Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr James Keane, a resident at Mandeville House Approved Premises, on 9 January 2021

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk
T I 020 7633 4100
F I 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*

OGL

© Crown copyright, 2022

This report is licensed under the terms of the Open Government Licence v3.0. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

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 James Keane died in hospital on 9 January 2021, while a resident at Mandeville House Approved Premises. He was 36 years old. Mr Keane's cause of death was hypoxic brain injury following respiratory arrest caused by a drug overdose on 22 December 2020. I offer my condolences to Mr Keane's family and friends.

Mr Keane arrived at Mandeville House on 14 December 2020. Mr Keane had a history of drug misuse and I am concerned that insufficient action was taken after he was seen in apparent possession of a syringe and when wrappers with possible drug residue were found in his room.

I am also concerned that staff did not attempt to rouse Mr Keane when he was found apparently under the influence of drugs on the afternoon of 22 December.

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 **November 2021**

Contents

Summary

Events

1. On 14 December 2020, Mr James Keane was released from HMP Parc on licence and was required to live at Mandeville House Approved Premises (AP) in Cardiff. Mr Keane had a history of substance misuse.

2. Mr Keane spent his first six days at Mandeville House in isolation as his cellmate at Parc had tested positive for COVID-19. However, Mr Keane received a full AP induction on 20 December and was advised about the dangers of drug misuse.

3. In the late evening of 21 December, Mr Keane was seen holding what appeared to be a syringe. The residential support worker did not telephone the on-call manager, although he sent an email to staff and they conducted a room search the next day. Two wrappers with possible heroin residue were found in Mr Keane's waste bin, but when questioned, Mr Keane denied using drugs and denied knowledge of the wrappers.

4. On 22 December, one of Mr Keane's probation officers tried to telephone him about the wrappers. He did not answer his phone and the probation officer did not telephone AP staff. There is no evidence that the AP reported Mr Keane's potential drug use to the local substance misuse team.

5. Mr Keane was thought to be asleep when he was checked during the morning of 23 December. When he was checked again at 1.00pm, staff found evidence of drug use, but Mr Keane was allowed to continue sleeping. He was noted to be snoring when checked again 30 minutes later. When staff tried to rouse him at 2.00pm, they found him unresponsive. An ambulance was called and staff carried out cardiopulmonary resuscitation.

6. Mr Keane was taken to hospital, where he died on 9 January 2021 without regaining consciousness.

7. Mr Keane's death was due to hypoxic brain injury following respiratory arrest caused by drug overdose. The form of drug involved was undetermined.

Findings

8. The residential support worker should have telephoned the on-call manager on the evening of 21 December to report the possible sighting of a syringe.

9. We are concerned at the lack of collaborative working between AP staff, the probation officer and the substance misuse team.

10. We are concerned that when Mr Keane was found apparently under the influence of drugs at 1.00pm on 23 December, staff did not attempt to rouse him and when he was noted to be snoring 30 minutes later, staff did not recognise this as a possible sign of drug overdose.

Recommendations

- The Probation Service should ensure that approved premises and probation staff work collaboratively to identify and minimise risks to residents.
- The Probation Service should ensure that AP staff know that snoring can be a sign of a drug overdose.

The Investigation Process

11. The investigator issued notices to staff and residents at Mandeville House informing them of the investigation and asking anyone with relevant information to contact her. Staff provided statements of their involvement with Mr Keane, but none of the residents responded.

12. The investigation was then transferred to one to another investigator. He obtained copies of relevant extracts from Mr Keane's prison and probation records.

13. The investigator interviewed seven members of staff from Mandeville House during March and April 2021. All of the interviews were conducted by telephone due to revised working practices during the COVID-19 pandemic.

14. We informed HM Coroner for South Wales, Cardiff and Vale of Glamorgan District of the investigation. The Coroner gave us Mr Keane's cause of death. We have sent the Coroner a copy of this report.

15. The Ombudsman's family liaison officer contacted Mr Keane's sister to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Keane's sister did not raise any issues, but she asked to receive a copy of our report.

16. In response to our Initial Report, Mr Keane's sister wrote that it was never clear whether it was the Cardiff or Milton Keynes Probation Team who were responsible for her brother and she did not believe that both teams should have been dealing with him.

Background Information

Mandeville House Approved Premises (AP)

17. 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, for offenders who have been released from prison. Residents are no longer in custody and, although they must comply with their individual licence conditions, curfews and the APs rules, they are essentially free to come and go from the building.

18. Mandeville House is located in Cardiff and managed by the National Probation Service. It can usually house up to 26 men in 22 single rooms and two double rooms. Due to COVID-19, the capacity has been reduced to 24 with the double rooms being used only for single occupancy. Each resident has a key worker to oversee their progress and wellbeing and see that they adhere to their individual licence conditions and the AP's rules. Staff are on duty at Mandeville House 24 hours a day.

Previous deaths

19. Mr Keane was the first resident at Mandeville House to die since 2012. The previous death was a self-inflicted death by hanging with no similarities to Mr Keane's death.

Key Events

20. Mr James Keane had many convictions including grievous bodily harm and robbery. Much of his offending history centred on his misuse of drugs and alcohol.

21. In March 2019, Mr Keane was released from prison on licence. He moved to Mandeville House Approved Premises in Cardiff and subsequently moved to a rented flat, also in Cardiff. In June, Mr Keane was recalled to prison for breaching his licence for robbery to fund his drug use. Mr Keane was sent to HMP Swansea and later moved to HMP Parc.

22. On 14 December 2020, Mr Keane was again released on licence and was again found a place at Mandeville House AP. Ordinarily, Mr Keane would have first visited his probation officer in Cardiff, before going to Mandeville House. However, Mr Keane's cellmate at Parc had tested positive for COVID-19 so Mr Keane went directly to Mandeville House where he was located in an isolation flat.

23. The probation officer told the investigator that she spoke by telephone with Mr Keane on 16 December. She said he spoke in positive terms about rebuilding links with his family and was also positive about managing his previous drug problems. As Mr Keane's original offence had been in Oxford, the probation officer was working in co-operation with another probation officer from Milton Keynes.

24. Dyfodol is a service that provides support to people with drug and alcohol issues. Due to COVID-19, Dyfodol were providing all their services remotely so a community substance abuse worker from Cardiff Dyfodol contacted Mandeville House on 17 December and asked for Mr Keane to telephone him, but he failed to do so. Cardiff Dyfodol then arranged a video conference call to Mandeville House for 24 December.

25. On 20 December, Mr Keane moved from the isolation flat to a standard room. A probation service officer told the investigator that she knew Mr Keane from his previous time at Mandeville House and she spoke to him about his recall to custody and about re-establishing links with support workers in the community. She also spoke to him about the dangers of drug use, including the fact that his tolerance level would have reduced during his time back in prison custody. The probation service officer said that Mr Keane was adamant that he would not use drugs again. Mr Keane signed to agree to the AP's policies, including that he was not to bring drugs, drugs paraphernalia or alcohol onto the premises and must not be under the influence drugs or alcohol while a resident. Mr Keane was also given a copy of the AP's handbook, which reiterated the rules on drug and alcohol use and also warned about the reduced drug tolerance for those released from prison.

26. Residents at Mandeville House were subject to day-time room welfare checks at two hour intervals between 9.00am and 11.00pm. At night, the AP was supervised by one residential support worker and one security officer. The night security officer checked Mr Keane at 11.00pm on 21 December, and saw him apparently asleep and holding what appeared to be a syringe. He left the room,

but then questioned himself about what he believed he had seen. He checked Mr Keane again, but the syringe had gone. He reported the syringe to the night residential support worker

27. The residential support worker told the investigator that at the time the night security officer told him about the syringe he was busy trying to arrange a relief officer for the following day due to a staffing shortage. He said that he knew that he should have telephoned the on-call manager to report the incident, but he forgot to do so. He said that he checked Mr Keane at 1.00am. Mr Keane was asleep and there was no sign of a syringe. Before the end of his shift, the residential support worker sent an email to his colleagues about the syringe.

28. On 22 December, the AP manager, asked her staff to search Mr Keane's room. The staff and found two cellophane wrappers in his waste bin that showed traces of what appeared to be heroin residue. Mr Keane denied using drugs and said that he did not know how the wrappers had got into his bin.

29. Mr Keane's probation officer in Milton Keynes had been copied into the residential support workers email and she telephoned Mr Keane's mobile number to speak to him about the wrappers, but he did not answer.

30. Mr Keane left Mandeville House on two occasions on 22 December, as he was allowed to do. The first time he left at 10.36am and returned at 10.47am. He left again at 8.20pm and returned at 8.50pm.

23 December

31. When Mr Keane was checked at 9.00am and 11.00am on the morning of 23 December, he was in bed and he appeared to be sleeping. The residential support worker who made the 11.00am check, saw that Mr Keane was in exactly the same position when she checked him again at 1.00pm. Due to the incident on the night of 21 December, the residential support worker first completed checks on other residents and then returned to Mr Keane's room to look for evidence of drug use. When she checked, she saw a spoon and a lighter and then went to tell the AP manager that she believed Mr Keane had used heroin and that, although he was breathing, he seemed to be 'passed out' or was sleeping very heavily. The AP manager instructed that Mr Keane should be checked at 30 minute intervals.

32. At 1.30pm, the residential support worker and a colleague checked Mr Keane again and removed the spoon, lighter and a belt that was beside Mr Keane's arm. The residential support worker told the investigator that Mr Keane was breathing, he was snoring and he seemed 'okay'.

33. The residential support worker said that when she and her colleague went to check Mr Keane again at 2.00pm she intended to wake him, which she thought she should have done when she checked him at 1.30pm. She shook Mr Keane and called his name but he did not respond. She then pressed his thumb into his palm and as she did so, she heard a gurgling sound in his throat. She and her colleague moved him onto his side and the colleague ran to tell the AP manager that they needed an ambulance.

34. The AP manager ran to Mr Keane's room and telephoned the ambulance service as she went. When she arrived, she noted that Mr Keane's breathing was quite laboured. The ambulance call handler told her to start cardiopulmonary resuscitation (CPR). She continued giving CPR until ambulance paramedics arrived around eight minutes later.

35. The paramedics treated Mr Keane for around an hour and administered several doses of naloxone (a medication that counters decreased breathing in opioid overdose). The paramedics then took Mr Keane to the University Hospital of Wales, where he remained in intensive care until he died in the early hours of 9 January 2021.

Contact with Mr Keane's family

36. Mandeville House staff gave Mr Keane's sister's contact details to the ambulance paramedics and the hospital made direct contact with her to tell her that her brother had been admitted to hospital.

37. The AP contributed to the cost of Mr Keane's funeral.

Support for staff and residents

38. Staff involved in the response were offered support and counselling. One of the residents who witnessed Mr Keane being given first aid was told that Mr Keane had been taken to hospital. Residents were later told of Mr Keane's death and staff hosted a breakfast where they discussed issues surrounding bereavement and substance misuse.

Cause of death

39. Mr Keane did not have a post-mortem examination, but his cause of death as proposed by the hospital, and accepted by the Coroner, was hypoxic brain injury (lack of oxygen to the brain) with respiratory arrest secondary to unspecified drug overdose.

Findings

Response on 21 December

40. When Mr Keane was seen holding what appeared to be a syringe in the late evening of 21 December, the night residential support worker knew he should have telephoned the on-call manager. However, he was busy at the time and he forgot to make the call.

41. The AP manager spoke to the night residential support worker the following day to remind him that he had failed to follow established protocol and she arranged further training for him. We are satisfied that the AP has already taken appropriate action, so we make no recommendation.

Collaborative working

42. In response to the apparent sighting of a syringe on 21 December, the AP manager also ordered a room search the following day. Staff discovered cellophane wrappers in Mr Keane's waste bin that showed remnants of a substance that might have been heroin. However, when questioned, Mr Keane denied any knowledge of the wrappers and how they had got into his waste bin.

43. Mr Keane's probation officer at Milton Keynes, tried to telephone Mr Keane directly on his mobile phone, but he did not answer her calls so she never spoke to him. We do not consider this acceptable. When she failed to make contact with Mr Keane, she should have telephoned the AP to arrange a discussion with him, possibly a three-way discussion, including AP staff.

44. Cardiff Dyfodol told the investigator that they had no record of being informed about the discovery of potential drug use on 21 December. They said that if they had been informed, their usual course of action would have been to contact Mr Keane to ask that he attend their premises for a urine test and to encourage him to take a naloxone kit.

45. We cannot say whether closer working between Mandeville House, Mr Keane's probation officer at Milton Keynes and Cardiff Dyfodol would have affected the outcome, but we are disappointed at the apparent lack of collaborative working. We make the following recommendation:

    The Probation Service should ensure that approved premises and probation staff work collaboratively to identify and minimise risks to premises residents.

Response on 23 December

46. At room checks on the morning of 23 December, Mr Keane was in bed apparently asleep. When he was checked again at 1.00pm, he was in the same position as he had been at 11.00am, so staff went into his room and found evidence that he had used drugs. The AP manager ordered that Mr Keane should be checked every 30 minutes. Mr Keane was snoring and staff believed he was sleeping heavily. At 2.00pm, staff tried to rouse Mr Keane and as they did so they recognised it was a medical emergency and they gave emergency assistance until an ambulance arrived.

47. We see many drug-related deaths where snoring is taken as a sign that the individual is alive and 'sleeping off' drug use, when in fact snoring can be a sign of respiratory distress caused by drug overdose. We are concerned that AP staff did not recognise this and did not immediately try to establish if Mr Keane was unwell or needed assistance. We consider that the residential support worker, should have tried to obtain a response from Mr Keane at 1.30pm, as she acknowledged at interview with the investigator. We recently identified a similar failure with a death at an AP in Birmingham and we repeat our recommendation:

The Probation Service should ensure that AP staff know that snoring can be a sign of a drug overdose.

48. Following Mr Keane's death, the Approved Premises Area Manager, sent an email to the staff at Mandeville House reminding them of the importance of welfare checks. Among other matters, the Approved Premises Area Manager, said that staff should rouse residents who are displaying laboured breathing or who appear under the influence of alcohol or drugs. The Approved Premises Area Manager also told the investigator that all APs in Wales have now been supplied with naloxone and that staff have received training in dealing with emergency drug situations. In view of these actions, we make no recommendation.

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100
F I 020 7633 4141