Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Leonard Clarke a resident at Stonnall Road Approved Premises on 10 June 2018

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*

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 Leonard Clarke died in hospital from heart disease on 10 June 2018 while a resident at Stonnall Road Approved Premises in Walsall. He was 72 years old. I offer my condolences to Mr Clarke's family and friends.

Mr Clarke arrived at Stonnall Road on 24 May 2018, after his release from HMP Dovegate. He suffered from several chronic conditions including high blood pressure, high cholesterol and dementia. I am satisfied that staff at Stonnall Road appropriately supported Mr Clarke and there was nothing they could have done to prevent his death.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman **November 2018**

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Summary

Events

1. On 24 May 2018, Mr Leonard Clarke was released from prison on licence and was required to live at Stonnall Road Approved Premises in Walsall. He had several long-term health conditions, including high blood pressure, high cholesterol and dementia. Staff at Stonnall Road issued him with his medication daily and facilitated his attendance at medical appointments.

2. At 10pm, on 9 June, two residential workers conducted a welfare check and noticed that Mr Clarke was asleep on his bed and breathing. An hour later, they checked him again and found that he appeared to have stopped breathing. At 11.07pm, one of the residential workers used his mobile phone to call an ambulance and they both subsequently started cardiopulmonary resuscitation (CPR). Paramedics arrived at Stonnall Road at 11.15pm, and transferred Mr Clarke to New Cross Hospital, Wolverhampton, at 11.46pm.

3. On 10 June, at 2.45am, hospital staff pronounced that Mr Clarke had died.

4. The coroner gave Mr Clarke's cause of death as heart disease caused by coronary atherosclerosis (a condition that causes the arteries of the heart to harden and narrow).

Findings

5. We are satisfied that the level of care and support Mr Clarke received at Stonnall Road was of a very high standard. The staff could not have done anything to prevent Mr Clarke's death and responded appropriately when they found him unresponsive.

The Investigation Process

6. The investigator issued notices to staff and residents at Stonnall Road Approved Premises informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

7. The investigator obtained copies of relevant extracts from Mr Clarke's prison, probation and medical record.

8. The investigator interviewed six members of staff at Stonnall Road on 19 July 2018.

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

10. The investigator wrote to Mr Clarke's sister to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not respond to our letter.

11. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not point out any factual inaccuracies.

Background Information

Stonnall Road Approved Premises

12. Approved premises (formerly known as probation or 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.

13. Stonnall Road Approved Premises is located in Walsall and managed by the National Probation Service. It has six single rooms and three double rooms. 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 premises' rules. Staff are on duty at Stonnall Road 24 hours a day.

Previous deaths

14. Mr Clarke was the second resident to die at Stonnall Road since June 2015. There are no significant similarities between the two deaths.

Key Events

15. In March 1999, Mr Leonard Clarke was sentenced to life in prison for murder. He was released on licence in July 2015, but was recalled to HMP Birmingham on 14 June 2016, after breaching the conditions of his licence. He was moved to HMP Dovegate on 17 June. Mr Clarke was aged 72 and suffered from several long-term conditions including high cholesterol, high blood pressure and dementia.

16. On 17 May 2018, a prison psychiatrist saw Mr Clarke for a review and noted that he had stopped taking most of his medication as he did not want to get into trouble in the community. He strongly encouraged him to take his medication and recorded that he appeared to have a robust package of care and supervision in place for when he left prison.

17. On 24 May, Mr Clarke was released on licence and was required to live at Stonnall Road Approved Premises in Walsall. An offender supervisor and a member of prison staff escorted him. When Mr Clarke arrived, a residential worker went through the first stage of the induction process, which included the approved premises' rules and confirmation of any support needs. Mr Clarke was assigned a ground floor room opposite the staff office and assessed as requiring hourly welfare checks. The residential worker recorded that Mr Clarke had arthritis and dementia but did not have prescribed medication.

18. On 25 May, Mr Clarke's offender manager, his key worker and a community social worker saw him for a joint meeting. They spoke about developing an appropriate moving-on plan and enquired about medication. Mr Clarke said his previous prescription contained co-codamol (an opiate based pain relief medication) and that he was worried about being recalled to prison. The key worker assured Mr Clarke that he would not be recalled for taking prescribed medication and arranged for him to register with a GP.

19. On 31 May, Mr Clarke attended a GP appointment and a local pharmacy sent his prescribed medication to Stonnall Road. Mr Clarke did not have his medication in possession and had to collect it daily from staff.

20. Over the next five days, staff monitored Mr Clarke frequently and issued his prescribed medication, when required. There were several occasions when Mr Clarke became lost and disorientated while in the community and staff arranged for taxis to collect him.

21. On 6 June, staff noticed that Mr Clarke had a rash on his face and booked him a GP appointment. Later the same day, a GP contacted staff at Stonnall Road to inform them that Mr Clarke had been told not to take medication that he was not prescribed, such as the paracetamol and codeine, which he had brought over the counter.

22. Over the next two days, staff started to become concerned that residents might be exploiting Mr Clarke's deteriorating memory for their own financial gain, as he reported giving them money to buy gifts. Staff advised Mr Clarke not to give money to other residents and monitored his associations more closely.

23. On 9 June, at around 5.30pm, Mr Clarke told his key worker that he felt that his memory had deteriorated and that he was still giving money to residents. At interview, she told us that Mr Clarke looked unkempt and that she raised her concerns with the approved premises manager. At 9pm, Mr Clarke took his evening medication and went to his room. Shortly afterwards, his key worker and a residential worker went to see him to check they had his correct mobile phone number. At interview, the residential worker said Mr Clarke was having a joke with them and did not report any issues or concerns about his health.

24. At 10pm, two residential workers went to Mr Clarke's room to conduct an hourly welfare check. They opened the door and noticed that Mr Clarke was lying on his bed asleep and breathing. At 11pm, they went to conduct another welfare check and noticed that Mr Clarke appeared to have stopped breathing. They entered Mr Clarke's room and attempted to rouse him, but he did not respond. At 11.07pm, one of the residential workers used his mobile phone to call an ambulance.

25. They moved Mr Clarke onto the floor so that they could start cardiopulmonary resuscitation (CPR). Residential worker A started chest compressions and residential worker B attached a defibrillator. Residential worker A then took over chest compressions and followed the defibrillator's instructions, while residential worker B opened the gates for the ambulance. Paramedics arrived at the approved premises at 11.15pm, and at Mr Clarke's room, at 11.17pm. They took over resuscitation and transferred him to the Hospital in Wolverhampton at 11.46pm. On 10 June, at 2.45am, hospital doctors pronounced that Mr Clarke had died.

Contact with Mr Clarke's family

26. At around 11.50pm, on 9 June, the approved premises manager arrived at Stonnall Road and phoned Mr Clarke's daughter to inform her of the situation. His daughter advised her that his sister, who shared the same first name, was his named next of kin and that she would contact her. Mr Clarke's sister attended the hospital and later told staff at Stonnall Road that Mr Clarke had died.

27. On 10 June, the approved premises manager phoned Mr Clarke's sister to offer her condolences and support. She provided ongoing support to Mr Clarke's sister and arranged for her to visit Stonnall Road to collect his belongings. Mr Clarke's funeral took place on 2 July and she attended with several members of staff. The National Probation Service contributed toward the cost, in line with national policy.

Support for residents and staff

28. On 10 June, the approved premises manager held a morning meeting and told all the residents and staff that Mr Clarke had died and offered support. Notices were posted to inform all staff and residents of Mr Clarke's death and offering support.

Cause of death

29. The coroner gave Mr Clarke's cause of death as heart disease caused by coronary artery atherosclerosis (a condition that causes the arteries of the heart to harden and narrow).

Findings

30. Mr Clarke was 72 years old and had several chronic health conditions including, high cholesterol, high blood pressure and dementia. Following his release on licence, the staff at Stonnall Road conducted a full induction and reassured Mr Clarke that he would not be recalled to prison if he failed a drugs test for taking prescribed medication. They arranged for him to register with a local GP and assisted with booking appointments. Mr Clarke did not have his prescribed medication in his possession but collected it from staff daily. The approved premises manager told the investigator that they decided to personally dispense his medication so that staff could ensure he took it. We consider that this arrangement was appropriate.

31. Mr Clarke was relatively independent and, as with anyone else in the community, he was responsible for managing his own health and attending medical appointments. Nevertheless, the staff at Stonnall Road supported Mr Clarke with managing his conditions and helped ensure that he got home safely by providing taxis when he became disorientated. Staff completed regular welfare checks and appropriately addressed Mr Clarke's concerns about the other residents.

32. We are satisfied that staff at Stonnall Road could not have done anything to prevent Mr Clarke's death. They ensured that he received emergency treatment by calling an ambulance as soon as they realised he was unresponsive and started CPR appropriately.

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