Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr David Richardson a resident of St Joseph's Approved Premises on 22 December 2016

**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.

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 Richardson died in a traffic incident on 22 December 2016. He was 36 years old. I offer my condolences to Mr Richardson's family and friends.

Mr Richardson was a resident at St Joseph's Approved Premises. During his time at the hostel there were some concerns over his adherence to his curfew and over low levels of drug and alcohol usage, but these had not been of great significance. On 21 December, he failed a drug test and that night he was found to have stolen from a fellow resident. The following morning, he failed a further drug test. The decision was taken that he should be recalled to prison, although this was not communicated to him. That evening, Mr Richardson climbed over the garden fence and left the hostel. He was later involved in a motorway traffic incident in which he died.

There were some gaps in his records, and I am concerned that there are no notes of keywork sessions in the hostel. There is, however, nothing to suggest that hostel staff could have anticipated or prevented what happened to Mr Richardson.

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

**Nigel Newcomen CBE**
**Prisons and Probation Ombudsman** **November 2017**

## Contents

# Summary

## Events

1. Mr David Richardson was released from HMP Risley on 14 November 2016. One of the conditions of his licence was that he should reside at St Joseph's Approved Premises in Eccles, Manchester.

2. Mr Richardson had some mental health problems. St Joseph's has a mental health team working within the hostel, and Mr Richardson engaged with them and with the visiting psychiatrist. There were no apparent difficulties. He had a history of substance misuse and during his time in St Joseph's there were some concerns over his adherence to his curfew and over low levels of drug and alcohol usage. These had not been serious concerns, although he had been issued with a warning letter.

3. On 20 December, Mr Richardson's behaviour began to deteriorate and he was seen to be behaving oddly. On 21 December, Mr Richardson failed a drug test and that night he was found to have stolen from a fellow resident, which resulted in the police being called. The following morning, he appeared to be under the influence of drugs, and admitted taking diazepam. The decision was taken by hostel staff that Mr Richardson should be recalled to prison, although this was not communicated to him.

4. That evening, Mr Richardson climbed over the garden fence and left the hostel. He was later involved in a traffic incident on a motorway, where he died. Toxicology reports showed the presence of drugs in his system in sufficient quantities to have impaired his judgment.

## Findings

### Record-keeping

5. During Mr Richardson's time at the hostel, staff helped him access services and gave him a degree of support from which he undoubtedly benefited. Guidance for Approved Premises states that residents should have weekly sessions with their keyworkers. Mr Richardson's keyworker said that he did carry out these sessions but did not note them on Mr Richardson's case file.

6. Approved Premises staff should monitor residents' presence, in line with their curfew. While staff seemed to have been vigilant when Mr Richardson missed his curfew, his daily movement monitoring sheets were poorly maintained, with most days showing only one entry and some days showing none.

### Contact with Mr Richardson's family

7. When a resident dies, guidance states that the Probation Service should contribute to funeral costs. When Mr Richardson died his family was offered a level of financial assistance and booked the funeral on that basis. Senior managers subsequently realised that the initial offer had been higher than stipulated by the guidance. They explained that there had been a mistake and said that they would have to revise their figure. Although managers

subsequently agreed to stand by their original agreement, their indicating that they would not pay what they had originally agreed after the funeral had been booked was insensitive, and added to Mr Richardson's family's distress.

## Recommendations

- The Approved Premises manager should ensure that keyworkers supervise residents in line with guidance.
- The Approved Premises manager should ensure that residents' daily movement monitoring sheets are properly maintained.
- The Director of the Probation Service, Northwest Division, should ensure that senior managers are aware of, and follow, national policy on the payment of funeral expenses after the death of a resident.

# The Investigation Process

8. The investigator issued notices to staff and residents at St Joseph's, informing them of the investigation and asking anyone with relevant information to contact him. One resident responded, and he interviewed him.

9. The investigator visited St Joseph's on 8 and 9 February 2017. He obtained copies of relevant extracts from Mr Richardson's probation and medical records. He was also given access to police statements from Greater Manchester Police. He interviewed four members of staff and one resident. He also conducted a telephone interview with Mr Richardson's offender manager.

10. We informed HM Coroner for Greater Manchester West District of the investigation. She sent us the results of the post-mortem examination and we have given the Coroner a copy of this report.

11. One of the Ombudsman's family liaison officers contacted Mr Richardson's mother to explain the investigation and to ask whether she had any matters she wanted the investigation to consider. Mr Richardson's mother asked a number of questions, including why he had not been recalled to prison when he failed drug tests, and how his medication was monitored. She was also upset at the arrangements that had been made to pay for Mr Richardson's funeral.

12. Solicitors representing Mr Richardson's family received the initial report and subsequently replied raising a number of points. These have been dealt with in separate correspondence.

# Background Information

## St Joseph's Approved Premises

13. 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 must abide by a curfew. They are responsible for their own health and are expected to register with a GP.

14. St Joseph's Approved Premises in Eccles, Manchester has 29 beds and is one of six approved premises in Greater Manchester. It provides evening meals and there is a communal area for dining and socialising, and areas for group work. Each resident is allocated a key worker or offender supervisor to oversee his progress, wellbeing, and adherence to licence conditions and the premises' rules. Probation Service employees are on duty at St Joseph's 24 hours a day.

15. St Joseph's has an on-site mental health team, employed by Greater Manchester Mental Health Foundation Trust (at the time of Mr Richardson's residence, by Greater Manchester West Mental Health Foundation Trust). Mental health nurses are on site Monday to Friday during normal office hours, and consultant psychiatrists also visit regularly to see residents under their care.

## Previous deaths at St Joseph's

16. Mr Richardson was the second St Joseph's resident to die since 2008. We previously made a recommendation to the Probation Service about contact with bereaved families.

# Key Events

17. Mr David Richardson was released from HMP Risley on licence on Monday 14 November 2016. Because Mr Richardson said that in the past he had taken an overdose, one of the hostel's residential service officers and Mr Richardson's keyworker completed a Risk of Self-Harm and Suicide evaluation form prior to his arrival. The form noted no mental health diagnosis, but recorded that Mr Richardson had been working with the mental health team in prison. One of the conditions of Mr Richardson's licence was to reside at St Joseph's Approved Premises, which had an on-site mental health facility, for two months.

18. On his arrival at St Joseph's, one of the hostel's residential services officers gave Mr Richardson an induction. The following day, Mr Richardson asked a member of hostel staff where he could collect his methadone prescription. She contacted the drug and alcohol recovery service in Salford (called Achieve) and arranged an appointment for Mr Richardson that afternoon. Mr Richardson, however, had left the hostel. She did not have a mobile telephone number for him and was unable to contact him, so he missed the meeting. Mr Richardson was under a 9.00pm curfew but did not return to the hostel until 10.10pm that night. Staff gave him a breath test for alcohol, which was negative.

19. On 16 November, Mr Richardson visited Achieve and collected his methadone prescription. He then had a meeting with his offender manager and his keyworker at the hostel. He said that he was settling in well. When his time in the hostel was over he said he would like to move to the Bolton area to be near family. He was adamant that he would not use drugs.

20. That afternoon, another resident told a member of staff that Mr Richardson had persuaded him to have a drink, and he was worried about the consequences. When Mr Richardson returned to the hostel staff told him that they were going to carry out a breathalyser test. Mr Richardson said he had drunk a can of lager, not realising that he was not allowed to drink alcohol. The test was positive, but staff confirmed that Mr Richardson's licence did not specify that he could not drink alcohol and that, erroneously, he had not been asked to sign the hostel's no-alcohol contract. Mr Richardson signed the contract, and hostel staff agreed that they would take no further action on that occasion.

21. On 17 November, Mr Richardson registered with the local GP surgery.

22. On the morning of 23 November, Mr Richardson had an appointment with a nurse from the hostel's mental health team. She noted that he would be under the care of one of the hostel's visiting consultant psychiatrists. Mr Richardson engaged well with her, being relaxed, well-kempt, and showing no sign of depression. He denied any thoughts of self-harm, and was making plans for when he was able to leave the hostel. He told her that he had had longstanding paranoid and anxious thoughts. He experienced auditory hallucinations but said that he was good at using distraction techniques to deal with the voices and felt able to cope. She said in interview that she had no concerns about Mr Richardson's wellbeing.

23. On 21 November, Mr Richardson returned to the hostel 10 minutes after his curfew. He was carrying a takeaway meal, and said that his lateness was due to

waiting for his food to be cooked. He was reminded that he had to abide by his curfew and if he was likely to be delayed then he should ring the hostel.

24. For residents who are taking prescribed medication, staff hold the medication and residents collect each dosage as required. Records show that on 22 November Mr Richardson did not collect his medication.

25. On 24 November, hostel staff helped Mr Richardson contact the benefits office to apply for his benefits.

26. A consultant psychiatrist visited the hostel on 29 November and saw Mr Richardson. He noted a provisional diagnosis of schizophrenia, complicated by substance misuse, along with a secondary diagnosis of mental and behavioural disorders, arising from multiple drug use. He was on daily prescriptions of 10mg of Olanzapine (used to treat psychotic disorders such as schizophrenia), 45mg of Mirtazapine (an antidepressant), and 8mg of Subutex (to treat opioid dependence). He told the doctor that these medications improved his mood and reduced his persistent hallucinatory voices. He said he had been admitted to hospital under the Mental Health Act on three occasions, most recently in 2012, but that his mental state had been stable during his recent time in prison. He denied any history of self-harm, and had no significant medical problems.

27. During the consultation he appeared to be mildly intoxicated with slurred speech and drowsiness, though he was polite and engaged with the doctor. He said he did not feel depressed and was content to continue with his current medication. He asked to be additionally prescribed pregabalin to combat his anxiety, but the doctor did not think it necessary. (Pregabalin is usually prescribed for anxiety, but is also misused by drug users as it enhances the effect of other drugs.) The doctor noted on Mr Richardson's record that he should continue with his current medication, be subject to random drug tests in the hostel, and that he would review him after four weeks.

28. On 1 December, Mr Richardson passed a hostel breathalyser test. On 2 December, he did not collect his medication and, on 4 December, staff found him in another resident's room, which is not allowed, and breathalysed him. This was also negative. On 5 December, staff again found Mr Richardson in another resident's room. It smelled of smoke, smoking being against hostel rules.

29. On 6 December, the offender manager gave Mr Richardson a drug test. He told her that he was suffering from financial problems, had not paid any rent at the hostel, and had not received any benefits. He had already been fined for travelling on public transport without a ticket and had had to do so again to come and see her. He said he had drunk a can of lager before the meeting as he had been stressed, but denied using drugs. He said that he had, however, taken a small amount of cocaine at the weekend. He told her that he had been assessed by child services and was to be allowed to see his children fortnightly. That evening, Mr Richardson did not collect his medication, and did not return to the hostel in time for his 9.00pm curfew. He sent a text message to a member of hostel staff to say he was going to be late, and arrived back at 10.15pm.

30. On 9 December the offender manager received the results of Mr Richardson's drug test. It was positive for cocaine.

31. On 11 December, Mr Richardson arrived at the hostel late for his curfew and appeared to be under the influence of some substance; staggering and asking a member of staff to help him open his bedroom door. One of the hostel's residential service workers gave him a breathalyser test, which was negative. The following morning, Mr Richardson was due to see the nurse, but overslept. He later apologised, and they rearranged the appointment for 16 December.

32. On 13 December, hostel staff gave Mr Richardson a drug test, which was negative. That afternoon, he and the offender manager discussed his last drug test showing positive for cocaine. Mr Richardson admitted sharing a marijuana cigarette, afterwards being told that there had been cocaine in it. He was upset that he had failed a drug test and said that he would not do so again, concerned it would affect his ability to maintain contact with his children. She asked him about having returned to the hostel on 11 December apparently under the influence of something, and he denied it. He said he had only had a can of strong lager. Mr Richardson said that he had struggled to register for housing for after his departure from the hostel, and she said she would ask hostel staff to help him. She raised the issue of his returning late to the hostel. He said he had been spending time with his daughter and had been returning late after seeing her. She said that she would issue a warning letter, and would have to inform his children's social worker of his failed drug test.

33. The next day, the offender manager issued a formal warning letter, noting his positive drug test, late returns to the hostel, and staff suspicions that he had been under the influence of drugs or alcohol. The letter said that his continued release on licence was dependent on his behaviour and that he should speak to her or hostel staff if he was experiencing problems.

34. On 15 December, Mr Richardson had not returned to the hostel by his curfew. A residential service officer telephoned Mr Richardson's mother, who said she had not seen him. Mr Richardson returned some 20 minutes late but was nonchalant about his timeliness. The officer reminded him that he had just received a warning letter and was putting his liberty at risk but Mr Richardson remained apparently unconcerned. A number of residents, including Mr Richardson, were then seen going in and out of each other's rooms. Staff carried out breathalyser tests; Mr Richardson's was negative.

35. On 16 December, Mr Richardson had his rearranged appointment with the nurse. He told her that he had been feeling anxious, and had asked for medication from both doctors at the Achieve drugs service. He said that each doctor had told him he must consult with the other, although she saw from his records that a doctor had, in fact, discussed this with Mr Richardson and explained that he did not think he needed any further medication. Mr Richardson told her that he had recently taken a Pregabalin tablet that had been prescribed to another resident. He said he would make an appointment with his GP to ask them to prescribe pregabalin to him.

36. That day, the offender manager received the results of Mr Richardson's drug test on 13 December. It was positive. The following day, 17 December, one of the hostel's residential services officers gave Mr Richardson a breathalyser test. It was also positive.

37. During the night of 20 December, staff monitoring CCTV cameras saw Mr Richardson in the corridor behaving oddly, gesticulating wildly. Staff asked him whether he was alright, and he said that he was. The next morning the nurse went to see Mr Richardson and also found him exhibiting odd behaviour. He told her that his auditory hallucinations had become more intense and he was trying to distract himself, although she thought he looked as if he was under the influence of something. He denied this, but a drug test showed a small result for cocaine. She emailed the doctor and asked him to see Mr Richardson due to the change in his behaviour and presentation.

38. At 9.05pm, a residential service officer saw Mr Richardson and another resident leaving the hostel. She called both their mobile phones, but both were switched off. When they arrived back at 9.25pm, she asked Mr Richardson to come and speak to her in the office. He replied "I won't be a minute" and ran up the stairs and into the room of another resident. She followed him and arrived as he came out of the room. She told him that he shouldn't be in another resident's room, and that his curfew was 9.00pm. Mr Richardson said that his offender manager had extended it to 10.00pm. (In interview, she confirmed that this was the case.)

39. At 10.00pm, the residential service officer went to another resident's room. His door was open, and he was asleep. On his bedside table, in clear sight, were two cans of lager. She woke him and asked why he had alcohol. He seemed genuinely surprised and denied that they were his, pointing out that he had not left the hostel. She recalled that they had not been there when she carried out a check at 9.00pm. He asked her to leave them, as whoever had put them there might return for them and he would find out who they belonged to. She agreed, and returned to the office where she could monitor the CCTV cameras. At 10.45pm, Mr Richardson went into the resident's room for a few seconds then returned to his own. She searched his room, where she found the two cans of lager.

40. At 11.20pm, the resident told the residential service officer that £30 had been taken from his bank account and he wanted this reported to the police. He suspected that Mr Richardson and another resident had planted the cans of lager so he would be recalled to prison, and so not notice that his money had been stolen. Fifteen minutes later, the resident returned to the office and said that the other resident had told him that Mr Richardson had taken the £30 from his account and given £10 to him. He had apologised and returned the £10. Police were called and the resident told them that Mr Richardson had asked to borrow £10 to buy drugs. He had agreed to lend him £10 and given him his bank card and PIN number. He later realised that rather than £10, £30 had been withdrawn. Officers then spoke to Mr Richardson who, after initial denials, admitted to taking the money. All involved agreed that if Mr Richardson returned the money within a week, he would not be arrested and face charges of theft. Mr Richardson agreed to do so but, after the police left, became agitated. He set the fire alarms off more than once and banged on other residents' doors before eventually retiring to bed in the early hours of the morning.

41. The next morning, a residential service officer thought Mr Richardson appeared to be under the influence of something. He was lethargic and drowsy, and failing to complete ordinary actions. The offender manager at St Joseph's spoke to him

and she too thought that he appeared to be under the influence of something. Mr Richardson admitted that he had taken some diazepam because he felt "stressed". A drug test showed positive for cocaine, benzodiazepine and cannabis. She telephoned Mr Richardson's offender manager, who subsequently discussed Mr Richardson's deteriorating behaviour and the consequent rise in the risk he presented with her own manager. They decided that he should be recalled to prison and informed the hostel. Mr Richardson had an appointment with her that afternoon but was told that he was clearly under the influence and therefore should not attend. She did not tell him that he was to be recalled. At 1.30pm, the nurse saw Mr Richardson for a planned appointment. His speech was slurred and he seemed drowsy. He was unable to sustain a conversation and appeared to be under the influence of something. He denied using drugs, despite having tested positive. He was not willing to engage further with her and left the room.

42. At 5.31pm, Mr Richardson used the telephone in the hostel's front office. He left the office at 5.36pm and went out to the hostel's patio area. From there he climbed over the wall, and CCTV footage showed him in the street walking away from the hostel. He failed to return to the hostel by the time of his curfew. St Joseph's offender manager called his mobile telephone, but it was switched off. At 10.15pm, she telephoned the police to ensure they knew that his licence had been revoked, and to tell them that he had not returned.

43. At 11.20pm, police attended the hostel. They said that a man had died in a traffic accident and suspected it was Mr Richardson. At 2.10am, the police telephoned and confirmed that it was Mr Richardson who had died.

### Contact with Mr Richardson's family

44. The police told hostel staff not to contact Mr Richardson's family until they had informed them of his death. The hostel manager later spoke to members of Mr Richardson's family, some of whom visited the hostel. In line with national guidance, the hostel contributed to the costs of the funeral.

### Support for residents and staff

45. On 23 December, hostel staff arranged a residents' meeting where residents had an opportunity to discuss Mr Richardson. Support was offered to those who felt they needed it. Staff told the investigator that support was also available to them.

### Post-mortem report

50. The post-mortem report showed that Mr Richardson died of multiple injuries. Tests showed that, as well as the presence of prescription drugs, there were traces of cocaine and cannabis in his system. The combination of drugs may have affected his general awareness, reflexes, and his perception of the speed of motor vehicles.

# Findings

### Mr Richardson's supervision

46. During Mr Richardson's time at the hostel, staff helped him access services including Achieve. They helped him apply for benefits, and helped him in day to day matters such as recovering his mobile phone when he left it on public transport. It is clear that the support Mr Richardson received was greater than that he would have received had he lived alone in the community. Aside from the incident on 21 December, there were no indications that he had accrued any debt or had any issues with other residents.

47. The Approved Premises Manual notes that weekly keyworker sessions should be held for at least the first month of residence. Residents' records should contain weekly keywork records that show a clear link to the supervision plan. Mr Richardson's records contain no recorded keywork sessions during his time at St Joseph's. His keyworker said that he did meet with Mr Richardson but did not note the sessions on the electronic record, nor did he keep notes. He said that Mr Richardson also missed appointments with him, but again these are not noted on the records We make the following recommendation:

    **The Approved Premises manager should ensure that keyworkers supervise residents in line with guidance.**

48. The Approved Premises Manual says that staff should monitor residents' presence, behaviour and wellbeing. Mr Richardson's curfew meant that he had to be physically present in the hostel between 9.00pm and 7.00am. This is monitored either by the resident attending the hostel office and signing his own movement sheet or by staff confirming his presence and signing the sheet on the resident's behalf. Mr Richardson's daily movement monitoring sheets were poorly maintained, with most days only showing one entry and some days none. We make the following recommendation:

    **The Approved Premises manager should ensure that residents' daily movement monitoring sheets are properly maintained.**

### Assessment of risk

49. During his time in St Joseph's, Mr Richardson failed to meet his curfew on a number of occasions, and also failed alcohol and drug tests. After he failed his drug test on 6 December, his offender manager discussed this with him, and agreed that he should be given an opportunity to prove himself. When she received the results of his failed test of 13 December, she planned to address it with him at their next appointment. This was subsequently overtaken by events when Mr Richardson's behaviour deteriorated rapidly and the decision was taken to recall him to prison. Until 20 December there were no concerns that he presented a heightened degree of risk to himself or others. Once fears developed that he did, indeed, present a greater risk, procedures were quickly implemented to recall him to prison. Sadly, before this could be effected, Mr Richardson had died. There is no reason, however, to think that probation staff could have anticipated or prevented his death.

## Medication

50. The Approved Premises Manual notes that hostels should record the issuing of medication in order to establish that residents have taken the correct dose at the required interval. However, it also states that it is the resident's responsibility to take his medication at the right time. The manual emphasises that staff are not obliged to keep reminding a resident to take his medication, unless the failure to do so would result in an increase in risk. Staff at St Joseph's conduct nightly medication checks and if a resident has not collected his medication they will speak to the resident the following day. During his time in St Joseph's, Mr Richardson did not collect his medication on three occasions, one of which was because he had not arrived back at the hostel in time. None of these occasions were in the week before he died. There is no indication of any failing by the hostel in relation to Mr Richardson's medication.

## The road traffic incident

51. Mr Richardson's death was investigated by the Serious Collision Team of Greater Manchester Police. The police were satisfied that nobody else was involved in causing Mr Richardson to be hit by a vehicle and nobody was to face criminal charges. The post-mortem report confirmed the presence of drugs in Mr Richardson's system that might have impaired his judgement.

## Contact with Mr Richardson's family

52. The Approved Premises Manual states that when a resident dies, the Probation Service should contribute to funeral costs. When Mr Richardson died, the hostel manager was on leave, and the deputy manager asked duty senior managers what level of contribution they should offer. It was agreed that they would offer up to £4,000. The deputy manager conveyed this to Mr Richardson's mother.

53. Mr Richardson's mother then arranged his funeral, mindful of the level of assistance she had been offered. The cost came to just over £3,000, and the funeral director submitted the bill to the Probation Service. While the charge was being processed, a senior manager pointed out that the Approved Premises Manual stated that the Probation Service should pay reasonable funeral costs of up to £3,000. This was relayed back to Mr Richardson's mother. When she pointed out that she had arranged the funeral on the basis of what had already been agreed, the Probation Service agreed to honour the original agreement.

54. It is unfortunate that an offer that was made in good faith became problematic. Mr Richardson's mother said that although the matter was ultimately concluded, it caused her additional unnecessary distress at an already difficult time. We make the following recommendation:

**The Director of the Probation Service, Northwest Division, should ensure that senior managers are aware of, and follow, national policy on the payment of funeral expenses after the death of a resident.**

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