

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Stephen Gidley, a resident at Stonnall Road Approved Premises, on 25 November 2020

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 Stephen Gidley, who was a resident at Stonnall Road Approved Premises (AP) in Walsall, died on 25 November 2020 of opioid (heroin) poisoning and cocaine toxicity.

Mr Gidley was upset about his placement at the AP being unexpectedly brief. Staff who completed Mr Gidley's induction did not know that he would only be staying at the AP until 1 December (a total of eight days). His offender manager's contact was limited to the telephone because of COVID restrictions so she could not offer support in person when she told him that he would be moving elsewhere. With hindsight, the news might have been broken to him differently.

We do not consider that AP staff could have foreseen or prevented Mr Gidley's risk of overdose or his death.

We were impressed by the commitment of AP staff, their concern for the safety and wellbeing of their residents, and their willingness to learn lessons and improve processes where necessary.

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

July 2021

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Summary

Events

1. On 23 November 2020, Mr Stephen Gidley was released from prison on licence to live at Stonnall Road Approved Premises (AP) in Walsall.
2. Mr Gidley had a history of substance misuse and mental health problems. He had repeatedly told prison staff that he was worried about accommodation on his release and was relieved to have secured an AP placement. Although he did not know it, his placement at the AP was only for eight days while suitable longer-term accommodation was arranged.
3. When Mr Gidley first arrived at Stonnall Road AP, two members of staff completed his induction. They say they did not know his placement would be very brief and so did not discuss it with him. Mr Gidley had to self-isolate in his room as he had recently been in contact with someone with COVID-19. Still, he settled in well and raised no concerns.
4. At around 11.30am on 25 November, Mr Gidley's offender manager told him over the phone that he would only be staying at the AP until 1 December, although longer-term accommodation had been identified elsewhere for him. Mr Gidley became very distressed and left the AP at around 11.50am. AP staff contacted the police straightaway and his offender manager called him several times.
5. At around 4.15pm, a member of the public found Mr Gidley collapsed in a car park in central Birmingham and phoned an ambulance. At 4.47pm, paramedics confirmed that Mr Gidley had died.
6. An inquest was held on 19 January and concluded that Mr Gidley died of opioid (heroin) poisoning and cocaine toxicity.

Findings

7. Mr Gidley was upset about his placement at Stonnall Road being unexpectedly brief. Staff who completed Mr Gidley's induction did not know that his stay at the AP would only be until 1 December (a total of eight days). His offender manager's contact was limited to the telephone because of COVID restrictions, so she could not offer him support when she told him he would be moving elsewhere.
8. With hindsight, Mr Gidley's move could have been explained to him in a more considered way.
9. We do not consider that AP staff could have foreseen or prevented Mr Gidley's risk of overdose or his death.

Recommendations

- The manager of Stonnall Road AP should ensure that staff members who induct new residents confirm their length of stay during their inductions unless there are exceptional circumstances.

The Investigation Process

10. The investigator issued notices to staff and residents at Stonnall Road informing them of the investigation and asking anyone with relevant information to contact him.
11. The investigator obtained copies of relevant extracts from Mr Gidley's prison, probation and medical records.
12. The investigator interviewed five members of staff at Stonnall Road AP. The interviews were completed by video link and telephone due to the restrictions imposed as a result of the COVID-19 pandemic. He also interviewed Mr Gidley's offender manager and her line manager.
13. We informed HM Coroner for Birmingham and Solihull of the investigation and have sent the coroner a copy of this report.
14. Mr Gidley had not identified anyone as his next of kin before he died.
15. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS raised some issues which have been addressed in this report and through separate correspondence.

Background Information

Stonnall Road Approved Premises

16. 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.
17. Stonnall Road Approved Premises is 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 at Stonnall Road

18. Mr Gidley was the first resident at Stonnall Road to die since June 2018. There are no significant similarities with the previous death, which was from natural causes.

Key Events

Background

19. Mr Stephen Gidley had several previous convictions dating back to 1991, for fraud, theft, public order and drug-related offences. He was 47 years old and had a long history of mental health and substance misuse issues.
20. On 25 November 2019, Mr Gidley was remanded into custody at HMP Birmingham for violent offences. On 3 September 2020, he was sentenced to 24 months imprisonment, to be released on licence after one year.
21. On 17 September, Mr Gidley told his new Drug and Alcohol Recovery Team (DART) worker that that he wanted to go to an Approved Premises (AP) with a focus on drug and alcohol recovery when he was released from prison, as he wanted to change his lifestyle.
22. On 29 September, Mr Gidley was transferred to HMP Oakwood. On 5 October, Mr Gidley had a resettlement review with a probation officer. Among other things they discussed his methadone detoxification programme, which Mr Gidley was positive about.
23. On 5 November, staff at Oakwood began monitoring Mr Gidley under HMPPS suicide prevention measures, known as ACCT, after he said he wanted to die. Mr Gidley told staff he was struggling with childhood trauma. His main concern was around accommodation on release, and he said he should stay in prison as his sentence was not long enough. Staff referred Mr Gidley to the mental health team. Mr Gidley also said he would hurt someone to lengthen his stay in prison, as he feared what he would do if released. He disclosed thoughts of taking someone hostage.
24. On 13 November, staff closed Mr Gidley's ACCT after his presentation and mood improved. Mr Gidley told staff he had been given assurances that suitable accommodation would be secured for him on release, which was a big relief for him.
25. On 17 November, West Midlands Community Rehabilitation Company (CRC), who manage low and medium risk offenders, escalated Mr Gidley's case to the National Probation Service (NPS) due to concerns about his recent threatening behaviour in prison.
26. As Mr Gidley was due to be released six days later, the CRC and NPS worked together to find Mr Gidley a room in an approved premises (AP) which would suit his complex needs and provide a structured environment for him. On 20 November, the manager of Stonnall Road AP accepted Mr Gidley for a short-term stay of eight days while suitable longer-term accommodation was arranged for him. Additional funding was approved to manage Mr Gidley's risk to staff and other residents at Stonnall Road.
27. On 23 November, Mr Gidley was given a copy of his licence and conditions and released from Oakwood. (His licence paperwork did not mention his length of

stay at Stonnall Road, and prison staff did not tell him about it before his release.)

Stonnall Road Approved Premises

28. At around 12.50pm, Mr Gidley arrived at Stonnall Road. He had to self-isolate until 30 November due to having been in contact with someone who had tested positive for COVID-19.
29. Two probation residential workers completed Mr Gidley's induction. They explained the approved premises rules and procedures. Mr Gidley said that he had a naloxone pen (to reverse the effects of opioid drugs) with him. In interview, one of the residential workers said that neither of them knew how long Mr Gidley's stay would be, so they did not talk to him about it. (She said that new residents normally knew how long they were staying for already.) During the induction interview, Mr Gidley was informed that because of his recent COVID-19 exposure, he would need to be accompanied by a member of staff wearing Personal Protective Equipment (PPE) whenever he left his room to ensure that he did not come into close contact with staff or other residents.
30. That afternoon, a residential worker went to the local pharmacy to collect Mr Gidley's prescription for amitriptyline (an antidepressant, which is also used for pain relief), naproxen (a painkiller) and lansoprazole (to reduce stomach acid levels).
31. At 10.00am on 24 November, a probation service officer introduced herself to Mr Gidley as his key worker. Their meeting was brief because of the COVID restrictions. Mr Gidley told her he had settled in well at the AP and had no concerns. (Although she told us in interview that she was aware Mr Gidley's stay was only until 1 December, she did not discuss this with him during their brief meeting.)

25 November

32. Mr Gidley's offender manager told us that she would normally have completed Mr Gidley's induction at the Probation Service offices immediately after his release from prison. However, due to COVID-19 safety measures, this had to be done by phone. Due to the safety measures put in place, Mr Gidley was not allowed to use the landline phone at the AP. She therefore arranged for a colleague to deliver a mobile phone to the AP for Mr Gidley to use in his room.
33. The offender manager first spoke to Mr Gidley by mobile phone shortly before 9.00am on 25 November. They talked about his past, problems and logistical issues such as arranging benefit payments.
34. Shortly after the phone call, the offender manager emailed the probation service officer about getting Mr Gidley set up with universal credit payments and a GP, and to arrange a three-way meeting in line with the usual procedures. The probation service officer responded to say that it would not be worthwhile registering Mr Gidley with the local GP as he was leaving on 1 December.
35. At this point, the offender manager realised that Mr Gidley's stay was only short-term (rather than the standard 12 weeks), and from her recent conversation with

him, she thought he probably had not realised this himself. She wanted to tell Mr Gidley as a matter of urgency. (She told us that she did not have access to “NDeIius”, the probation service case management system, as her laptop was broken, which was why she did not know how short Mr Gidley’s planned stay was from the outset.)

36. At around 11.30am, the offender manager told Mr Gidley over the phone that he would only be staying at the AP until 1 December, although longer-term accommodation had been arranged for him after that in Birmingham. Mr Gidley became very upset and told AP staff he wanted to leave immediately. They urged Mr Gidley to reconsider and told him that it was possible that a place would arise at the AP when another resident left, but he was adamant that he wanted to go. Staff returned Mr Gidley’s clothes to him (which were still wet from the washing machine) and the rent he had paid earlier in the day. When asked if he wanted to take his medication with him, Mr Gidley declined to do so. Mr Gidley left the premises at around 11.50am.
37. Due to the risk Mr Gidley posed to the public, staff at the AP informed the police that he had left the premises.
38. The offender manager phoned Mr Gidley several times that afternoon. Mr Gidley told her that he had “no strength or positivity left” and that he was going to “do something”, so he could be sent back to prison. At 2.40pm, probation service staff revoked Mr Gidley’s licence and completed emergency recall paperwork due to the risk he posed to the public.
39. At around 4.15pm, a member of the public found Mr Gidley collapsed on the ground floor of a car park in central Birmingham and phoned an ambulance. At 4.47pm, paramedics confirmed that Mr Gidley had died.
40. At 4.50pm, the police phoned the AP and spoke to a residential worker. They informed her of Mr Gidley’s death.

Contact with Mr Gidley’s family

41. Mr Gidley had not identified a next of kin before he died. We understand that social services have since located Mr Gidley’s family and informed them of his death.

Support for residents and staff

42. The AP manager spoke to staff who had had interactions with Mr Gidley and provided contact details for support organisations if they wanted further support.
43. As Mr Gidley had been self-isolating in his room due to potential exposure to someone with COVID-19, he had had practically no contact with other residents. As a result, the AP manager decided that support for residents was not required.

Post-mortem report

44. A post-mortem examination identified Mr Gidley’s cause of death as opioid (heroin) poisoning and cocaine toxicity, together with tri-cyclic antidepressant

(amitriptyline) toxicity. The post-mortem report also noted that Mr Gidley had a heart condition and heart disease which might have contributed to his death.

Inquest

45. On 19 January 2021, the Coroner's inquest took place and concluded that Mr Gidley's death was drug-related.

Findings

46. The West Midlands Community Rehabilitation Company (CRC) only referred Mr Gidley to the National Probation Service (NPS) shortly before his release on licence. This was no-one's fault as Mr Gidley's risk to others was only identified close to his release when he started making threats. However, it put everyone under a lot of pressure to find somewhere quickly for Mr Gidley to stay when he was released from prison. They successfully identified an immediate short-term placement at the AP to be followed by a longer-term solution.
47. This was not explained to Mr Gidley. As Mr Gidley was known to be very anxious about his accommodation in the community, he was, therefore, understandably agitated and upset when he was informed on 25 November (two days after his arrival) that he would only be staying at the AP until 1 December.
48. We cannot know whether earlier or more effective communication to Mr Gidley about his length of stay would have prevented his death. If staff at Stonnall Road had known that his stay was to be brief, they could have told him face-to-face, managing his expectations and possibly providing additional support. We consider that AP staff should confirm new residents know their length of stay as part of their induction.
49. With hindsight, Mr Gidley's offender manager should have told Mr Gidley about the length of his stay in a more planned and considered way, perhaps working with AP staff to do so. It is also unfortunate that COVID restrictions meant that she had to tell him over the phone and not in person.
50. Despite this, we were impressed by the dedication shown by staff at Stonnall Road, their concern for the safety and wellbeing of their residents, and their willingness to learn lessons and improve processes where necessary.
51. We make the following recommendation:

The manager of Stonnall Road AP should ensure that staff members who induct new residents confirm their length of stay during their inductions, unless there are exceptional circumstances.

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