

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Robert Stacey a resident at Rookwood Approved Premises on 15 February 2019

**A report by the Prisons and Probation Ombudsman**

## 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.

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 Robert Stacey died on 15 February 2019 at Rookwood Approved Premises from the toxic effects of heroin, cocaine and prescription medication. He was 38 years old. I offer my condolences to Mr Stacey's family and friends.

Mr Stacey had been at Rookwood since 11 February, after being released from HMP Moorlands. He completed a methadone detoxification programme in prison and had become drug free.

I am satisfied that staff at Rookwood had no reason to suspect that Mr Stacey was taking illicit drugs and that they could not have predicted or prevented 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.

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

**October 2019**

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# Summary

## Events

1. Mr Robert Stacey was released on licence from HMP Moorlands on 11 February 2019. He was allocated a room at Rookwood Approved Premises (AP) for a maximum period of three months.
2. On arrival at Rookwood, Mr Stacey had a two-day induction, and a meeting with his offender manager and key worker. They discussed his plans for when he left Rookwood, and applying for jobs and benefits. Mr Stacey agreed to a referral to a community psychiatric nurse (CPN) because of anxiety and depression. Mr Stacey told staff at Rookwood he had become drug free while in prison, and did not want to return to his previous lifestyle.
3. During the evening of 14 February, Mr Stacey mixed with staff and other residents at Rookwood, before going to his room for the night just after 11.00pm. He did not leave his room during the night.
4. A member of staff started the morning welfare check for residents at 7.00am the next morning and found Mr Stacey lying on the floor of his room. He checked for vital signs but found none and he realised that rigor mortis had set in, so he did not attempt resuscitation. Staff called an ambulance and the police. Paramedics confirmed that Mr Stacey had died.
5. Four needles were found next to Mr Stacey's body. The post-mortem examination found that Mr Stacey died from the toxic effects of heroin, cocaine and pregabalin (a prescription only medication that is widely abused).

## Findings

6. Staff at Rookwood had no reason to suspect that Mr Stacey might be using illicit drugs and therefore, neither a room or bag search was ever warranted. We found that staff at Rookwood could not have predicted or prevented Mr Stacey's death.
7. We make no recommendations.

## The Investigation Process

8. The investigator issued notices to staff and residents at Rookwood Approved Premises, informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
9. The investigator visited Rookwood on 19 February 2019. She obtained copies of relevant extracts from Mr Stacey's records.
10. The investigator interviewed four members of staff 12 March and carried out one telephone interview on 20 March.
11. We informed HM Coroner for South Yorkshire of the investigation who gave us the results of the post-mortem examination and toxicology report. We have sent the coroner a copy of this report.
12. One of the Ombudsman's family liaison officers contacted Mr Stacey's father to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He wanted to know why his son had been sent to Rookwood when his family had offered him a home, and whether his son had been tested for drugs while at Rookwood.
13. We shared our initial report with the Probation Service. They found no factual inaccuracies.
14. We provided a copy of our initial report to Mr Stacey's family and their representative. They raised a number of issues that do not impact on the factual accuracy of the report and is dealt with in separate correspondence.

# Background Information

## Rookwood Approved Premises

15. Rookwood Approved Premises, in Rotherham, South Yorkshire, started out as a probation bail hostel in 1973. Its purpose was to accommodate men who were subject to bail conditions by the courts. The building was refurbished in 1993 and became Rookwood Approved Premises for offenders released from prison on licence. Its purpose is to provide an enhanced level of residential supervision in the community, as well as a supportive and structured environment. It can accommodate 25 adult men, with two rooms suitable for men with disabilities or wheelchair users.
16. All residents are assessed as being a high risk of causing serious harm to others and most have complex issues including mental health issues, personality disorders, substance misuse issues and a history of violent or sexual offending. Some will have spent substantial periods of their lives in a custodial environment and may struggle managing the transition from custody to community.
17. Residents are visited by staff prior to their release from custody to explain about Rookwood and how they can help them. Residents are given a two-day induction at Rookwood.

## Previous deaths at Rookwood Approved Premises

18. Mr Stacey's death was the first at Rookwood Approved Premises.

## Key Events

19. Mr Robert Stacey was sentenced to 52 months in prison on 17 August 2017. He was due to be conditionally released from HMP Moorlands on 11 February 2019.
20. Mr Stacey's offender manager (probation officer) in the community was responsible for deciding where Mr Stacey should live on his release from prison. She completed an Approved Premises (AP) referral form, and identified Rookwood AP in Rotherham as the first choice as Mr Stacey was from the local area.
21. Mr Stacey's offender manager noted that Mr Stacey had self-harmed in the past, that he had a restraining order preventing him contacting his ex-partner, and that he had been convicted of conspiring to pervert the course of justice by falsifying evidence. She noted that Mr Stacey had previously been violent towards his parents and there had been interventions for his personality disorder. She concluded that Mr Stacey should live for a maximum of three months in an AP, before being assessed for his suitability to return to his parents' address.
22. Mr Stacey's parents telephoned Mr Stacey's offender manager on 24 October to say they were unhappy that Mr Stacey was moving into an AP on his release from prison. They told her they were worried that he would be bullied and subsequently be recalled to prison. She told Mr Stacey's parents that he would be at the AP for a maximum of three months, and would be closely monitored. She said that Mr Stacey's keyworker at Rookwood would visit Mr Stacey in prison the following month to discuss moving to Rookwood.
23. On 15 November 2018, while at Moorlands, Mr Stacey received introduction paperwork for Rookwood. The paperwork introduced the staff as his keyworker at Rookwood and explained how she would be able to help him. Included was a list of rules, including a curfew between 11.00pm and 7.00am, when Mr Stacey must be in the AP; that he might be subject to a drug or alcohol test if staff requested this; and that staff were permitted to search his room or personal items if they felt there was a good reason to do so. The rules specifically stated that residents must not bring any illegal drugs or drugs paraphernalia into the AP.
24. Mr Stacey's keyworker visited Mr Stacey in Moorlands on 9 January 2019, to discuss his release from prison and what he could expect at Rookwood. She noted that they discussed his level of risk to staff and residents because of his behaviour in prison. She noted there were some issues around Mr Stacey's mental health and that he had self-harmed in the past while using psychoactive substances (PS). Mr Stacey told her that he had anxiety and depression and a possible personality disorder. They discussed Mr Stacey's previous drug and alcohol use and that the plan was for Mr Stacey to return to live with his parents, depending on his behaviour at Rookwood.
25. Mr Stacey was released from Moorlands on 11 February, and met probation staff at the probation office, where they discussed his licence conditions and his plans for the future. After this meeting, Mr Stacey arrived at Rookwood, a Sodexo employee completed the first stage of his induction with him. This involved explaining his licence conditions and Mr Stacey signing a copy of the AP rules.

26. Mr Stacey completed the second stage of his induction on 13 February with his keyworker. During this meeting she gave Mr Stacey a copy of a document called 'Reducing the risk of drug related deaths'. This explained that residents might be at increased risk of drug-related deaths and that opioid drugs, including heroin, were involved in most deaths. It said that a person's tolerance to drugs was lessened dramatically if they had stopped taking drugs, even if they had only stopped a week or so before. It said users who injected drugs were at heightened risk of overdose and injecting alone was particularly risky. The document included contact details for organisations that might help.
27. After the second induction, Mr Stacey had a meeting with his offender manager and his keyworker. During this meeting Mr Stacey said he was eager to move forward and that he was supported by his parents and his son. He said he was a little anxious because he did not want to become involved with other residents and fall into his old ways. He said he saw Rookwood as a risk because of the residents he knew from prison, but said he intended to "keep my head down".
28. Mr Stacey said he would like to move to his own accommodation as he needed his own space when he left Rookwood, and his offender manager said she would arrange for Mr Stacey to meet with a housing officer (which was arranged for 21 February). Mr Stacey said he wanted to find a job and one option was to apply to be a refuse collector and to work with his son (also arranged for 21 February).
29. Mr Stacey said that he had not used illicit drugs or alcohol since his release from prison. He said he saw "Spice" (PS) as a prison drug so would not use it again, and they talked about his past use of Subutex and cocaine. They discussed his mental health, in particular his anxiety and depression, and his keyworker said she would complete a referral for Mr Stacey to see a Community Psychiatric Nurse (CPN). Mr Stacey remained on medication he had previously been prescribed: mirtazapine 30mg (antidepressant), amitriptyline 50mg (for pain) and quetiapine 150mg (anti-psychotic drug) which he kept in his possession. She also helped Mr Stacey apply for state benefits and he had an appointment at the benefit office the following Monday.
30. A Sodexo employee remembered seeing Mr Stacey during the evening of 14 February. They played pool with another member of staff. Afterwards, Mr Stacey asked if it was okay for him to take a jigsaw puzzle to his room. The Sodexo employee said it was, but reminded Mr Stacey to put it back when he had finished with it. Mr Stacey left to go to his room at 10.00pm.
31. CCTV shows Mr Stacey talking to another resident in the corridor by his room at 10.25pm, and Mr Stacey returns to his room holding a DVD case. Another resident enters Mr Stacey's room at 10.42pm. Between that time and 11.02pm, Mr Stacey and the other resident can be seen going in and out of each other's rooms and talking in the corridor. Mr Stacey did not leave his room after he returned at 11.02pm, and a member of staff can be seen going into Mr Stacey's room for the welfare check shortly afterwards. Mr Stacey did not leave his room again that night.
32. The Sodexo employee and the other member of staff carried out welfare checks on all residents starting at 11.00pm. There were no issues with any residents

and after the checks, they both stayed in the office, which has CCTV screens covering the inside of the building and corridors.

33. On 15 February, the Sodexo employee started a welfare check on residents at 7.00am. He arrived at Mr Stacey's room at approximately 7.10am, and knocked on the door. He told the investigator he needed a verbal response from each resident, before he could move on. There was no answer from Mr Stacey so he opened the door, but could only open it a few inches. He thought that Mr Stacey might have put a chair up against the door, so pushed it open enough to look around the door. He saw Mr Stacey on the floor behind the door.
34. The Sodexo employee pushed open the door further and checked Mr Stacey for vital signs, but found none. He took out a resus-aid he kept on his belt (to administer rescue breaths) and pressed his personal emergency alarm and the room's panic alarm. He tried to turn Mr Stacey on to his back, but was unable to as rigor mortis was present. By this time, the other member of staff had arrived and immediately telephoned for police and an ambulance.
35. The Sodexo employee told the investigator he saw four spent needles by the side of Mr Stacey, and there appeared to be a pool of dark red substance by his mouth. The paramedics arrived at approximately 7.45am and pronounced Mr Stacey dead, and the police arrived soon afterwards.
36. After Mr Stacey's death, it was found that he had made a video call on his telephone at 1.30am. During the call, Mr Stacey had been injecting heroin and then using crack cocaine, a practice known as 'snowballing'.

### **Contact with Mr Stacey's family**

37. The police notified Mr Stacey's family of his death. Staff at Rookwood met with Mr Stacey's family when they visited the AP to collect his belongings. Rookwood contributed towards Mr Stacey's funeral, in line with national guidance.

### **Support for residents and staff**

38. After Mr Stacey died, Rookwood held a house meeting to inform residents of Mr Stacey's death and offer support to staff and residents.

### **Post-mortem report**

39. Mr Stacey's post-mortem and toxicology reports conclude that he died from intoxication caused by heroin, cocaine and pregabalin use. (Pregabalin is a prescription only medication used to treat epilepsy and nerve pain but it is widely abused, particularly to enhance the euphoric effects of other drugs, such as opiates.)

# Findings

## Substance misuse

40. Mr Stacey had completed a methadone programme while in prison and was drug free by the time he was due to be released. His offender manager in the community had assessed Mr Stacey's risk of harm to himself and to others and decided that, before Mr Stacey could move to his parents' address, he should first live at an AP for a maximum of three months. Mr Stacey's offender manager noted that Mr Stacey had a history of violence and drug use, both in the community and in prison. She also assessed that Mr Stacey was a risk to his parents, who he had been violent towards in the past.
41. Before Mr Stacey left Moorlands, he was warned about the dangers of taking drugs and that his tolerance levels for any drugs would have been greatly reduced. During his induction at the AP he was again reminded of the consequences of taking illicit drugs following an extended period of abstinence.
42. Staff at the AP have a searching policy and drug testing policy. It says that as drug testing engages the human rights of residents, staff must take care that they have good reason to carry out a test. Similarly, room searches must only be undertaken if staff have good reason to suspect the resident has unauthorised items in their possession. Staff may ask to look into a resident's bag if they have a good reason to suspect the resident is bringing unauthorised articles into the AP, but the resident must agree to this. Staff had no reason, nor any intelligence, to suspect Mr Stacey might try to bring illegal drugs into Rookwood. We conclude that staff at the AP had no good reason to conduct bag or room searches on Mr Stacey and that they could not have predicted or prevented Mr Stacey's death.
43. Once Mr Stacey had been discovered, staff complied with Rookwood's emergency response protocol and called for an ambulance and the police immediately. Both staff on duty overnight, and on the morning of 15 February, were trained in emergency first aid.

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