

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Luke Friend, a resident at Jackie Harriett House Approved Premises, on 4 February 2021

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 Luke Friend died from heroin poisoning and cocaine toxicity in his room at Jackie Harriett House Approved Premises (AP) on 4 February 2021. He also had chronic liver disease which contributed to but did not cause his death. He was 29 years old. I offer my condolences to his family and friends.

Mr Friend was released from HMP Birmingham on 26 January 2021 and was at Jackie Harriett House for just 10 days before he was found dead in his room.

Mr Friend had a history of significant substance misuse issues. Although there is evidence that he used illicit drugs in prison up to September 2020, he subsequently said he was drug free and was positive about addressing his drug issues on release.

Although he pushed boundaries while at the approved premises, I am satisfied that staff at Jackie Harriett House had no reason to suspect that Mr Friend was taking illicit drugs.

I am concerned that staff at the AP did not discuss his increased risk of overdose with Mr Friend when he arrived at the AP. However, this is unlikely to have affected the choice that he was to take days later, as he had been advised of the risks of reduced drug tolerance levels before he left prison and on the day of his release.

I am also concerned that staff at Jackie Harriett House did not perform an adequate welfare check on the morning of Mr Friend's death and that a subsequent scheduled check did not take place. Although staff heard Mr Friend snoring during the early morning check, a more thorough check would have identified that he might have needed medical assistance. We cannot say whether the outcome might have been different if the subsequent check had taken place.

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

December 2021

Contents

Summary	1
The Investigation Process	3
Background Information	4
Key Events	5
Findings.....	12

Summary

Events

1. Mr Luke Friend had a history of substance misuse and mental ill health, for which he was receiving medication. He was known to misuse drugs in custody. He was last observed under the influence of drugs in prison in September 2020, although he said he was drug free before his release.
2. On 26 January 2021, Mr Friend was released on licence from HMP Birmingham to Jackie Harriett House Approved Premises (AP). In the days before his death, Mr Friend left the AP on several occasions, often for several hours, and broke local curfew times. He was noted to have “pushed boundaries” and he was warned that if this behaviour continued, it may result in him being recalled to prison. However, there was no evidence to suggest that he was using drugs.
3. At about 6.00am on 4 February, a member of staff carried out a welfare check of residents and reported that Mr Friend was asleep on his bedroom floor, snoring. The next welfare check scheduled for 8.00am did not take place.
4. At around 11.00am, staff checked on him again and found him unresponsive in the same position on the floor. Paramedics, who were already at the AP, dealing with another incident, pronounced that Mr Friend had died.
5. Evidence of drug use was found in Mr Friend’s room. A post-mortem examination found that he died from heroin poisoning and cocaine toxicity, aggravated by pre-existing chronic liver disease.

Findings

6. Before and after his release, Mr Friend appears to have wanted to change his lifestyle and stop taking drugs, with the support of community drug services.
7. We are satisfied that Mr Friend was told about his likely reduced tolerance to drugs and his increased risk of overdose before he was released from prison and again by his offender manager on the day of his release. However, we are concerned that he was not told by AP staff and that the AP had no local substance misuse policy.
8. Although Mr Friend had to be warned about his behaviour at Jackie Harriett House, we are satisfied that staff had no reason to suspect that he was using illicit drugs and to search his room.
9. We are concerned about the welfare checks on the morning that Mr Friend was found. Given the circumstances in which Mr Friend was seen at the 6.00am check, we consider staff should have tried to get a response from him to confirm his wellbeing.
10. We are also concerned that staff failed to carry out a scheduled welfare check at 8.00am, as required. We cannot say when Mr Friend died or whether the outcome might have been different if the 8.00am check had taken place.

Recommendations

- **The Approved Premises Area Manager and Approved Premises Manager should ensure that staff have an audited discussion with new residents about their reduced drug tolerance post-release during their induction and that they give residents written information about drug tolerance issues.**
- **The Head of Public Protection for Midlands, together with Staffordshire and West Midlands AP Area should ensure that all approved premises have a local substance misuse policy in place, including procedures for requesting substance misuse tests and room searches.**
- **The Probation Service should ensure that AP staff know that snoring can be a sign of a drug overdose.**
- **The Head of Public Protection for Midlands, together with Staffordshire and West Midlands AP Area Managers and the AP Area Manager should ensure that:**
 - **staff understand the importance of welfare checks to ensure the wellbeing of residents;**
 - **staff are given guidance on what signs or engagement from residents would be acceptable to confirm they are safe and well during a welfare check; and**
 - **wellbeing checks are completed when scheduled.**
- **The Approved Premises Area Manager should ensure that a copy of this report is shared with all staff named in this report and that a senior manager discusses the Ombudsman's findings with them.**

The Investigation Process

11. The investigator issued notices to staff and residents at Jackie Harriett House Approved Premises, informing them of the investigation and asking anyone with relevant information to contact him.
12. The investigator obtained copies of relevant extracts from Mr Friend's prison, probation and medical records.
13. The investigator interviewed seven members of staff at Jackie Harriett House AP and Mr Friend's offender manager. All the interviews were carried out by telephone because of the restrictions in place during the CPOVID-19 pandemic. The investigator also tried to speak to a resident at Jackie Harriett House at the time of Mr Friend's death, but he declined to do so.
14. We informed HM Coroner for Birmingham & Solihull of the investigation. She gave us the results of the post-mortem examination. We have sent her a copy of this report.
15. We contacted Mr Friend's named next of kin, his partner, to explain our investigation and asked if she had any matters, she wanted us to consider. She had no questions but asked for a copy of this report.
16. Mr Friend's mother also contacted us. She asked:
 - where her son was found;
 - when welfare checks were carried out;
 - how staff knew that he was alive when he was checked at 6.00am; and
 - why she was not listed as Mr Friend's primary next of kin and told in person about his death?

We have answered her questions in this report.

Background Information

Jackie Harriett House Approved Premises (AP)

17. Approved premises (formerly known as probation 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 AP's rules, they are essentially free to come and go from the building.
18. Jackie Harriett House in Birmingham is managed by the Staffordshire and West Midlands Probation Trust. Residents are given their own bedroom but share bathroom facilities. The AP has communal areas for dining and socialising and areas set aside for group work. Residents are provided with meals.
19. The AP is staffed 24 hours a day by probation employees. Each resident is allocated a key worker responsible for discussing their progress and wellbeing with them. A key worker also helps to ensure that residents adhere to their individual licence conditions and the rules of the AP.
20. Room searches are carried out at random and also if staff suspect that residents have stolen property or have illicit drugs or alcohol in their rooms. There are several CCTV cameras in communal areas which are monitored from the main office. AP staff carry out daily health and safety and welfare checks on residents at various times throughout the day and evening.

Previous deaths at Jackie Harriett House Approved Premises

21. This is the first death at Jackie Harriett House that the Prisons and Probation Ombudsman has investigated.

Key Events

Background

22. Mr Luke Friend had convictions for burglary and robbery committed in 2014 and 2018, for which he served concurrent sentences. Mr Friend's offending history centred around his significant misuse of drugs and he had served previous custodial sentences.

HMP Birmingham

23. On 18 September 2018, Mr Friend was transferred to HMP Birmingham. He behaved poorly in custody, he continually pushed boundaries and failed to engage with his sentence plan objectives. Although Mr Friend made some progress in engaging with the prison's substance misuse team, he continued to use drugs in custody, and built drug debts as a result. Staff found Mr Friend under the influence of illicit substances in September 2020.
24. Mr Friend had a history of mental health issues and was often monitored under suicide and self-harm procedures, known as ACCT. He was last monitored under ACCT procedures in September 2020.
25. A drug and alcohol recovery practitioner with the prison's substance misuse team, saw Mr Friend several times towards the end of 2020. Mr Friend told him that he was free from drugs and did not need any further support from the substance misuse team. There is no evidence that Mr Friend used drugs between September 2020 and his release in January 2021. The drug recovery worker said that Mr Friend was very polite, appeared stable and focused and wanted to engage with community drug support services on his release to remain free from drugs.
26. On 19 January 2021, Mr Friend told his key worker that he was nervous about his release from prison due to the time he had spent in custody but would do all he could not to return to prison. The keyworker told him that his feelings were understandable and that he should adhere to his licence conditions.
27. On 21 January, the drug and alcohol recovery practitioner, completed a release plan for Mr Friend. They spoke about Mr Friend's previous use of cocaine and alcohol in the community, about his use of psychoactive substances (PS) in custody, and about harm reduction and reduced drug tolerance levels which would increase his risk of overdose on release. Mr Friend was told that he would be subject to random drug testing when he was released to Jackie Harriet House AP. He told the drug and alcohol recovery practitioner that this would motivate him not to take drugs. He said that Mr Friend was happy to engage with community drug support services - an appointment had been made for him to meet with them on 27 January - and that he had a positive outlook about his drug use.
28. The drug and alcohol recovery practitioner said that that Mr Friend was not offered naloxone because Mr Friend did not have a history of heroin or opiate use. (Naloxone is a medication used as an emergency antidote for overdoses caused by heroin and other opiates.)

29. On 25 January, the drug and alcohol recovery practitioner met Mr Friend and they again discussed the dangers of reduced drug tolerance levels. He said that Mr Friend understood the dangers and was aware of the risks of drug use from his work with the substance misuse team. He noted that Mr Friend was also at risk of relapsing into problematic substance misuse, of breaking AP rules and breaching his licence conditions.
30. On 26 January, a nurse saw Mr Friend before his release from Birmingham. The nurse raised no concerns about his fitness to be released and he was released with his prescribed medication of mirtazapine (an antidepressant) and quetiapine (an antipsychotic).
31. After Mr Friend's death, a number of prisoners, including his former cell mate, told his partner that Mr Friend had been smoking psychoactive substances (PS) a few days before he was released from prison. Mr Friend's partner also told us that he had been scared at the prospect of leaving prison.

Jackie Harriett House Approved Premises

26 January

32. On 26 January, after his release, Mr Friend saw his offender manager (probation officer), to discuss his licence conditions, including that he was to engage with community substance misuse services and that he needed to comply with drug testing, when required. The offender manager said that Mr Friend was positive about his release and said he would comply with his licence conditions and asked for daily drug testing. She explained that due to the COVID-19 lockdown, there was only so much could be done, that he should not mix with residents outside the AP, that AP staff would support him and if he felt he might relapse into substance misuse, he should speak to her or a member of staff for support. She also discussed reduced drug tolerance levels and said that Mr Friend told her that once he started taking drugs, he would just continue and could not control the amount of drugs he used. He had told her that this was why he wanted daily drug testing.
33. On Mr Friend's arrival at Jackie Harriett House AP, a residential worker gave him information about the AP, including the AP's rules, curfew times and the additional rules imposed because of the COVID-19 lockdown. Mr Friend gave staff the prescribed medication that he had been given on his release from prison. It was also noted that staff should be aware of his history of self-harm. The residential worker said that Mr Friend acknowledged that he had drug issues. He told Mr Friend not to get drawn into drug use and about the AP's zero tolerance to drug use. He did not explicitly discuss reduced drug tolerance levels with him. He said that Mr Friend was in "a good place" at the time.
34. Mr Friend's keyworker briefly introduced herself and explained her role. Mr Friend had dinner and was checked at 11.00pm during a welfare check. Staff raised no concerns.

27 January

35. On 27 January, a sessional worker noted that Mr Friend had been checked three times during the night as a new arrival, and that he had had a good first night and had raised no concerns. That morning, Mr Friend attended his appointment with Change Grow Live, the community drug service team, by telephone due to COVID-19 restrictions. He left the AP that afternoon to go shopping and spent the evening in his room, leaving several times to smoke.

28 January

36. On 28 January, the sessional worker and Mr Friend met the offender manager remotely to discuss what was expected of him while living at Jackie Harriett House. A residential key worker explained in more detail the role of the keyworker and reminded him about the AP's rules.
37. The sessional worker said Mr Friend was told that he would normally have been randomly drug tested, but that due to the COVID-19 pandemic, this would not be the case because drug testing had been suspended. The offender manager said Mr Friend was unhappy that he would not be drug tested and she told him that she did not know when drug testing would be reintroduced. The sessional worker said that she could not recall drug tolerance levels being discussed during the meeting.
38. Mr Friend was also told that due to the COVID-19 lockdown, he could only leave the AP for a short time for specific and essential reasons such as shopping or attending appointments.
39. Mr Friend completed a GP registration form and left the AP in the afternoon for just under two hours. It is not known where he went. Mr Friend reported no significant issues during the day. He was seen smoking in the AP garden and took his medication before going to his room for the night. A residential worker said that staff had no concerns about Mr Friend's behaviour during his first few days at the AP and that she never saw him under the influence of drugs.

29 January

40. On 29 January, Mr Friend left the AP at around 10.15am to sort out his benefits. He did not return to the AP for his 1.00pm curfew, but he called staff at around 1.10pm to tell them that the job centre had sent him to a benefit office and that he was on his way back to the AP.
41. The approved premises area manager and acting AP manager told the offender manager about Mr Friend's curfew breach as she was concerned that he could have made his benefit claim online from the AP and that he might have been seeing his partner. She asked the offender manager to consider enforcement action.
42. On his return to the AP at around 2.00pm, a residential worker reminded Mr Friend of the need to comply with the AP's curfew hours. Mr Friend apologised for being late and staff raised no further concerns during the day.

30 January

43. On 30 January, Mr Friend socialised with other residents at the AP and was noted to be in “good spirits”. He went to the shops with another resident, and did not return until four hours later when staff noted that he was “caught with a whiff of alcohol”. He was seen socialising with other residents in the smoker’s area and on the landing outside his room that evening.

31 January

44. On 31 January, Mr Friend was noted to have been in good spirits at lunch time. At around 12.50pm, Mr Friend left the AP, and said that he was going to the shops. The other resident also left the AP at around the same time. He said that he was going to visit his girlfriend. They both got into a car which was waiting for them outside the AP. Mr Friend did not return to the AP until five hours later. That evening, he was seen mixing with other residents, including the other resident, on one of the AP’s landings.

1 February

45. On 1 February, Mr Friend left the AP at 11.25am. He said that he was going to the bank and he came back an hour and a half later. He signed out to go to the bank again at 2.00pm and returned three hours later.
46. Mr Friend was seen on CCTV footage from around 8.00pm to 10.50pm on the landing outside his bedroom with two other residents. They were described as “being loud”. Staff challenged, warned and reminded Mr Friend and the other residents about their behaviour and of the AP rule prohibiting congregating outside residents’ rooms. Despite the warning, Mr Friend and the other residents continued to congregate, with one resident sitting on a chair outside Mr Friend’s door. (Records do not indicate what happened next although a curfew check was completed at 11.00pm.)
47. The offender manager wrote to Mr Friend reminding him that if his behaviour at the AP continued, including not abiding with COVID-19 restrictions, curfew times and mixing inappropriately with other residents, enforcement action might be taken which could result in him being recalled to prison. She told colleagues that she would talk to him about it during their scheduled, remote meeting the following day.

2 February

48. On 2 February, Mr Friend left Jackie Harriett House to go to the bank at around 10.00am. He returned an hour later.
49. During the day, Mr Friend spoke to his offender manager remotely. She noted that there was no evidence that he was using drugs and discussed with him how he had recently “pushed boundaries” at the AP. Mr Friend apologised for his behaviour and put it down to the excitement of being released from prison.
50. Mr Friend left the AP at 2.00pm to meet his partner. He returned at 6.40pm. He took his medication that evening, and it was noted that he was in good spirits. He had remarked that there were a lot of CCTV cameras at the AP.

3 February

51. On 3 February, Mr Friend left Jackie Harriett House at around 9.30am to go to the chemist. He returned an hour later. He left again for a short time in the afternoon to go to the shops. It was noted that during the day, his mood seemed fine and that he raised no concerns.
52. The residential key worker and a residential worker said that Mr Friend offered sweets to staff in their office that evening. The residential worker said that he appeared absolutely fine. She and other members of staff said that they had never seen Mr Friend under the influence of drugs.
53. A sessional worker arrived on duty for his night shift. He said that during the handover, the day staff did not raise any issues about Mr Friend.
54. CCTV footage shows that at around 8.20pm, two residents were seen standing near the door of Mr Friend's room, and this continued on and off throughout the evening. Mr Friend's door was open, and the residents appeared in good spirits, coming and going together.
55. At around 10.00pm, the sessional worker told Mr Friend that he appeared very red in the face. Mr Friend told him that he had just had a hot shower. He took Mr Friend's temperature, which was normal. He said that Mr Friend was in a good mood and did not appear to be under the influence of drugs.
56. Mr Friend was checked at 10.40pm and no concerns were raised.
57. The sessional worker said that after the curfew check, it became apparent that another resident at the AP had absconded. He was suspected of selling drugs at the AP.
58. CCTV footage shows that at 11.45pm, a resident returned to Mr Friend's room and Mr Friend appears to hand him something, although this cannot be seen clearly as the resident's back is to the CCTV camera. The resident left around four minutes later. Mr Friend left his room to go to the toilet at 12.20am and again at 2.24am.

4 February

59. At 6.00am on 4 February, the sessional worker checked on Mr Friend during his early morning welfare check. He said that he opened the bedroom door and saw Mr Friend lying clothed on the floor with his back to the door, on his left side, with his left arm extended and a vape pen in his open hand. He said that Mr Friend was breathing and that there was nothing to give him concern. He said he was surprised that the room lights and television were switched on. He said that although Mr Friend's sleeping position was odd, he had no cause for concern because Mr Friend was breathing, was not struggling for breath and his "colour was good". He then went on to check on other residents.
60. The residential key worker arrived for her dayshift at around 7.50am and the sessional residential worker gave her and a residential worker a handover. She said that the sessional residential worker told them about a resident absconding the previous evening and that when Mr Friend was checked at 6.00am, he was

asleep on the floor, snoring. The residential worker said that she asked the sessional residential worker if Mr Friend had been using drugs. He had said there was no smell of drugs, that Mr Friend looked like he was sleeping soundly and that he did not want to disturb him as he was snoring. He left the AP at around 8.30am.

61. The 8.00am welfare check was not completed as it should have been. The residential key worker said that she and the residential worker began the 10.00am welfare check late, at around 10.15am, as they had been dealing with a resident in crisis. When the residential worker checked on a resident, she found him unresponsive, apparently under the influence of drugs. An ambulance was called, and the residential worker stayed with the resident until paramedics arrived.
62. After paramedics arrived, the residential worker completed the delayed 10.00am welfare checks. At 11.07am, She checked on Mr Friend. She said that his room door did not open wide as Mr Friend was blocking the door, but she managed to get her head around the door and saw him lying on the floor on his right hand side, with his right arm stretched out. (After Mr Friend's death, the police reported that Mr Friend had been found lying in the same position as at 6.00am, holding the vape pen in his left hand. They noted that Mr Friend had sustained a cut to the bridge of his nose and was not wearing a top.) She said that Mr Friend's face was blue and she immediately concluded that he had died as he did not respond to her calls and was not breathing. She returned to the resident's room and asked for assistance from a paramedic.
63. The residential worker returned to Mr Friend's room with the paramedic who confirmed that Mr Friend had died.
64. Police attended and found drugs paraphernalia in Mr Friend's room and what appeared to be crack cocaine.
65. The residential key worker said that after Mr Friend's death, his partner had told staff at the AP that at around 2.00am in the morning, Mr Friend had told her that he had relapsed and had been taking crack cocaine. She said that staff were not previously aware of this information. Mr Friend's partner confirmed this to the investigator.
66. On 17 February, a manager of Jackie Harriet House, told a colleague about her conversation with another resident. The resident told the manager that, on an unspecified date, Mr Friend had gone to Stoke with a man called 'NAME', thought to be a resident, who wanted to buy drugs to sell. He said that Mr Friend was going to get some money from someone, and that name had persuaded Mr Friend to buy heroin. (This information is in line with the fact that on 31 January, Mr Friend left the AP with a resident and did not return for several hours and did so again on 2 February when it was reported that Mr Friend left to meet his partner and a resident had said he had got lost on his way to the doctor.)

Contact with Mr Friend's family

67. Mr Friend's partner, his nominated next of kin, was made aware of his death by another resident at Jackie Harriett House. The approved premises manager of Stonnall Road AP had been called in to Jackie Harriett House after Mr Friend's death. When he arrived, Mr Friend's partner was already at the AP and she was formally told of Mr Friend's death. Mr Friend's sister was also notified of her brother's death and she too arrived at the AP. He also spoke to Mr Friend's mother who had phoned her daughter when she was at the AP.
68. Mr Friend had not named his mother as his next of kin and she was not therefore told in person of his death. However, we understand that the approved premises manager of Stonnall Road AP spoke to her on the morning of his death and offered support.

Support for residents and staff

69. The approved premises manager of Stonnall Road AP met staff and residents at Jackie Harriett House to ensure their wellbeing after the death of Mr Friend.

Post-mortem report

70. Post-mortem toxicology tests carried out after Mr Friend's death found that he had used heroin and cocaine before his death.
71. The pathologist concluded that Mr Friend's death was directly due to acute poisoning after taking heroin and cocaine, and that this was aggravated by pre-existing chronic liver disease.

Findings

Substance misuse

Information about drug tolerance at induction

72. Mr Friend had a significant history of substance misuse. He was found under the influence of drugs at HMP Birmingham in September 2020, but there is no evidence that he used drugs between then and his release on licence to Jackie Harriett House in late January 2021. Before his release from Birmingham, Mr Friend told his substance misuse worker that he was not taking drugs and wanted to engage with community drug support services to remain drug-free.
73. Before Mr Friend was released from Birmingham, he was warned about the dangers of taking an overdose because his tolerance levels for drugs would have reduced in custody.
74. The risk of relapse for a released prisoner with a history of substance misuse is high. The risk of fatal overdose is also high as, after a period of abstinence, drug users are particularly vulnerable due to a diminished tolerance, especially in the immediate post-release period. The Approved Premises Manual (APM) says that one of the main causes of deaths among AP residents is drug overdose.
75. The APM says that lowered drug tolerance levels should always be covered during a resident's induction following release from prison custody. It says that best practice would also include giving residents a leaflet about tolerance levels, including contact details for drug agencies and support groups, and that a checklist should be used to ensure that AP staff cover all relevant areas, including drug tolerance, during the induction process.
76. On his release from prison, the offender manager discussed the dangers of reduced tolerance levels with Mr Friend. However, when he arrived at Jackie Harriett House, a residential worker did not explicitly discuss reduced drug tolerance levels with Mr Friend or provide him with written information, such as a leaflet, advising him about the heightened risk. The induction paperwork signed by Mr Friend did not have a specific section on reduced drug tolerance levels.
77. In response to a previous PPO investigation in October 2019, the National Approved Premises Team issued a revised version of the nationally-used induction template, with a section on reduced drug tolerance. While we are satisfied that a new template is now in use, we are concerned that it does not appear to have been used with Mr Friend and that Mr Friend's heightened risks were not discussed with him during his induction at Jackie Harriett House.
78. We recently identified an identical issue in our report into the death of a man in May 2020 at an AP in Sheffield and made a recommendation which was accepted by the National Probation Service. We repeat that recommendation:

The Approved Premises Area Manager and Approved Premises Manager should ensure that staff have an audited discussion with new residents about their reduced drug tolerance post-release during their induction and that they give residents written information about drug tolerance issues.

79. During his time at Jackie Harriett House, Mr Friend was free to leave the AP, although he was expected to abide by his licence conditions, AP curfew times and the Government guidelines in place at the time during the COVID-19 pandemic.
80. APs are designed to provide a supportive and structured environment to reduce the likelihood of further offending, but AP residents are no longer in custody and are free to make their own choices. Part of the role of AP staff is to monitor residents' behaviour. However, if a resident breaks the AP's rules, their licence conditions or uses illicit drugs, AP staff can only inform the resident's offender manager (probation officer) or, in extreme cases, the police, with a view to having the resident recalled to prison. They cannot take physical action to enforce the rules themselves.
81. AP staff identified that Mr Friend was "pushing boundaries" during his short time at the AP, returning late and socialising inappropriately with other residents. He was formally reminded that if his behaviour continued, it might lead to him being recalled to prison. Staff had no reason to believe at the time that he might have been leaving the AP to buy drugs, and staff could not have prevented him from doing so.
82. Although Mr Friend was not told about the risks of reduced drug tolerance levels when he arrived at the AP, we are satisfied that he had been told about the risks before he was released from prison and by his offender manager earlier that day. We are satisfied that there is nothing that staff at Jackie Harriett House could reasonably have done to prevent Mr Friend obtaining and using drugs.

Drug testing

83. The post-mortem report established that Mr Friend died from heroin and cocaine use.
84. Before his release from Birmingham, Mr Friend had displayed a positive attitude towards change and there was no recent evidence of drug use. Although staff contact with Mr Friend at Jackie Harriett House was more limited than would normally have been the case due to the COVID-19 pandemic, none of the staff who had contact with him in the days leading to his death considered that he was under the influence of any substances. He gave staff no reason for concern, other than that a sessional residential worker noted that he appeared red-faced. Although the sessional residential worker had not considered at the time that Mr Friend was under the influence of drugs, his red face might have been as a consequence of him using drugs.
85. Drug testing at Jackie Harriett House had been suspended on 11 January 2021 due to COVID-19 restrictions. However, we are satisfied that even if drug testing had been available, staff had no reason to suspect that Mr Friend was using drugs which in turn would have prompted them to conduct a drug test.

Searching

86. Under Jackie Harriett House's searching policy, room searches are only undertaken if staff have good reason to suspect the resident has unauthorised items in their possession. We are satisfied that AP staff had no reason to

suspect that Mr Friend was bringing illicit drugs into the AP during his short time there. Another resident was suspected of dealing in drugs the night before Mr Friend died and intelligence gathered after Mr Friend's death suggested that Mr Friend might have bought drugs during his prolonged absences from the AP on two occasions in the days before his death

Local substance misuse policy

87. The Approved Premises Manual says that APs should have a local substance misuse policy and that staff should be familiar with it. The policy should contain clear procedures and instructions for staff on how to deal with situations commonly faced (such as residents using illicit substances or being found unconscious or with breathing difficulties) and when searches are appropriate.
88. Jackie Harriett House does not have a local substance misuse policy in line with national requirements. We make the following recommendation:

The Head of Public Protection for Midlands, together with Staffordshire and West Midlands AP Area should ensure that all approved premises have a local substance misuse policy in place, including procedures for requesting substance misuse tests and room searches

Welfare checks

89. Staff at Jackie Harriett House carry out health and wellbeing checks on residents at set times during the day, beginning at 6.00am. Although some aspects of Jackie Harriett House's daily regime were suspended due to the COVID-19 pandemic, health and wellbeing checks were not affected.
90. When the sessional residential worker carried out the early morning welfare check at 6.00am, he assumed that Mr Friend was asleep on the floor because he was snoring, and he did not seek a response from him, although he thought it unusual that his light and TV were on. The sessional residential worker said he did not wake Mr Friend because he did not know how he might react. He said that residents sometimes became aggressive if woken during the early morning check and that he had been recently assaulted by a resident after waking him.
91. The Approved Premises manager said that staff were not expected to get a verbal response from the resident but were expected to check that they were breathing and physically in the AP.
92. We see many drug-related deaths where snoring is taken as a sign that the individual is alive and 'sleeping it off', when in fact it can be a recognised sign of respiratory distress caused by a drug overdose. We are concerned that the sessional residential worker did not know that snoring can be a sign of a drug overdose, and did not try to establish if Mr Friend was unwell or needed assistance, particularly given the circumstances in which he was found, lying on the floor, with the light and TV on. In these circumstances, we consider that the sessional residential worker should have tried to obtain a response from Mr Friend. If a member of staff feels unsafe in seeking a response, the expectation should be for them to radio a colleague for assistance. We recommend:

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

93. The next welfare check was scheduled for 8.00am. The sessional residential worker confirmed that he did not do this check, and although the residential key worker signed that the check had taken place, it had not. The residential key worker told police that this was a mistake and she had signed the check because she mistakenly thought that the sessional residential worker said he had completed the check.
94. The AP's staff task lists for day and night shifts both have 8.00am checks on them and it is not clear which shift, day or night, is responsible for carrying out this check. The residential key worker said it was her understanding that the night staff would do both the 6.00am and 8.00am check and the first check for day staff would be 10.00am. The manager said that historically, it had not been clear whether night or day staff were responsible for doing the 8.00am check.
95. This confusion meant that no one checked on Mr Friend between 6.00am and 10.00am, although we accept that the 10.00am check was delayed by the emergency involving a resident.
96. In November 2017, we published a Learning Lessons Bulletin into deaths in Approved Premises. We concluded that staff undertaking welfare checks of residents must satisfy themselves that the resident is safe and well. We found that the APM did not provide enough clarity on what is expected of staff, what constitutes a welfare check or what engagement from the resident would be acceptable to confirm they are safe and well. We said that the National Probation Service should review the guidance on welfare checks to ensure it is clear why the checks are needed and what they should entail. We are therefore very concerned that staff at Jackie Harriett House, including the manager, did not understand the importance of the checks or how they should be carried out.
97. We cannot say when Mr Friend died, although the post-mortem concluded that that he died some hours after taking drugs. We know that Mr Friend told his partner at around 2.00am that he had relapsed. He may have died anytime between 6.00am (when the sessional residential worker found him snoring) and when he was found at 11.00am. We cannot, therefore, know whether or not the outcome might have been different if the 8.00am welfare check had taken place.
98. Jackie Harriett House have introduced new procedures for staff, clarifying that it is the responsibility of the day staff to carry out the 8.00am welfare check. Having recently identified a similar issue in our investigation report into the recent death of an AP resident in Sheffield, we repeat the following recommendation, which was accepted by the National Probation Service:

The Head of Public Protection for Midlands, together with Staffordshire and West Midlands AP Area Managers and the AP Area Manager should ensure that:

- **staff understand the importance of welfare checks to ensure the wellbeing of residents;**

- **staff are given guidance on what signs or engagement from residents would be acceptable to confirm they are safe and well during a welfare check; and**
- **wellbeing checks are completed when scheduled.**

Learning Lessons

99. We have identified a significant number of concerns in this report. We consider it is important that staff learn from our findings. We recommend that:
100. **The Approved Premises Area Manager should ensure that a copy of this report is shared with all staff named in this report and that a senior manager discusses the Ombudsman's findings with them.**

**Prisons &
Probation**

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