Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Billy-Jo Rye a resident at Fleming House Approved Premises on 21 May 2017

A report by the Prisons and Probation Ombudsman

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Our Vision

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

Our Values

We are:

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

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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.

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 Billy-Jo Rye died on 21 May of pneumonia at Fleming House Approved Premises in Maidstone. Mr Rye was 27 years old. We offer our condolences to Mr Rye's family and friends.

Mr Rye had lived at Fleming House for just over three weeks. On the morning of Mr Rye's death, staff were unable to wake him and assumed he was in a deep sleep. We found that staff waited too long to check on him again and failed to call an ambulance when he did not respond to further attempts to wake him.

While we cannot say whether the delay in calling an ambulance affected the eventual outcome for Mr Rye, we are concerned that staff missed an opportunity for earlier medical intervention.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman **December 2017**

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Summary

Events

1. On 28 April 2017, Mr Billy-Jo Rye was released from prison on licence and was required to live at Fleming House Approved Premises in Maidstone. Mr Rye spent a lot of time away from the approved premises and other than some minor issues relating to his curfew and a positive breath test for alcohol, he generally abided by the premise's rules.

2. At around 9am on 21 May, a member of staff took a telephone call from a member of Mr Rye's family, who was having difficulty contacting him. The member of staff went to Mr Rye's room and knocked on the door but Mr Rye did not respond. He fetched the key and entered Mr Rye's room at 9.10am. He found him lying on his bed, snoring.

3. Over the next forty minutes, two staff members went to Mr Rye's room together on two occasions to try to wake him. He did not respond to their shouting or shaking and continued to snore loudly. Staff told us that Mr Rye's family had informed them that Mr Rye could be difficult to wake up, but the family dispute having said this. After speaking to Mr Rye's mother at 1pm, staff went to try to wake him again at 1.44pm. Mr Rye was still snoring and did not respond to their attempts to rouse him.

4. At 1.48pm, a member of staff decided to call the NHS 111 helpline. The operator said they would send a paramedic as a precaution and advised staff to move Mr Rye on his side in the meantime. A member of staff entered Mr Rye's room at 1.57pm and noticed that he had stopped breathing. He used a mobile telephone to call an ambulance and started cardiopulmonary resuscitation (CPR). Paramedics arrived at 2.03pm and continued CPR until 3.04pm, when they confirmed that Mr Rye had died.

Findings

5. While we accept that it was reasonable for staff to assume that Mr Rye was sleeping when they first checked on him before 10am, we are concerned that staff did not check on him again until four hours later. When staff failed to wake Mr Rye on this occasion, we consider that they should have called an ambulance. This was a missed opportunity to seek medical intervention. We are also concerned that the staff on duty did not have emergency first aid training.

6. The National Probation Service did not contact Mr Rye's family until four weeks after his death, which meant that the family was unaware of the support that was available to them, including financial assistance with the cost of Mr Rye's funeral.

Recommendations

- The manager of Fleming House should ensure that where a resident is found unresponsive, staff call an ambulance immediately.
- The manager of Fleming House should ensure that all staff working at the approved premises are first aid trained.

- The manager of Fleming House should ensure that following a death, the resident's family is provided with appropriate support and offered financial assistance with funeral costs in line with national guidance.

The Investigation Process

7. The investigator issued notices to staff and prisoners at Fleming House informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

8. The investigator visited Fleming House on 26 May 2017. He obtained copies of relevant extracts of Mr Rye's records.

9. The investigator interviewed one member of staff at Fleming House on 3 July and a further five members of staff on 5 July. He wrote to one of the residents asking if he was willing to contribute to the investigation, but he did not respond and he was not available when the investigator visited Fleming House.

10. We informed HM Coroner for Mid Kent and Medway of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

11. One of the Ombudsman's family liaison officers contacted Mr Rye's mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Rye's mother raised a number of issues including:

    - Mr Rye routinely woke up at the same time each day and she wanted to know whether staff completed any welfare checks on him on the morning he died;
    - she asked what staff did to try to wake Mr Rye following the telephone calls made to Fleming House by her and Mr Rye's partner;
    - she wanted to know how staff realised that Mr Rye was not asleep;
    - she asked for details of the emergency response, about which she had concerns; and
    - she wanted to know why she had to wait so long to find out that Mr Rye had died.

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

13. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

Fleming House Approved Premises

14. Approved premises (formerly known as probation and bail hostels) accommodate offenders released from prison on licence and those directed to live 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.

15. Fleming House Approved Premises in Maidstone, Kent, is managed by the National Probation Service. It has twenty-three single rooms and four shared rooms, including a ground floor room with disabled facilities. Breakfast and evening meals are provided and there is a communal area for eating and socialising. Each resident has a key worker to oversee their progress and well-being and see that they adhere to their individual licence conditions and the premise's rules. Staff are on duty at Fleming House 24 hours a day.

Previous deaths at Fleming House

16. Mr Rye was the first person to die at Fleming House.

Key Events

17. On 26 April 2013, Mr Billy-Jo Rye was sentenced to eight years imprisonment for grievous bodily harm and sent to HMP Elmley. He progressed through his sentence and was moved to HMP Rochester on 15 October 2014. Mr Rye suffered from asthma and prison GPs prescribed inhalers, but records indicate that he did not use them regularly. He also had a history of substance misuse and failed a number of mandatory drug tests (MDTs) for various substances, including new psychoactive substances (NPS) and opiates, while in prison.

18. On 3 November 2016, Mr Rye complained of chest pain and a nurse sent him to hospital by ambulance. A hospital consultant conducted an examination and discharged him the same day, satisfied that the episode was not a cause for concern. Prior to Mr Rye's release, healthcare staff offered him two appointments on 14 and 25 April 2017, but he failed to attend. On 28 April, Mr Rye was released on licence and was required to live at Fleming House Approved Premises, Maidstone.

19. When Mr Rye arrived at Fleming House, a key worker (a permanent member of staff who is allocated a number of residents to support and monitor) went through his licence conditions and the rules of the premises with him. He noted that Mr Rye did not have any medical conditions or prescribed medication and intended to register with a local GP practice. His approved premises referral form and probation risk assessment tool (OASys) suggested intervention from community substance misuse services, but there is no evidence that a referral was made. Mr Rye was allocated a single room on the first floor, which he could lock at night. He did not spend much of his time at the approved premises and although there were some issues relating to his curfew and a positive breath test for alcohol, he mostly abided by the rules.

20. On 7 May, Mr Rye returned 12 minutes late for his 12pm curfew and told a key worker that he had been to a see a GP for breathing problems. He said that he had a prescription that was at his partner's house and she reminded him to show it to a member of staff so they could make a note of what he was taking. There is no record that Mr Rye subsequently provided a prescription or details of any medication.

21. On 11 May, a key worker detected alcohol on Mr Rye's breath and conducted a breath test. He tested positive (0.66mg/l – the current UK drink drive limit is 0.35mg/l) and received a formal warning letter, in line with approved premises rules.

Events of Saturday 20 and Sunday 21 May

22. At 9pm on Saturday 20 May, Mr Rye returned to the approved premises to sign in and briefly spoke to a key worker, who did not notice any cause for concern. At 10.30pm, Mr Rye left the building to go to a local shop. A sessional worker (a member of staff who carries out ad hoc shifts at the approved premises and is not based there permanently) noted that although he did not see Mr Rye return, he was present for a fire alarm roll check at 10.47pm.

23. On 21 May, at 12.18am, Mr Rye went outside for a cigarette and returned to his room six minutes later. At 12.25am, CCTV shows a resident enter Mr Rye’s room for just under one minute, before going back two minutes later, for around eight seconds. A police report indicates that the resident went to get a cigarette but forgot to get tobacco and went back. At 7.34am, a sessional worker opened the door of Mr Rye’s room to conduct a welfare check and noticed him turn over on his bed. He had no concerns and went onto the next room.

24. At 8.30am, two sessional workers took over from the night staff. As it was a weekend, there were only two people on duty per shift. At around 9am, a sessional worker took a telephone call from Mr Rye’s partner asking him to wake Mr Rye as she needed to go to hospital. CCTV shows that he went to Mr Rye’s room at 9.07am. He heard snoring and a phone ringing. He knocked on the door and tried to enter but it was locked, so he went to get a key from the office. At 9.10am, he entered Mr Rye’s room while calling his name and noticed that he was lying on his back with a leg hanging off the side of his bed, that his chest was moving, and that he was snoring loudly. There were no signs of substance misuse and he returned to the office under the impression Mr Rye was sleeping.

25. The sessional worker told his colleague that he could not wake Mr Rye and considered that maybe he had not been forceful enough. CCTV shows that at 9.14am, they both went to Mr Rye’s room together and noticed that he remained in the same position as before. One sessional worker clapped her hands and they both called out his name and gave his body a shake. Although Mr Rye did not respond to their attempts to wake him, they noted that he continued to breathe and snore in a manner which appeared normal. They left the room at 9.16am.

26. Both sessional workers took a number of telephone calls from Mr Rye’s mother and partner and, according to CCTV, went back into Mr Rye’s room at 9.48am. One sessional worker noticed that Mr Rye’s right leg had moved back onto the bed and that he was snoring loudly. His colleague shook one of Mr Rye’s arms, before answering his mobile telephone and putting it to his ear so that his partner could speak to him and hear him snoring. Although Mr Rye did not respond, his colour and breathing appeared normal. A sessional worker told the investigator that Mr Rye’s partner said he could be very difficult to wake up and that she responded by saying there was not much else they could do. Mr Rye’s family continued to call his mobile telephone in an attempt to wake him.

27. At around 1pm, Mr Rye’s mother spoke to a sessional worker by telephone and told her that she was worried and really wanted them to wake him up. She told the investigator that Mr Rye’s mother told her that he had once gone into a ‘sleep coma’, so they decided to check his probation records. Both sessional workers checked various sources of information and noted that Mr Rye did not appear to have any medical conditions or sleeping difficulties, but he did have a history of substance misuse in prison. At 1.44pm, they went to Mr Rye’s room and noted that he was still snoring and did not appear to have any trouble breathing. They gave his body a shake and flicked water in his face, but he did not wake up.

28. At 1.48pm, a sessional worker called 111 (the National Health Service’s non-emergency telephone number). The 111 operator advised her to go to Mr Rye’s

room and turn him on his side, and said they would send a paramedic as a precaution.

29. At 1.57pm, a sessional worker went to Mr Rye's room and noticed that he had stopped breathing and did not have a pulse. He could not get through to his colleague using a radio, so used his mobile telephone to call an ambulance and started cardiopulmonary resuscitation (CPR). A first response paramedic arrived at 2.03pm and he continued to assist with the resuscitation attempt as more paramedics arrived. In the meantime, Mr Rye's partner arrived at the approved premises and spoke to the other sessional worker. She told her that she could only let residents into the building and that she would call her with an update once she had more information. At 3.04pm, a paramedic confirmed that Mr Rye had died.

Contact with Mr Rye's family

30. At around 3.40 pm, Mr Rye's mother, partner and a young boy arrived at the approved premises and spoke to a sessional relief worker. They wanted to know what had happened to Mr Rye and a police officer joined them outside. The relief worker spoke to a probation manager, who gave permission for Mr Rye's relatives to enter the building. Another sessional worker helped escort the family members to a private room and was present when the police decided to break the news of Mr Rye's death. The staff at Fleming House continued to support Mr Rye's family that afternoon, but there is no record they provided them with a point of contact for ongoing support.

31. Mr Rye's funeral took place on 13 June. Two days later, one of the Ombudsman's family liaison officers contacted Mr Rye's mother to explain our investigation. She advised him that she had not had any contact or offer of financial support from probation staff. Following a prompt from the investigator, an approved premises area manager met with Mr Rye's mother and partner at Fleming House on 23 June. He noted their concerns, advised them to contact the police regarding Mr Rye's property and offered a financial contribution towards the cost of Mr Rye's funeral.

Support for residents and staff

32. On 21 May, a manager spoke to the members of staff present at the approved premises individually to ensure they had the opportunity to discuss any issues arising, and to offer support. On 22 May, the approved premises manager contacted staff to offer additional support.

33. On 21 May, a manager initially told the residents present that there had been an incident before later confirming that Mr Rye had died. Notices were posted informing all staff and residents of Mr Rye's death and offering support.

Post-mortem report

34. A post-mortem examination found that Mr Rye died of pneumonia (a swelling of the lung tissue in one or both lungs, usually cause by a bacterial infection). The post-mortem report noted that although a high level of morphine was found in Mr Rye's urine, the low level in his blood meant it was unlikely to have had a direct

influence on the cause of death. Codeine and tetrahydrocannabinol were also found in Mr Rye's urine.

Findings

Emergency response

35. Mr Rye's family expressed concern about the delay in identifying that there was something wrong with Mr Rye and in calling an ambulance. The two sessional workers told the investigator that they did not consider calling an ambulance any sooner, because they did not consider Mr Rye's presentation was anything to worry about. They added that the family had told them that Mr Rye could be difficult to wake up, which alleviated any concerns they might have had. The family dispute this and we have been unable to make a finding on whether or not the family made these statements to staff.

36. Staff went into Mr Rye's room on three occasions between 9.10am and 9.48am on 21 May, trying various different methods to wake him up. They told us that despite not being able to rouse Mr Rye, they did not suspect that anything was wrong, as Mr Rye was breathing and snoring as if he was in a deep sleep. We consider it reasonable that staff assumed Mr Rye was sleeping at that time. However, we are concerned that they did not check on him again until four hours later, and only after Mr Rye's mother telephoned staff to say she was worried about her son. We consider that staff should have checked on Mr Rye earlier, particularly given his family were trying to contact him.

37. When the sessional workers were unable to wake Mr Rye at 1.44pm, they decided to contact the NHS 111 helpline because they did not consider Mr Rye's condition was serious. We consider that staff should have called an ambulance when they failed to get a response from Mr Rye on this occasion. Over four hours had passed since staff had first tried to wake Mr Rye, and staff had received numerous calls from his family, who were becoming increasingly concerned. A sessional worker called for an ambulance when he noticed that Mr Rye had stopped breathing, but we are concerned that staff missed an opportunity to seek medical intervention earlier.

38. We are also concerned that both sessional workers were not trained in emergency first aid. The Approved Premises Manual 2014 states, "All staff involved in the supervision of residents should attend an emergency first aid course". The safe working practice document specific to Fleming House states that "all staff must be trained in Emergency First Aid at Work" (a training course recognised by the Health and Safety Executive that enables a first-aider to provide emergency first aid to someone who is injured or becomes ill while at work). While we consider it unlikely that this affected the eventual outcome for Mr Rye, the ability of staff to administer emergency first aid in future cases could be crucial to saving a resident's life.

39. We make the following recommendations:

The manager of Fleming House should ensure that where a resident is found unresponsive, staff call an ambulance immediately.

The manager of Fleming House should ensure that all staff working at the approved premises are trained in emergency first aid.

Family liaison and payment of funeral expenses

40. The approved premises manual sets out the expected procedures and standards for making contact with a resident's family following a death. It states that a representative of the approved premises should be appointed to make contact with the deceased's family, providing them with a single point of contact and a degree of continuity. The approved premises manual also says that the probation service is required to offer a financial contribution towards the cost of a resident's funeral.

41. Although we recognise that an approved premises area manager made contact with Mr Rye's family and offered a contribution towards the funeral cost, this did not occur until four weeks after his death, and only after a prompt by the investigator. This meant that Mr Rye's family had to arrange his funeral without additional support or knowledge that they were entitled to financial assistance, which is likely to have caused additional stress at an already difficult time.

42. The area manager told us that he decided not to contact Mr Rye's family until he had something to tell them. He said that in previous cases, residents' families had made contact with the approved premises and that he did not want to impose on them. While we consider it reasonable not to want to put Mr Rye's family under any pressure, ensuring that the families of deceased residents have a point of contact and know that financial assistance is available at an early stage is of vital importance. We make the following recommendation:

    The manager of Fleming House should ensure that following a death, the resident's family is provided with appropriate support and offered financial assistance with funeral costs in line with national guidance.

Illicit substances

43. Toxicology tests after Mr Rye's death showed a number of substances in his system including, methadone (a pain relief medication commonly used to treat opioid dependence), codeine (an opiate based pain relief medication) and tetrahydrocannabinol (the active ingredient in cannabis). There is no evidence that Mr Rye was taking prescribed medication, which would suggest that he may have been using illicit substances in the community.

44. Mr Rye's offender manager told the investigator that she did not have any concerns about his substance misuse following his release. She said that she was aware Mr Rye's probation records identified substance misuse as a potential risk factor, but did not feel a specialist referral was required as he never presented as under the influence and did not report any concerns about his own usage. Although we recognise that Mr Rye gave a positive alcohol test at the approved premises, we are satisfied that there were no indications that he was using illicit substances or that he was at risk of an overdose, while living at Fleming House.

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