Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Livesey a resident at Southwood Approved Premises on 5 December 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 David Livesey died in hospital on 5 December 2018 following a cardiac arrest while living at Southwood Approved Premises. Mr Livesey was 48 years old. I offer my condolences to Mr Livesey's family and friends.

In September 2018, Mr Livesey was released from prison into the supervision of the Probation Service at Southwood. He was known to misuse illicit substances and staff regularly documented incidents when this happened. However, I am concerned that there were occasions when his substance misuse was not recorded. I am also concerned that Approved Premises still do not test for psychoactive substances.

I am satisfied that staff at Southwood responded promptly and professionally when Mr Livesey collapsed at Southwood.

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

Sue McAllister CB
Prisons and Probation Ombudsman **August 2019**

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Summary

Events

1. On 20 September 2018, Mr David Livesey was admitted to Southwood Approved Premises after being released from prison on licence. During his induction, Mr Livesey disclosed his history of substance misuse.

2. A week after Mr Livesey arrived at Southwood, staff suspected that he was under the influence of psychoactive substances (PS). Staff gave him an informal warning and advised him about the dangers of PS. During the next two months, staff recorded on several occasions that Mr Livesey was under the influence of an unknown substance. He was twice issued with a formal warning. By November, staff noted that he seemed more positive and recorded only one instance of suspected substance misuse.

3. On 24 November, staff reported that they suspected that Mr Livesey had been under the influence of an illicit substance the previous night. He was monitored during the day and staff again suspected that he was under the influence. He went out and returned in the evening. At approximately 7.50pm, staff responded after he collapsed in a communal room. They immediately called for an ambulance and performed cardiopulmonary resuscitation until ambulance staff arrived.

4. At 9.15pm, the ambulance crew took Mr Livesey to hospital. He did not regain consciousness and was pronounced dead at 8.30pm on 5 December.

5. The hospital took no blood samples for drug testing following Mr Livesey's admission to hospital and no toxicology tests were ever performed.

Findings

Substance misuse management

6. We recognise that staff at Southwood recorded many instances when they suspected that Mr Livesey was under the influence of illicit substances. We are also satisfied with their use of informal and formal warnings. However, we are concerned that there were occasions when Mr Livesey's suspected illicit substance misuse was not recorded.

7. We are also concerned that Approved Premises are still not able to test for psychoactive substances.

Emergency response

8. We consider that the emergency response was appropriate once staff became aware that Mr Livesey had collapsed.

Contact with Mr Livesey's family

9. We are satisfied that Southwood conducted its contact with Mr Livesey's family appropriately.

Recommendations

- The National Probation Service should ensure that when staff suspect that a resident is under the influence of an illicit substance, they challenge this behaviour and record it in line with the requirements of the AP Manual.
- The National Approved Premises Team should review its strategy to reduce the supply and demand for PS in Approved Premises, including developing mechanisms to test for PS use.

The Investigation Process

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

11. The investigator visited Southwood on 6 February 2019. He obtained copies of relevant extracts from Mr Livesey's probation records.

12. The investigator interviewed four members of staff at Southwood during his visit.

13. We informed HM Coroner for Liverpool of the investigation. Although no post-mortem was carried out, the Coroner confirmed Mr Livesey's cause of death. We have sent the coroner a copy of this report.

14. The Investigator wrote to Mr Livesey's mother, to explain the investigation and to ask whether there were any matters she wanted the investigation to consider. She did not respond to our letter.

15. The initial report was shared with the National Probation Service (NPS). NPS pointed out some factual inaccuracies and this report has been amended accordingly. The action plan has been annexed to this report.

Background Information

Southwood Approved Premises

16. Approved Premises (APs, 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 health and are expected to register with a GP.

17. Southwood, in Liverpool, is managed by the National Probation Service. It has 29 single rooms. All meals are provided and there is a communal area for dining and socialising and areas for group work. Each resident is allocated a key worker/offender supervisor to oversee his progress and well-being, and to ensure that residents adhere to licence conditions and the premises' rules. Probation Service employees are on duty at Southwood 24 hours a day. Sodexo provide contracted staff during the evenings.

Previous deaths at Southwood

18. Mr Livesey's was the second death to occur at Southwood since 2016. There were no similarities between his death and the previous one.

19. There are, however, some similarities between Mr Livesey's death and deaths we have investigated in other APs where PS has been used. In our investigation into a death at another AP in June 2018, we noted that some staff said they did not always challenge residents when they suspected PS use because they could not test for PS and residents knew this. We recommended in that case that the National Approved Premises Team should develop mechanisms to test for PS use, and we are awaiting the response to that recommendation.

Psychoactive Substances (PS)

20. Psychoactive substances (formerly known as 'new psychoactive substances' or 'legal highs') are a serious problem. 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. People under the influence of PS 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.

21. Approved premises test for six controlled drugs (amphetamine, benzodiazepine, cocaine, methamphetamine, methadone, opiates and cannabis) using an oral swab test. They do not test for PS, which requires a urine sample.

22. In a Learning Lessons Bulletin that we published in November 2017, we raised concerns about the implications of PS for the Approved Premises estate. We found deficiencies in information-sharing about substance misuse by residents of Approved Premises and in the effectiveness of welfare checks. We identified the

need for the National Probation Service to review its drug testing policy in APs and to consider introducing testing for PS and to give staff better guidance on PS use.

23. Her Majesty's Prison and Probation Service (HMPPS) issued guidance on PS to prisons and Approved Premises in August 2017 but it did not specify that Approved Premises should start testing for PS.

24. The National Probation Service accepted our recommendation from a previous investigation in January 2017 that they should review drug testing arrangements in Approved Premises and take steps to enable staff to identify PS use and advise residents of the dangers of using PS.

Key Events

25. On 10 September 2018, Mr David Livesey was released on licence from HMP Stocken. Mr Livesey's licence conditions required him to live at Southwood Approved Premises, Liverpool. He also had a condition to comply with his supervising officer to address his substance misuse. Mr Livesey was also subject to a curfew requiring him to return to Southwood each night by 11.00pm.

26. Mr Livesey's offender supervisor carried out his induction on his arrival at Southwood. They discussed his history of substance misuse and the fact that he had used 'spice' (a psychoactive substance - PS) and cannabis the last time he had been living in the community. Mr Livesey told his offender supervisor that he had no intention of using either again. A week later, she reviewed him and noted that he was doing well but that things could deteriorate quickly if Mr Livesey started using spice or cannabis again.

27. On 17 September, a Probation Service Officer recorded that when Mr Livesey returned to Southwood at 12.45pm, he could not speak and could hardly walk. He noted that staff believed that he was under the influence of PS so staff monitored him. The AP Manager authorised a search of Mr Livesey's room and found a used drug bag on the floor. Mr Livesey admitted that it had contained cannabis and that he had smoked a cannabis joint earlier. Staff warned him informally about breaking AP rules and advised him not to smoke PS.

28. On 19 September, a residential worker recorded that Mr Livesey was clearly under the influence of an unknown substance. The following day, he tested positive for cannabis but negative for all other substances. The AP manager noted that that staff suspected that Mr Livesey was misusing PS but that they did not have a kit to test for PS. She recorded that he was deteriorating quite quickly, so she arranged a three-way meeting with herself, Mr Livesey and another member of the AP staff.

29. On 22 September, a staff member recorded that he was to become Mr Livesey's keyworker. (A keyworker is a resident's immediate point of support and assistance.) He noted that his first interaction with Mr Livesey was to assist him to his room because he was unsteady on his feet and unable to communicate effectively.

30. Later that day, Mr Livesey's keyworker formally introduced himself to Mr Livesey. He told him that staff had concerns about him using PS but he noted that Mr Livesey said that he had not smoked PS since shortly after his release. His keyworker told Mr Livesey that he believed he had been using it earlier.

31. Two days later, an acting Probation Service Officer documented that she and his offender supervisor discussed Mr Livesey's suspected PS use with him. He told them that a friend had given him a joint and that he had not known that it had contained PS. They warned Mr Livesey about the dangers of PS use and offered to refer him for help if he needed it.

32. Over the next few weeks, staff recorded that Mr Livesey was thought to be under the influence of PS on several occasions. On 15 October, Mr Livesey's offender supervisor and his keyworker met with him to discuss his PS use. He accepted

that he had a problem with PS use and that he was now actively seeking PS. They told him that he risked losing his place at Southwood and possibly jeopardising his release. Mr Livesey informed them that he was reducing his usage and agreed to attend a meeting about PS the following week.

33. On 20 October, a Probation Service Officer recorded that Mr Livesey was under the influence of PS in another resident's room. He sent him back to his room and staff conducted half-hourly checks on him. Two days later, his keyworker recorded that he gave Mr Livesey a formal warning for PS use and told him that he would be tested the following day. That evening, Mr Livesey attended a group meeting discussing the effects of PS use. On 28 October, his keyworker observed that Mr Livesey appeared focused, and seemed genuinely to want to make a positive change.

34. On 31 October, an acting Probation Service Officer recorded that Mr Livesey told staff that he was not feeling well because he was 'coming down' from PS. He declined medical attention when it was offered, so staff told him to contact them if he changed his mind. Later that day, Mr Livesey told staff that he felt better. The next day, his offender supervisor noted that Mr Livesey said he had not used PS for five days. On 5 November, his keyworker saw Mr Livesey and documented no concerns. The following week he reviewed him and again recorded no concerns. On 14 November, Mr Livesey's offender supervisor reviewed him and noted that he appeared positive and more open during the review.

35. On 18 November, a residential worker noted that Mr Livesey appeared under the influence of an unknown substance and that staff would monitor him as a result. Three days later, Mr Livesey's offender supervisor recorded that he told her that he had not smoked PS in over a month, because it was "getting too much".

24 November

36. On 24 November, an acting Probation Service Officer was on duty between 9.00am and 10.00pm. A Probation Service Officer was also on duty during the day. At a handover, night staff informed them that they suspected Mr Livesey had used PS during the night. In interview, the Probation Service Officer said that he was aware that Mr Livesey was a PS user and that they had to monitor him. At 2.20pm, during a routine fire drill, Mr Livesey failed to vacate the building as required. In interview, the acting Probation Service Officer said that she checked on him and found that "he was clearly under the influence of spice. He was in bed; he was very drowsy; his colour was very pale". She said Mr Livesey went out some time between 3.00pm and 5.00pm but she did not see him leave or return.

37. Another Probation Service Officer began her shift at 4.45pm. She was to replace the Probation Service Officer who finished at 5pm. In interview, she said that no major incidents were reported during the handover but she was advised that some residents had been taking PS.

Emergency response

38. The acting Probation Service Officer was in a room next to the AP's reception when, at approximately 7.50pm, she heard shouting nearby. In interview, she

said that she went into reception where the Probation Service Officer was working. They reviewed the CCTV together to try to identify where the noise was coming from. The acting Probation Service Officer saw what she thought was a fight in a communal room so went to investigate, while the Probation Service Officer monitored the CCTV. She said that she quickly realised it was not a fight, but that another resident was hitting Mr Livesey on the back as though he was choking. The acting Probation Service Officer said that as she went to assist, she realised that Mr Livesey was not choking either. With the help of the other resident, they placed him on the floor in the recovery position.

39. In interview, the Probation Service Officer said that while watching the CCTV, she realised that there was something wrong with Mr Livesey. She initially went to help but immediately returned to reception to call an ambulance. The operator asked her to report on Mr Livesey's condition, so she returned to the room. She said that when she returned, someone was speaking to the ambulance operator on a mobile phone.

40. The acting Probation Service Officer said that she called for an ambulance using the other resident's mobile phone. She said that the operator instructed her to place Mr Livesey flat on his back to check whether he was breathing. She said that when she told the operator that he was not breathing, the operator asked her to fetch the defibrillator. She handed the telephone to the Probation Service Officer and fetched the defibrillator. On her return, she connected the defibrillator to Mr Livesey and started CPR. She said that the defibrillator quickly advised and delivered a shock. She continued to administer CPR and followed the instructions given by the machine.

41. The acting Probation Service Officer said that a lot of residents had gathered in the room while Mr Livesey was being helped. She said that the resident whose mobile phone she had used was very helpful but that some of the other residents got in the way. She said that at one point a resident tried to remove the defibrillator pads from Mr Livesey's body although she did not think this was with any malicious intent. She said that a resident also said she was performing chest compressions too hard but when she eased off, the defibrillator advised her to push harder. She said that, ideally, she would have cleared the room and locked the door but that she was too focused on assisting Mr Livesey.

42. She said that after approximately 20 minutes, the ambulance crew arrived and took over Mr Livesey's care. The ambulance crew continued to provide life support for approximately 30 minutes.

43. At approximately 9.00pm, the AP manager arrived at Southwood because of the emergency. At 9.15pm, the ambulance crew took Mr Livesey to Broadgreen Hospital in Liverpool. The AP manager recorded that she told the crew that Mr Livesey was on licence. The following day, Mr Livesey was transferred to the Royal Liverpool Hospital.

44. Mr Livesey did not regain consciousness and, on 5 December, at 8.30pm, he was pronounced dead at the hospital.

Issues arising after Mr Livesey's death

45. Following Mr Livesey's collapse, staff reviewed the CCTV and observed two residents going in and out of Mr Livesey's room prior to the incident. Staff investigated both residents and recorded that they both appeared to be under the influence of an illicit substance. The AP manager documented that a search of Mr Livesey's room revealed an empty, clear, plastic clip bag, which could be associated with drugs. She interviewed the residents, and both said that Mr Livesey regularly used PS. One resident said that Mr Livesey had got it from a local dealer. The other resident said that Mr Livesey had given him a PS "spliff" earlier that day.

46. The AP manager also interviewed the resident who had helped with the emergency response. She commended him for his intervention and thanked him for the support he had provided to her and the AP staff.

47. In interview, Mr Livesey's keyworker told the investigator that staff should enter any suspicions relating to PS use in the centre's observations log, and as an electronic entry in a resident's log. He said that offender managers and other staff would refer to these entries whenever they performed reviews.

48. A Probation Service Officer said in interview that staff should log any incidents where they suspected a resident of taking illicit substances. He said that this helped to show patterns of behaviour and enabled offender managers and others to monitor residents' behaviour. He said that certain staff members seemed to log such incidents with more regularity, and that it was unlikely that Mr Livesey was only taking illicit substances when certain people were on duty. He said that some AP staff do not log every drug-related incident, either because they are too busy or because they do not feel that the resident is causing any problems.

Post-mortem report

49. There was no post-mortem for Mr Livesey. The Coroner concluded that his death was caused by hypoxic brain injury (oxygen starvation to the brain caused by blood loss) caused by an out-of-hospital cardiac arrest. The report noted that Mr Livesey had coronary heart disease.

50. The Coroner confirmed that the hospital was aware that Mr Livesey may have used PS on the day he collapsed but could not conclude whether this had contributed to his death because the hospital did not take any blood samples on admission. The Coroner added that there was no possibility of a post-mortem determining that Mr Livesey had used drugs on the day he died because of the failure to carry out the appropriate tests at the time. The Coroner therefore accepted the cause of death provided by the hospital.

Contact with Mr Livesey's family

51. Mr Livesey's next of kin was his mother. At 9.45pm on the day Mr Livesey collapsed, the AP manager telephoned her. There was no answer so she left a voice message. At 8.30am, the next day, Mr Livesey's mother returned the call and spoke to a residential worker. He told her that Mr Livesey had been taken to Broadgreen Hospital. At 9.45pm, the AP manager called Mr Livesey's mother to express her concerns and to offer help.

52. On 7 December, after Mr Livesey's death, his mother asked the AP manager to speak to her daughter. She also requested that Mr Livesey's personal belongings be given to his cousin. Later that day, Mr Livesey's cousin collected his personal belongings. Shortly afterwards, Mr Livesey's daughter asked the AP manager about collecting her father's belongings. The AP manager said that they had already been collected, and Mr Livesey's daughter became very upset. The AP manager called Mr Livesey's mother, who assured her not to worry and said that she would speak to her daughter.

53. Mr Livesey's funeral was held on 19 December. The National Probation Service contributed to the costs in line with national guidance.

Support for residents and staff

54. The AP manager held a meeting with residents in the evening following Mr Livesey's collapse. She offered support to all staff, including those staff not on duty at the time of the incident.

55. On 7 December, the AP manager held a residents' meeting to share the news of Mr Livesey's death and to offer support.

Findings

Substance misuse management

56. The Approved Premises Manual acknowledges the risk associated with substance misuse in APs, and the additional problems that residents face due to reduced tolerance levels following release from prison. The Manual makes it clear that substance misuse does not necessarily lead to a breach of conditions but that appropriate enforcement action should be taken. It also makes it clear that substance misuse should always be challenged, and never condoned. The Manual states that residents should be tested for substance misuse if they have a history of substance misuse, or if staff reasonably suspect that they have taken an illicit substance. However, APs are currently unable to test for PS.

57. Mr Livesey had a long history of substance misuse which staff were aware of. Staff also frequently suspected that he was under the influence of PS. He was challenged about his substance misuse on numerous occasions, but we are concerned that staff at the AP may not have recorded every occasion when they suspected he had taken an illicit substance. The night before Mr Livesey suffered his cardiac arrest, staff suspected he was under the influence of an illicit substance but did not record this. We are satisfied that staff appropriately issued formal warnings when substance misuse was established.

    The National Probation Service should ensure that when staff suspect that a resident is under the influence of an illicit substance, they challenge this behaviour and record this in line with the requirements of the AP Manual.

58. We are also concerned that despite Mr Livesey being tested for drugs several times, the AP was unable to test for PS so these tests proved pointless. We repeat a recommendation made in a recent case:

    The National Approved Premises Team should review its strategy to reduce the supply and demand for PS in Approved Premises, including developing mechanisms to test for PS use.

Emergency response

59. We are satisfied that AP staff conducted the emergency response appropriately. As soon as staff became aware that Mr Livesey had collapsed, they responded promptly and called an ambulance immediately. They performed life support commendably in very trying circumstances until the ambulance crew arrived.

60. We also commend the efforts of the resident who assisted in the emergency response, and who supported staff during and following the incident.

Contact with Mr Livesey's family

61. The Approved Premises Manual recognises that it can sometimes be difficult to establish the next of kin for a resident, but requires APs to keep a record of the next of kin. It also requires APs to appoint a responsible member of staff to act as the family liaison officer in the event of a resident's death, and to remain the main point of contact.

62. We are satisfied that Southwood conducted its contact with Mr Livesey's family appropriately. His mother was listed as his next of kin, and her wishes were consistently followed. The AP manager was the primary point of contact throughout.

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