drug toxicity.
- The National Probation Service should review the current policy as set out in the Approved Premises Manual to address more effectively the risk of residents misusing prescribed medication.
- The manager of Westgate Approved Premises should ensure that when a resident is suspected of substance misuse, staff conduct a thorough search of the resident's room and test him for substance misuse.
- The National Probation Service should implement a strategy to reduce the supply of and demand for NPS in approved premises, including developing mechanisms to test for NPS use.
- The probation divisional office for the North East should ensure that offender managers share intelligence about residents suspected of substance misuse or at risk of suicide or self-harm.

The Investigation Process

16. The investigator issued notices to staff and residents at Westgate Approved Premises, informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

17. The investigator obtained copies of relevant extracts from Westgate's resident records.

18. The investigator interviewed nine members of staff at Westgate on 23 February 2017.

19. We informed HM Coroner for West Yorkshire of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

20. One of the Ombudsman's family liaison officers contacted Mr Carton's mother, to explain the investigation and to ask if she had any matters they wanted the investigation to consider. She asked us why her son was released to Westgate, and to consider whether he received enough support there.

21. The initial report was shared with the National Probation Service (NPS). NPS did not find any factual inaccuracies.

22. Mr Carton's mother received a copy of the initial report and indicated that they were satisfied with the findings.

Background Information

Westgate Approved Premises

23. 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.

24. Westgate is managed by the National Probation Service. It has 18 bedrooms. Each resident is allocated a key worker to oversee their progress and wellbeing and to help them adhere to licence conditions and the premises' rules. Staff are on duty 24 hours a day to monitor residents' behaviour and report to their offender manager.

Previous deaths at Westgate Approved Premises

25. Mr Carton is the only resident to have died at Westgate.

New Psychoactive Substances (NPS)

26. NPS, 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.

27. 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.

28. Approved premises do not currently test for NPS which require a urine sample, as they currently only have oral swab drug testing procedures in place. The National Probation Service says that this is because the nature of buildings and staffing make it impractical to implement urine testing across approved premises.

29. The National Probation Service accepted our recommendation in January 2017 that they should review drug testing arrangements in approved premises and take steps to enable staff to identify NPS use.

Prescribed medication

30. The Approved Premises Manual, issued by HMPPS, covers what staff and residents in all approved premises in England and Wales must do about residents' prescribed medication.

31. It says that staff should assess whether it is appropriate for residents to have their medication in possession or whether staff should retain and dispense it to them. Factors they should consider include whether residents are at risk of misusing substances or medication, selling their medication or are at risk of self-harm and/or bullying.

32. The instructions in the manual are unclear about what staff should do about medication and also contradict the standard contract, annexed to the manual, which sets out what residents must agree to do.

33. The manual says that staff must arrange with "relevant pharmacies" to collect or have delivered prescribed medication for all residents. Despite this, residents must sign a contract to say they will hand in any medication that they collect from the pharmacy if they are not allowed to retain their medication.

34. Unlike the prison environment, where the medical and pharmacy provision is contained within the establishment, residents in approved premises are in the community and therefore can access their own prescriptions through a GP, Accident and Emergency departments or other medical drop-in facilities, and can collect their prescriptions themselves from any pharmacy.

35. The manual's position on staff collecting prescribed medication (or pharmacies delivering it) does not address the fact that residents can obtain and collect prescribed medication themselves from a number of different services in the community.

Key Events

HMP Wealstun

36. On 17 September 2015, Mr Carton was recalled to HMP Wealstun. The offender manager, tried unsuccessfully to obtain a place for him at a Psychologically Informed Planned Environment (PIPE) approved premises. On 5 January 2017, he was released on licence to Westgate Approved Premises.

37. Mr Carton had a history of substance misuse, including NPS, and his licence conditions required him to address this. He was released from Wealstun with a 7-day methadone prescription and his drug worker had arranged an assessment at Inspiring Recovery (a drug and alcohol support service). He had a curfew between the hours of 7am and 7pm, and his drug-worker told the public protection casework section (PPCS) that he would be tested for alcohol and drugs at Westgate. She emailed the manager of Westgate, to remind her that Mr Carton must register with a GP and sign up for drug and alcohol support services straightaway upon release.

5 January

38. On 5 January, Mr Carton's offender manager was on leave and had briefed her colleague, a probation service officer, to meet Mr Carton. She discussed Mr Carton's mental health needs with him and she told him to register with a GP as soon as possible. He agreed to do so that day or the next day. She ensured that Mr Carton understood his licence conditions. She told the investigator that she was aware that Mr Carton had a history of substance misuse, but did not discuss it with him because she knew that the offender manager would do so when she returned from leave.

39. During the meeting, Mr Carton was positive, motivated and organised. He told her he was going to see his parents later that afternoon. When he left, she telephoned Westgate to ensure that he had arrived.

40. Mr Carton had an induction when he arrived at Westgate with a member of staff. They went through the rules of the approved premises which included not bringing into the premises any weapons or drugs, and briefly discussed Mr Carton's licence conditions. They did not discuss any release plans or support services. During his induction, Mr Carton was assessed as unsuitable to have medication in his possession due to his history of substance misuse. He signed a resident's contract in which he agreed to allow approved premises staff to make a list of his prescription medication, that he would show them any new medication, and any medication which he had to take under supervision would be handed in to staff.

6 January

41. On 6 January, Mr Carton went out in the afternoon, returned at 5.30pm, and went to his room. The manager of Westgate, and a member of staff, suspected Mr Carton was under the influence of "spice", an NPS. When they checked on him, Mr Carton was lying on his bed, with his mouth wide open. It took a while to wake him but he eventually acknowledged them. The manager of Westgate

finished work for the day and the member of staff consulted, the duty manager. Westgate does not have an NPS policy. They started suicide and self-harm prevention procedures and agreed to check on him at half hourly intervals.

42. Mr Carton went to the staff office at 6.26pm. He was still disoriented and incoherent. The member of staff twice asked if he had taken drugs but he repeatedly denied it and claimed he had had a blackout. Approved premises are currently unable to test for NPS, so no relevant drugs test could be carried out. She suggested he drink some water, get some sleep and staff would continue to check on him. He told her he was not able to sleep and wanted things to be sorted out. He left the office ten minutes later.

43. At 7.08pm, Mr Carton returned to the office. His face was dripping with blood and there was blood over his arms and shirt. He had two cuts above his eyes, and what appeared to be a puncture wound to his chest, and a cut to his stomach. Although he appeared relatively calm when he spoke, Mr Carton said he was going to cut himself even more and cut his testicles off. He was still holding a knife. The member of staff asked him to put the knife down on the desk and eventually she and another member of staff, managed to remove the knife and provide basic first aid. She called for an emergency ambulance and police who arrived at 7.25pm. Initially, Mr Carton refused to leave, but at 7.46pm, was taken to hospital. She explained to the police that she would not be able to manage Mr Carton if he returned to Westgate without seeing the crisis intervention team at hospital.

44. She and her colleague removed items from Mr Carton's room that he might use to self-harm and updated the duty manager on the events. They discussed the fact that there were several other residents being monitored under suicide and self-harm prevention procedures, and that Mr Carton appeared to be on a destructive path. They assessed him as at risk to himself, staff, residents and his parents. The duty manager started out of hours procedures to recall Mr Carton to prison for breaching his licence condition and the approved premises' rules. She hoped that this action would encourage the crisis team to admit him to hospital. The out of hours recall procedure was never completed.

45. At hospital, a doctor gave Mr Carton diazepam for anxiety and said he did not need further assessments. At 12.35am, Mr Carton returned to Westgate. He was very tired and went to bed. A member of staff checked him every half an hour until 3.30am when she was happy that he was settled and asleep. Another member of staff, a night officer, continued hourly checks thereafter.

7 January

46. On 7 January, Mr Carton left Westgate at 9.00am and returned at 3.20pm. He told a residential officer he felt better and had no thoughts of suicide or self-harm. She noticed that he appeared to be under the influence of drugs. He said he had drunk a bottle of alcohol, but had not taken any illicit substances. Westgate did not test him for drugs. Mr Carton said he had seen his parents, everything was okay and he wanted to succeed at Westgate. She reassured Mr Carton that staff were there to support him. She noted this information in the review section of Mr Carton's suicide and self-harm monitoring form and that he would be monitored for the next couple of hours. No date was recorded for the next review and his

risk was not subsequently reviewed. Mr Carton's father telephoned later that afternoon and said his son had not visited them that day, as he had claimed. Later that evening, Mr Carton signed registration forms for a GP, which a residential officer immediately faxed to the surgery.

47. Staff did not see Mr Carton go out at 7.30pm. He returned at 8.15pm with two residents who were aware of his curfew. A residential officer stopped him from going out at again at 8.15pm. Mr Carton said he did not like his room and asked if he could change. He moved rooms and appeared happier. He said he did not want to be checked through the night and that he was not going to harm himself. A night officer checked him at 12.48am, and hourly thereafter but reported no concerns.

8 January

48. On the morning of 8 January, Mr Carton complained to a member of staff, that residents had stolen his methadone prescription from his room. Mr Carton was not allowed medication in his possession and should have handed his dose of methadone to staff.

49. Mr Carton went out at 8.40am and returned later that morning with his father. Mr Carton told a member of staff that he did not want to stay at Westgate because he was not getting the support he needed and his medication had been stolen. He said he was going to complain. The member of staff asked Mr Carton why he had not handed his medication to staff. Mr Carton said that he was not told that he had to.

50. Mr Carton went out in the afternoon and failed to return for his 7.00pm curfew. At 11.30pm, a member of staff telephoned the police who confirmed he had been in police custody and was at a hospital. Mr Carton had been arrested for an alleged theft but released without charge. He returned from hospital at 3.55am, with cuts to his face. He told staff he had been mugged, and that the police had assaulted him, breaking his ribs.

9 January

51. On the morning of 9 January, staff recorded in the staff handover file that Mr Carton had threatened to kill himself. Staff did not make a record in his suicide and self-harm monitoring form. He went to his parents and then to a meeting with his offender manager.

52. The offender manager saw Mr Carton and his father at approximately 10.30am. She noted that Mr Carton's eyelids were drooping and that he appeared to be under the influence of drugs. Westgate did not test him for drugs. Mr Carton repeated his account of being mugged and of his money and medication being stolen. He said he had been arrested and beaten up by the police, which had resulted in broken ribs and a broken foot. She told Mr Carton that she had spoken to a member of staff at Westgate and was not sure this was the case.

53. During the meeting, Mr Carton said that residents were using his room to smoke "spice" and "weed", which was against the rules of the approved premises. She told him to report it to staff and said she would do the same. He told her that he just wanted to be left alone to live his life. He talked about a traumatic event he

had experienced in prison in 2013, and that he had lumps in his body he thought were cancerous. He said he felt he had no help and said that he was going to cut his ears off. She emphasised the need for him to see a GP. Mr Carton told her he wanted to move out of the area when his licence expired. She ended the meeting by confirming she would see him the next day, to which he responded, "If I make it". She recorded the details of the meeting and while she emailed staff at Westgate, she did not tell them about his last comment, or that she suspected Mr Carton had taken drugs.

54. Later that afternoon, a support worker at Inspiring Recovery telephoned a key-worker and explained that Mr Carton had arrived late for his 1pm assessment and although he was still seen, they could not provide the Valium prescription he had requested. Mr Carton told her he had taken pregabalin (for his anxiety) and that he was going to be attacked or killed by staff and/or residents at Westgate. The key-worker told the investigator that Mr Carton did not mix with other residents and that staff did not have any concerns for his safety. The support worker re-scheduled an appointment with Mr Carton at 1.00pm the next day.

55. At 6.30pm, police arrested Mr Carton and admitted him to hospital under the Mental Health Act. Before he left, he told the key-worker he wanted his pregabalin. She searched his room for medication but did not find any.

56. A mental health social worker, confirmed that Mr Carton was at a hospital (a psychiatric hospital) but was assessed as not at a high enough risk to himself or others to be admitted on an involuntary basis. He declined voluntary admission.

57. The police returned Mr Carton to Westgate at 10.50pm. A night officer told Mr Carton he would need to check on him regularly through the night. Mr Carton told him that he had attacked people in prison and told him that if anyone came into his room, they would "get stabbed up". Ten minutes later, a resident came to the office and told the night officer and a key-worker that Mr Carton had shown him a knife and said, "Either me or someone else is going to get hurt".

58. At the same time, Mr Carton's father telephoned the approved premises and told a key-worker that earlier in the day a GP had prescribed his son 14 pregabalin tablets, which he had taken all at once. She called the police, and explained his behaviour, including that he had overdosed on pregabalin. Paramedics arrived with the police, examined Mr Carton, and offered to take him back to hospital. He refused. The police searched Mr Carton's bedroom but they did not find a knife. The police stayed with Mr Carton until he settled down. The police concluded that because Mr Carton's threats were not made in a public place, they could not find a knife and the CCTV was not clear, they could only arrest him for breaching the peace, or if procedures were started to recall Mr Carton to prison out of hours.

59. The key-worker telephoned the duty manager and discussed an out of hours recall for Mr Carton. The duty manager spoke to Mr Carton and explained his options: recall, or compliance with staff checks. He opted for the latter. She decided against a recall and advised the key-worker to carry out two half-hourly suicide and self-harm prevention checks, and then hourly checks on Mr Carton. After his conversation with the duty manager, Mr Carton continued to threaten anyone who came into his room.

60. At 1.40am, Mr Carton was agitated because he did not have any cigarettes and went to the staff office. He eventually returned to his room and the night officer told the duty manager that he did not feel safe going into Mr Carton's room to check on him. She agreed that he did not have to do so but asked him to walk past his room a few times to check if he could be heard sleeping. The night officer conducted hourly checks around the premises but there are no records that he checked on Mr Carton specifically overnight.

10 January

61. At 6.40am, the duty manager telephoned the night officer who told her he had just been upstairs and had heard Mr Carton snoring.

62. The night officer recorded at 7.00am, that Mr Carton was, "heard sleeping".

63. At 8.00am and 9.10am, a key-worker checked on Mr Carton and recorded "seen in room asleep, no concerns". A check at 10.00am did not take place due to the staff handover, which lasted approximately 30 minutes. At 11.30am, a residential officer checked on Mr Carton and recorded "on his side asleep". A check did not take place at 12.30pm.

64. At 1.30pm, Residential Officer A checked on Mr Carton and thought it unusual that he had not changed position. Residential Officer A and Residential Officer B returned to Mr Carton's room and tried to wake him. When Residential Officer B touched his shoulder, he noticed that Mr Carton's body was cold and hard. He checked for a pulse and if he was breathing. Residential Officer B called an ambulance from his mobile at 1.40pm. He telephoned the manager at 1.45pm. Residential Officer A telephoned the police at 1.50pm. The manager arrived just before a paramedic, who arrived at 2.15pm. The paramedic checked for signs of life and pronounced Mr Carton dead at 2.20pm.

Contact with Mr Carton's family

65. The police arrived at Westgate at approximately 2.45pm. A police officer told the manager that it was the police's duty to notify Mr Carton's next of kin of his death. The police visited Mr Carton's parents at 8.00pm that day. The manager spoke to Mr Carton's father the next day and offered her condolences. The National Probation Service contributed toward the costs of Mr Carton's funeral in line with national policy.

Support for prisoners and staff

66. After Mr Carton's death, the manager debriefed all the staff to ensure they had the opportunity to discuss any issues arising, and to offer support.

67. The manager held a meeting with residents to tell them of Mr Carton's death and offered staff support.

Post-mortem report

68. The post-mortem examination concluded that Mr Carton died of mixed drugs poisoning of diazepam, methadone and pregabalin. New psychoactive substances were not detected.

Findings

Assessment of Mr Carton's risk of suicide and self-harm

69. Mr Carton had a number of risk factors for suicide and self-harm. He had a history of substance misuse and some mental health issues. During his short time at Westgate, he was a challenging resident and appeared under the influence of substances a number of times, threatened to kill himself, self-harmed, overdosed on medication and was arrested twice, once under the Mental Health Act. Although staff started monitoring his welfare after he was suspected of taking spice and despite a number of significant risk factors, they did not consider whether he was at an increased risk of suicide or self-harm and did not review him in line with local policy. Mr Carton's risk of suicide and self-harm was only reviewed once, on 7 January, and staff did not identify his significantly escalating risk, despite monitoring his general welfare. We make the following recommendation:

The manager of Westgate Approved Premises should ensure that all staff understand the procedure for identifying, managing and supporting residents at risk of suicide and self-harm. In particular, they should ensure that staff:

- **Review the risk of suicide and self-harm based on all available information and known risks factors; and**
- **Clearly record the appropriate frequency of monitoring.**

70. Although Mr Carton had self-harmed and threatened to kill himself at Westgate, we cannot say for certain whether or not he intended to take his life when he took the pregabalin tablets, or whether he had anticipated that the mixture of pregabalin, diazepam and methadone would prove fatal.

Welfare checks

71. The Approved Premises Manual says that staff should monitor residents' presence, behaviour and wellbeing.

72. Mr Carton's risk increased significantly the day before he died. Given his substantial risk factors, we would have expected staff to have had a care management plan in place to check on Mr Carton's wellbeing more thoroughly and regularly on the morning of 10 January, particularly as staff knew he had taken an overdose of medication the previous day. They did not try to get a response from Mr Carton on 10 January but noted he was asleep. In the circumstances, they should have tried to wake him. While we cannot say whether it would have changed the outcome for him, they might have identified that he needed urgent medical attention. We make the following recommendations:

The manager of Westgate Approved Premises should ensure that staff conducting welfare checks assure themselves of the safety of residents and that they have a care management plan in place for residents known to have taken an overdose.

Mixed drug toxicity

73. The Approved Premises Manual says that those who misuse substances are at high risk of self-harm or death, particularly from mixed drug toxicity when individuals simultaneously take a cocktail of drugs. This is often due to reduced tolerance after release from prison, and staff are required to advise residents of this on arrival. Mr Carton had a history of substance misuse, had been prescribed methadone and Westgate had assessed him as not suitable to retain and manage his medication. We are concerned that no one at Westgate advised him of the risk of mixed drug toxicity. We make the following recommendation:

The manager of Westgate Approved Premises should ensure that residents suspected of substance misuse understand the risks of mixed drug toxicity.

Medication

74. Staff at Westgate assessed Mr Carton as not suitable to have his medication in possession. Despite this, a GP prescribed him pregabalin and he was able to collect it himself from a pharmacy, with his father present and without Westgate knowing until after he had taken all 14 tablets prescribed.

75. While staff did not follow national instructions to collect residents' prescriptions, doing so would not have prevented Mr Carton being prescribed pregabalin from his GP or collecting his prescription himself. We are concerned that the current national policy is unclear and contradictory. It does not cover the risk that residents, who are assessed as not suitable to have medication in their possession, might themselves obtain a prescription from any number of services and collect it themselves from any pharmacy, other than that with which the approved premises has an agreement. We make the following recommendation

The National Probation Service should review the current policy as set out in the Approved Premises Manual to address more effectively the risk of residents misusing prescribed medication.

Substance misuse

76. The Approved Premises Manual says that testing known drug users on arrival or when they are suspected of renewed substance misuse is a targeted and prudent use of resources. It says that staff should have discretion to test residents if there is reasonable suspicion of substance misuse. Accepting this regime is a condition of living in approved premises.

77. Mr Carton had a history of substance misuse, including NPS. His offender manager agreed that he would be tested for substances at Westgate, as required and in line with his licence conditions. Despite this, the manager of Westgate told the investigator that drug testing at Westgate was only conducted when the offender manager instructed them to do so, or if drugs agencies, which work with residents, decided to do so.

78. Mr Carton was suspected of being under the influence of NPS and other substances on three out of his five days at Westgate. While staff at Westgate could not test for NPS, they had the facility to test for conventional drugs. We

are concerned that they failed to do so and saw no evidence that they had even considered it.

79. The Approved Premises Manual requires staff to search rooms when they suspect that alcohol or illicit drugs are present in the approved premises. Even where there is no direct suspicion, room searches should be carried out regularly, but not at set intervals. Staff at Westgate searched Mr Carton's room only once on 9 January and never searched him for illicit substances. We make the following recommendation:

The manager of Westgate Approved Premises should ensure that when a resident is suspected of substance misuse, staff conduct a thorough search of the resident's room and test him for substances.

NPS

80. Since September 2016, drug testing kits in prisons have been able to detect NPS from urine samples, and technologies are evolving all the time. The National Probation Service's analysis on NPS use in approved premises does not currently address the gap in NPS testing, as they agreed in early 2017. While we recognise the National Probation Service's ongoing work to address the issue of NPS, the prevalence of NPS continues to make their omission from testing in approved premises a serious impediment to identifying patterns of usage and providing appropriate support and interventions. We make the following recommendation:

The National Probation Service should implement a strategy to reduce the supply of and demand for NPS in approved premises, including developing mechanisms to test for NPS use.

Sharing intelligence about risk and substance misuse

81. On Monday 9 January, Mr Carton's offender manager suspected he was under the influence of substances during their meeting and should have told staff at Westgate to test Mr Carton for drugs. Mr Carton also suggested to her that he might take his life and although she emailed staff at Westgate, she failed to tell them about his comment, as she should have done. We make the following recommendation:

The probation divisional office for the north east should ensure that offender managers share intelligence about residents suspected of substance misuse or at risk of suicide or self-harm.

Prisons & Probation Ombudsman
Independent Investigations

PO Box 70769
London, SE1P 4XY

Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100
F | 020 7633 4141