Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr James Hall, a resident at Braley House Approved Premises, on 25 April 2021

A report by the Prisons and Probation Ombudsman

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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 James Hall died on 25 April 2021 of a prescription drug overdose at Braley House Approved Premises (AP) in Worcester. He was 34 years old. I offer my condolences to Mr Hall's family and friends.

Mr Hall had a long history of mental health and substance misuse issues and had overdosed on a mixture of prescription and illicit drugs six times since 2010 (most recently in January 2017).

However, despite this, we are satisfied that AP staff appropriately assessed Mr Hall's risk of self-harm during his induction and offered a supportive environment in which to address his offending behaviour. We do not consider that AP staff could have foreseen or prevented Mr Hall's risk of overdose or 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 **January 2022**

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Summary

Events

1. On 16 April 2021, Mr James Hall was released from HMP Oakwood on licence to live at Braley House Approved Premises (AP) in Worcester. Mr Hall had a long history of mental health and substance misuse issues and had overdosed on a mixture of prescription and illicit drugs six times since 2010 (most recently in January 2017).

2. Mr Hall was released from prison with prescriptions for antidepressants, antipsychotics and blood pressure medications. He was not allowed to hold his own medication at the AP, so he handed several packets of tablets to staff when he arrived so they could give it to him in line with his prescription.

3. On the evening of Friday 23 April, Mr Hall threatened another resident during an argument. As a result, AP staff completed emergency recall paperwork meaning that Mr Hall would be urgently returned to prison. (AP staff did not tell Mr Hall that he was being recalled, although he may have suspected it was likely.)

4. The next day, Mr Hall gave staff more prescription medication. At 3.55pm, Mr Hall signed out of the AP to go to "town / pharmacy". He signed back in at 7.03pm. Mr Hall's flatmate at the AP told us that, later that evening, another resident texted him to say Mr Hall had been "throwing blood up", taking pills and drinking alcohol downstairs in the AP.

5. At around 11.00pm, night staff at the AP completed a welfare check on Mr Hall in his room, in line with the usual protocol, and raised no concerns.

6. At around 7.00am the next day, staff found Mr Hall unresponsive during the morning welfare check. They quickly called an ambulance and started performing cardiopulmonary resuscitation (CPR). At 7.47am, paramedics confirmed that Mr Hall had died.

7. A post-mortem examination identified the cause of Mr Hall's death as excessive use of a combination of prescription drugs.

Findings

Management of Mr Hall's risk

8. We are satisfied that AP staff appropriately assessed Mr Hall's risk of self-harm during his induction and offered a supportive environment in which he could address his offending behaviour.

9. Neither this investigation nor post-mortem examinations could determine whether Mr Hall's overdose was deliberate or accidental.

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

11. We make no recommendations.

The Investigation Process

12. The investigator issued notices to staff and residents at Braley House informing them of the investigation and asking anyone with relevant information to contact him.

13. The investigator obtained copies of relevant extracts from Mr Hall's prison, probation and medical records.

14. The investigator interviewed six members of staff and one resident at Braley House AP. The interviews were completed by video link and telephone due to the restrictions imposed as a result of the COVID-19 pandemic. The investigator also interviewed Mr Hall's offender manager.

15. We informed HM Coroner for Worcestershire of the investigation and have sent the coroner a copy of this report.

16. We contacted Mr Hall's family to explain the investigation and to ask if they had any issues that they wanted the investigation to consider. Mr Hall's family received a copy of the draft report. The family asked if a sentence containing personal information could be removed from the report. As the sentence had no bearing on the findings of the report, we agreed to remove it.

17. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies. This report has been amended accordingly.

Background Information

Braley House Approved Premises

18. 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 are responsible for their own health and are expected to register with a GP.

19. Braley House in Worcester is managed by HM Prison and Probation Service. It consists of eight flats, five of which are two-bedroomed, one is three-bedroomed and two are one-bedroomed. Some of the larger bedrooms are shared between 2 residents. The AP can usually accommodate 20 residents however the capacity is currently 15, with all residents in single bedrooms due to COVID restrictions. All of the flats have cooking facilities and residents do their own cooking. Each resident is allocated a keyworker / offender supervisor to oversee their progress and wellbeing. The keyworker should ensure that residents adhere to licence conditions and the premises rules. Staff are on duty at Braley House 24 hours a day.

Previous deaths at Braley House

20. Mr Hall was the first resident at Braley House to die since February 2018. There are no significant similarities with the previous death, which was from inhalation of vomit following a heroin overdose.

Key Events

Background

21. Mr James Hall had several previous convictions dating back to 2009 for offences including arson, criminal damage, sexual assault and drug possession. He had a long history of mental health and substance misuse issues (involving prescription medication, cannabis, ecstasy and amphetamines), and had overdosed on a mixture of prescription and illicit drugs six times since 2010.

22. On 3 July 2020, Mr Hall was remanded into custody at HMP Hewell for threatening behaviour and possession of an offensive weapon. On 13 August, he was sentenced to 19 months in custody. He was transferred to HMP Oakwood later that month.

23. Mr Hall received some support for his mental health issues at Oakwood. In interview, a senior mental health nurse at the prison told us that Mr Hall suffered from emotionally unstable personality disorder, but described his needs as being "quite low level". She told us that Mr Hall informed the substance misuse team that he did not have any issues with drugs, so therefore did not receive any support in this regard. She said that Mr Hall did not have any physical health problems that she was aware of.

Braley House Approved Premises (AP)

24. On 16 April 2021, Mr Hall was released from Oakwood on licence to live at Braley House Approved Premises (AP) in Worcester. (He had lived at Braley House twice before.)

25. Mr Hall was released from Oakwood with prescriptions for the following medications: 28 citalopram tablets (an antidepressant) at 40mg; 28 olanzapine tablets (an antipsychotic) at 10mg; 28 olanzapine tablets at 2.5mg, and 56 propranolol tablets (used to treat high blood pressure) at 10mg.

26. Mr Hall arrived at Braley House around midday on 16 April. A residential worker at the AP completed his induction assessment and explained the AP rules and procedures to Mr Hall.

27. Mr Hall told the residential worker that he had self-harmed five years ago (by cutting his arms with razor blades and overdosing on drugs) after his mother's death but said he had not self-harmed recently. He also confirmed that he had not been subject to any suicide prevention measures while in prison. Mr Hall said he would tell AP staff if he was likely to harm himself and named his sister as someone who could support him. Mr Hall said he did not have any current thoughts of suicide or self-harm and felt positive, happy and well.

28. In interview, the residential worker told us that Mr Hall presented well, looked physically fit and had "high hopes" for the future. Mr Hall was given a room by himself in a two-bedroom flat where he shared a kitchen and small living area with another resident.

29. Mr Hall was not allowed to look after his own medication, so he handed 18 citalopram tablets (40mg), seven olanzapine tablets (10mg), five olanzapine

tablets (2.5mg) and 24 propranolol tablets (10mg) to staff when he arrived at the AP, in line with standard procedures.

30. On 22 April, a Probation Service Officer (PSO) introduced himself to Mr Hall as his key worker. A brief introductory meeting then took place, in line with national procedures, and Mr Hall's offender manager (probation officer) joined via video link. At the meeting, it was agreed that Mr Hall would keep his GP in Hereford so he could access mental health services. The PSO told us in interview that he was aware of Mr Hall's substance misuse history but that there was no indication that he was actively using drugs at the time. He also told us that if a new resident has not self-harmed in the previous 12 months, and they do not have other risk factors, they are generally considered to be at low risk of self-harm. Mr Hall was therefore assessed as being low risk.

31. On the evening of Friday 23 April, Mr Hall was involved in an argument during which he threatened another resident. As a result, the AP Duty Manager completed emergency recall paperwork, which was subsequently approved by the Parole Board, meaning that Mr Hall would be urgently returned to prison.

32. Staff did not tell Mr Hall about his recall due to the risk of absconding and/or risk of harm to himself or others. However, the offender manager told us that he thought Mr Hall would have known that he had passed the threshold for recall. He said that he does not work on Fridays and that when he switched on his work phone on Monday 26 April, the day after Mr Hall died, he saw that Mr Hall had tried to call him at 8.56pm on 23 April.

Saturday 24 April

33. At some point on 24 April, Mr Hall handed 28 diazepam tablets (used to treat anxiety) to staff, although the night audit counted 26 tablets. (It is unclear where Mr Hall got the diazepam from as it was not prescribed when he left Oakwood. It is possible it was prescribed by his GP in the community.) He also handed in 28 olanzapine tablets. (Mr Hall did not hand in all the medication that he was prescribed when he left Oakwood, so it is possible that he may have used some of that medication to overdose.)

34. At 11.00am, AP staff telephoned the police to ask when they were going to pick Mr Hall up to return him to prison. The police said they would arrange this as soon as they had someone available. (AP staff told us that it normally takes around four to six hours for the police to arrive at the AP to escort a recalled resident to prison, however on this occasion the police did not arrive before Mr Hall's death.)

35. At 3.55pm, Mr Hall signed out of the AP and recorded that he was going to "Town/Pharmacy". He signed back into the AP at 7.03pm.

36. Mr Hall's flatmate at the AP told us in interview that later that evening another resident texted him to say Mr Hall had been "throwing blood up" downstairs and was "taking these pills and drinking and all of that". He was told by his friend that Mr Hall went to the gym for half an hour to lift weights, then vomited some more before heading upstairs. He said he was in the kitchen cooking food and chatting

to someone via video link when Mr Hall came in. He said Mr Hall told him his food was not nice and then said goodnight.

37. At around 11.00pm, a residential night worker conducted a welfare check on Mr Hall, which was the final check of the day. In interview, he told us that Mr Hall was sitting in his bed watching television and gave him no cause for concern. He said he asked Mr Hall if he was alright, and Mr Hall replied, "Yeah".

Sunday 25 April

38. At around 7.00am, the residential worker and a colleague were conducting the morning welfare checks. The residential worker went into Mr Hall's room and called to him, but there was no response. He said that Mr Hall felt warm and looked like he was sleeping. He called his colleague over and together they tried shaking Mr Hall and calling his name, but he did not respond. At this point, they phoned for an ambulance and started performing cardiopulmonary resuscitation (CPR), following the Ambulance Service's instructions over the phone.

39. At 7.16am, paramedics arrived and took over CPR. At 7.47pm, paramedics confirmed that Mr Hall had died.

40. After Mr Hall's death, paramedics discovered vomit containing blood in the waste bin in his room. They also found empty medication packets (which a residential worker told us in interview were 28 diazepam tablets at 10mg), plus multiple packets of unopened medication and an empty bottle of beer.

41. Shortly after Mr Hall's death, a member of AP staff told the ambulance crew that Mr Hall looked to have been suffering from a cold and blocked nose the day before. AP residents also told staff that Mr Hall had been vomiting dark vomit for up to a week before he died, and this was relayed to the ambulance crew. There is no evidence that AP staff knew about this before Mr Hall died.

Contact with Mr Hall's family

42. Mr Hall had identified his sister as his next of kin. The Approved Premises Manager informed her of Mr Hall's death on 25 April.

Support for residents and staff

43. The AP manager spoke to staff and residents who had had interactions with Mr Hall and provided contact details for support organisations if they wanted further support.

Post-mortem report

44. A post-mortem examination identified the cause of Mr Hall's death as excessive use of dihydrocodeine (an opiate-based painkiller, which is only available via prescription), together with diazepam and olanzapine. (Mr Hall was prescribed olanzapine when he left Oakwood, but we do not know where he obtained the dihydrocodeine and diazepam, or whether they were prescribed by his community GP.)

45. Toxicology tests also found evidence that Mr Hall had used a number of other drugs before he died, including cocaine. However, the pathologist concluded that it was unlikely that the use of cocaine directly contributed to his death.

46. Post-mortem tests could not ascertain the cause of Mr Hall's vomiting or his other alleged physical symptoms.

Findings

Management of Mr Hall's risk

47. As Mr Hall had stayed at Braley House twice before, staff were aware of his history of substance misuse and self-harm.

48. A residential worker completed a suicide and self-harm risk assessment as part of Mr Hall's induction. He told us in interview that Mr Hall looked fitter, slimmer and healthier than on his previous stays, and that he was looking forward to using the on-site gym. In light of this, he assessed Mr Hall as being at low risk of self-harm. We are satisfied that he appropriately assessed Mr Hall's risk of self-harm during his induction, and that AP staff offered a supportive environment in which Mr Hall could address his offending behaviour.

49. During the nine days he spent at Braley House, Mr Hall gave staff no indication that he was taking illicit drugs, or any unauthorised prescription medication, or that he was likely to do so. We therefore consider that Mr Hall gave AP staff no reason to consider that he was at imminent risk of an overdose in the days before his death. The information from residents about Mr Hall "taking pills" only became known to staff after his death.

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

51. We make no recommendations.

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