

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Craig Walling, a resident at Wordsworth House Approved Premises, on 23 December 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 Craig Walling died from the toxic effects of morphine on 23 December 2019, while a resident at Wordsworth House Approved Premises. He was 37 years old. I offer my condolences to Mr Walling's family and friends.

Mr Walling arrived at Wordsworth House on 18 December 2019. The next day, when he was on his way to a housing office appointment, he collapsed in the street. He was taken to hospital where he died four days later. The post-mortem report concluded that Mr Walling had suffered a cardiac arrest as a result of morphine toxicity.

I am satisfied that staff at Wordsworth House appropriately supported Mr Walling 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 prisoners involved in my investigation.

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

**September 2020**

## Contents

Summary .....	3
The Investigation Process .....	4
Background Information .....	5
Key Events .....	6
Findings.....	8

# Summary

## Events

1. On 18 December 2019, Mr Craig Walling was released from prison on licence and was required to live at Wordsworth House Approved Premises in Lincoln.
2. When Mr Walling arrived at Wordsworth House on 18 December, he received a full induction. No concerns were raised by staff or by Mr Walling.
3. The next morning, Mr Walling left Wordsworth House at 7.00am. He visited his father and then, at around 10.40am, he went to a housing appointment that had been booked for him.
4. Mr Walling collapsed in the street and a member of the public called an ambulance. Mr Walling was taken to hospital.
5. Mr Walling did not regain consciousness and died in hospital on 23 December.
6. The post-mortem report concluded that Mr Walling died from a cardiac arrest, caused by morphine toxicity.

## Findings

7. We are satisfied that the level of care and support Mr Walling received at Wordsworth House was of a good standard and that the staff could not have done anything to prevent Mr Walling's death.
8. We make no recommendations.

## The Investigation Process

9. The investigator issued notices to staff and residents at Wordsworth House Approved Premises informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
10. The investigator obtained copies of relevant extracts from Mr Walling's prison, probation and medical record.
11. We informed HM Coroner for Lincolnshire of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
12. One of the Ombudsman's family liaison officers contacted Mr Walling's next of kin to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Ms Walling's next of kin raised several concerns but as they were not within the remit of our investigation, we have dealt with them in separate correspondence.
13. Mr Walling's family received a copy of the initial report. The solicitor representing Mr Walling's family wrote to us pointing out some factual inaccuracies. The report has been amended accordingly. They also raised a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.
14. The initial report was shared with the National Probation Service. The National Probation Service pointed out a minor factual inaccuracy and this report has been amended accordingly.

# Background Information

## Wordsworth House Approved Premises

15. 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.
16. Wordsworth House Approved Premises is located in Lincolnshire and managed by the National Probation Service. It can house up to 18 men. Each resident has a key worker to oversee their progress and wellbeing and see that they adhere to their individual licence conditions and the premises' rules. Staff are on duty at Wordsworth House 24 hours a day.

## Previous deaths

17. Mr Walling was the first resident at Wordsworth House to die since 2006.

## Key Events

18. On 26 September 2018, Mr Craig Walling was recalled to prison for breaching his licence. He was sent to HMP Lincoln, and later moved to HMP Lindholme
19. On 10 December 2019, Mr Walling was granted parole. It was agreed that he would be released on licence on 18 December, and he would be required to live at Wordsworth House Approved Premises (AP) in Lincoln.
20. On 18 December, Mr Walling was released from prison and went straight to Wordsworth House AP. One of the AP staff officers explained to Mr Walling his licence conditions, the AP rules and the drug and alcohol policy. Mr Walling signed and agreed to the AP's policies, including that he understood that he would have a reduced tolerance for drugs and alcohol since being released from prison.
21. The rest of the day and night, Mr Walling was checked by residential staff. There were no concerns raised, although it was documented that Mr Walling had refused to take his medication on the evening of 18 December. (Mr Walling was prescribed chlorpromazine (an antipsychotic) and duloxetine (an antidepressant)).
22. On 19 December at 7.00am, Mr Walling left Wordsworth House. He said that he was going to visit his mother and then attend an appointment that had been made for him at Spalding Framework, a housing provider. Mr Walling instead visited his father. At around 10.40am, when Mr Walling was on his way to the housing office, he was seen by a member of the public collapsed in the street, and so they called an ambulance. Mr Walling then had a fit and became unconscious. Staff in the housing office also saw this and immediately called 999 and an ambulance quickly arrived. Paramedics started cardiopulmonary resuscitation (CPR) and took Mr Walling to hospital.
23. When Mr Walling got to hospital he was taken straight to intensive care and placed on a life support machine. Mr Walling's next of kin was notified by a member of staff at the hospital. Mr Walling never regained consciousness and died on 23 December.

### Contact with Mr Walling's family

24. When Mr Walling collapsed in the housing office, a housing officer contacted Mr a senior probation officer. He contacted Mr Walling's next of kin to tell her what had happened. When Mr Walling signed his registration documents at the AP he said that he did not have a next of kin and signed to say that he did not want anyone to be contacted in the case of an emergency. However, the AP manager did call Mr Walling's mother to offer support.
25. The AP contributed £3000 towards the cost of Mr Walling's funeral.

## Post-mortem report

26. The post-mortem report concluded that Mr Walling had suffered a cardiac arrest caused by morphine toxicity.

# Findings

## Substance misuse

27. Mr Walling had a history of substance misuse, but while in prison he engaged well with the substance misuse team and had been drug free for some time. When Mr Walling arrived at Wordsworth House, there was no reason to believe that he would take drugs but as part of Mr Walling's induction, staff explained to him that he would have a lower drug tolerance since being in prison.
28. I am satisfied that in the short time Mr Walling was at Wordsworth House he was appropriately supported, and there was nothing staff could have done to prevent his death.

## Medication

29. Mr Walling had refused to take his medication on the evening he arrived at Wordsworth House. The residential manager considered that Mr Walling might relapse if he did not take his medication, so she discussed this at a staff meeting the next day, and they agreed to put extra measures in place to make sure that Mr Walling took his medication that evening.
30. Even though it is not the responsibility of the AP staff to make sure that residents take their medication, the AP manager was prepared to apply extra measures to try to help Mr Walling, and we are satisfied that they could have done no more to support him.

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