Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Ms Georgina Marshall, a resident at Crowley House Approved Premises, on 17 May 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*

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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.

Ms Georgina Marshall died on 17 May 2021 of an overdose of prescription medication and alcohol at Crowley House Approved Premises (AP) in Birmingham. She was 44 years old. I offer my condolences to Ms Marshall's family and friends.

Ms Marshall had been at the AP for 11 weeks and there had been no significant problems during that time. However, on the afternoon of her death, Ms Marshall returned to the AP drunk. At some point she took large amounts of her prescribed antidepressants and painkillers.

After AP staff breathalysed her, Ms Marshall became aggressive and then collapsed on the floor outside her room. Staff left her lying there for around 45 minutes before another resident told them she was not breathing. They called an ambulance and began CPR, but Ms Marshall was pronounced dead by the ambulance staff.

I am satisfied that that AP staff had no reason to consider that Ms Marshall was at imminent risk of suicide or self-harm on or before 17 May. However, our investigation found failings in the way staff responded when it became clear that Ms Marshall had been drinking.

I am concerned that staff did not realise there was a possibility that Ms Marshall had taken some of her medication on the day of her death; that they did not call the police when Ms Marshall became aggressive; and, most importantly, that they left her lying on the floor for 45 minutes unresponsive or semi-conscious without observing her.

There were only two junior staff on duty at the AP during this time and I question whether the staffing levels at the AP were adequate given that it houses high risk women with complex needs.

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 **March 2022**

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Summary

Events

1. On 20 November 2008, Ms Georgina Marshall was sentenced to life imprisonment for murder with a tariff of 12 years. Her offence and her previous offending history were associated with drug and alcohol abuse. She was diagnosed with borderline and anti-social personality disorders and received therapy in prison.

2. On 1 March 2021, Ms Marshall was released from HMP Drake Hall on parole to Crowley House Approved Premises (AP).

3. She was authorised to keep most of her medication (including antidepressants and pain killers) in her own possession at the AP, but from 29 March onwards, pregabalin (a controlled drug) was removed from her room and kept in the AP office and dispensed to her by staff.

4. Ms Marshall appeared to settle, and she became good friends with another resident with whom she shared a self-contained flat at the AP. She kept very busy and was generally described as a happy person, although she also got increasingly frustrated and depressed at the time it took to put some things in place for her (such as mental health services) and some activities were not taking place because of the COVID-19 pandemic.

5. On 13 May, Ms Marshall had a lengthy and difficult meeting by video-conference with her new offender manager and her AP key worker to discuss her plans for the future (which they considered to have challenges). Afterwards, Ms Marshall told her key worker that she was struggling and felt worthless, although she said she had no thoughts of suicide or self-harm.

6. On 15 May, Ms Marshall sent an email to her work coach at Jobcentre Plus saying that she was at breaking point and felt worthless and suicidal and would be better off dead. This email was not seen until 19 May – two days after Ms Marshall's death – and so was not shared with probation staff.

7. On the afternoon of 17 May, Ms Marshall and her flatmate, left the AP (as they were entitled to do). They bought and drank alcohol before returning to the AP, where they continued drinking.

8. At around 6.00pm, the two staff on duty at the AP went to the flat where Ms Marshall lived. They suspected she and her flatmate had been drinking and they breathalysed them both. They both tested positive for alcohol. Staff removed Ms Marshall's 'in possession' medication from her room and returned to the staff office.

9. At around 6.30pm, Ms Marshall went over to the staff office. She was angry and drunk and appeared worried that she would be recalled to prison. While at the staff office, she tried to hit a member of staff. She was prevented by her flatmate, who Ms Marshall then held by the neck and pushed against a door.

10. At 6.43pm, Ms Marshall left the main building and staggered back to her flat before collapsing on the floor. At 7.00pm, staff received a telephone call from the someone who identified themselves as the police, who told them that Ms Marshall's flatmate had reported that she had collapsed. They went over to see her in the flat and assessed her briefly before leaving.

11. At 7.45pm, Ms Marshall's flatmate returned to the flat and found Ms Marshall in the hall, face down and not breathing. She alerted staff, who immediately went to the flat. They called an ambulance and began CPR.

12. Paramedics arrived at 7.59pm and took over emergency care. Ms Marshall did not respond to treatment and at 8.32pm, the paramedics confirmed that Ms Marshall had died.

13. The post-mortem found that Ms Marshall died as a result of drug and alcohol toxicity. She had high levels of her antidepressant and pregabalin in her system, suggestive of a deliberate overdose.

Findings

14. We are satisfied that AP staff had no reason to consider that Ms Marshall was at imminent risk of suicide or self-harm on or before 17 May.

15. We did, however, find failings in the way staff responded when it became clear that Ms Marshall had been drinking.

16. Staff should have realised there was a possibility that Ms Marshall had taken at least some of her 'in possession' medication and should have sought advice from NHS 111 about whether this might put her at risk.

17. Staff should have called the police when Ms Marshall became aggressive and violent towards them and her flatmate.

18. We are very concerned that staff left Ms Marshall lying on the floor unresponsive or semi-conscious for 45 minutes without observing her in person.

19. When staff were told Ms Marshall was not breathing, there was a delay in calling an ambulance and the defibrillator was never used.

20. An error was made in Ms Marshall's 'in possession' medication risk assessment and this may have contributed to her being able to collect a substantial quantity of pregabalin.

21. We question whether the staffing levels at Crowley House were adequate for its complex, high risk residents.

22. No one offered Ms Marshall's next of kin a contribution to her funeral expenses.

Recommendations

- **The AP Manager should ensure that staff know how to respond if a resident is violent to staff or other residents.**

- **The AP Manager should ensure that all staff know what they should do if they find a resident unresponsive after suspected drug or alcohol misuse.**
- **The AP Area Manager should commission an investigation into the actions of Residential Worker A and Residential Worker B on 17 May 2021, with a view to considering whether disciplinary action is appropriate.**
- **The AP Manager should ensure that:**
    - **staff have clear guidance on how to respond to a medical emergency; and**
    - **all staff are trained to use a defibrillator and know they should always take a defibrillator to any medical emergency response.**
- **The AP Manager should ensure that staff are appropriately trained in completing 'in possession' medication risk assessments.**
- **The Probation Service should review:**
    - **whether evening and weekend staffing levels at APs are sufficient to support residents safely; and**
    - **whether remote working is appropriate in an AP setting.**
- **The AP Area Manager should ensure that:**
    - **when a resident dies in an AP, an offer of financial assistance with funeral expenses is made to the next of kin, in line with policy; and**
    - **an offer of financial assistance is now made to Ms Marshall's next of kin if this has not already happened.**

The Investigation Process

23. The investigator issued notices to staff and residents at Crowley House Approved Premises informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

24. The investigator visited Crowley House on 13 July 2021. He obtained copies of relevant extracts from Ms Marshall's prison, probation and prison medical records and viewed the available CCTV footage.

25. The investigator interviewed three members of staff at Crowley House on 13 July. He also interviewed five members of staff by telephone between 9 and 23 July, and a prisoner (who had been a resident at Crowley House) on 13 October.

26. We informed HM Coroner for Birmingham of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

27. The Ombudsman's family liaison officer contacted Ms Marshall's next of kin to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They had no specific questions, but they asked for a copy of our report.

28. Ms Marshall's family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.

29. The initial report was shared with the Probation Service. The Probation Service did not find any factual inaccuracies. The PPO and the Probation Service agreed to amend one recommendation from a local to a national recommendation.

Background Information

HMP & YOI Drake Hall

30. HMP & YOI Drake Hall is a women's prison near Stafford with a capacity of 340. It consists of a medium security prison (the 'closed' site) and a small low security unit (the 'open' site).

Crowley House Approved Premises

31. Approved Premises (APs), 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.

32. Crowley House AP in Birmingham is operated by the Midlands Probation Service and is one of very few approved premises solely for women. It is a Psychologically Informed Planned Environment (PIPE) site and caters for women with complex needs, many of whom have been assessed by the Probation Service as posing a high risk of harm to others.

33. Crowley House has three residential parts. The main building houses the staff office, kitchen, communal rooms and most of the bedrooms. New residents are placed in the main building on arrival. The second part is a three-bed 'upstairs flat' connected to the main building by an internal walkway. Residents can progress from the main building to the upstairs flat. The third residential part is the 'downstairs flat' which is not connected to the main building and is accessed via a courtyard. Residents in the downstairs flat have more independent facilities and are less supervised. The downstairs flat is often used by residents who are ready to leave Crowley House for independent accommodation.

34. Crowley House is staffed 24 hours a day, with a minimum of two staff on duty. Residents can leave the AP for work, social and other activities. All residents are required to be back in the AP by their curfew or risk recall to prison. Curfews are set in line with a resident's circumstances and risks.

35. Each resident has a key worker who is responsible for monitoring the behaviour of their residents and for providing advice and encouragement. Residents are expected to meet weekly with their key workers.

HM Inspectorate of Probation

36. The most recent inspection of Crowley House Approved Premises was as part of a thematic inspection of APs published in July 2017. Inspectors reported that APs that operated as PIPEs did good work but lacked suitable interventions to address personality disorders. They found this was a major limitation that eroded the morale and motivation of residents and staff.

37. The most recent inspection of the Midlands Probation Service was published in December 2018. It looked at all elements of the region's service, including APs.

Inspectors found a lack of resilience in the staffing resource in some teams, including APs.

Previous deaths at Crowley House Approved Premises

38. There has been one previous death at Crowley House: a death from natural causes in 2009.

Psychologically Informed Planned Environments (PIPEs)

39. PIPEs are specifically designed, contained environments where staff members have additional training to develop an increased psychological understanding of their work. This understanding enables them to create an enhanced safe and supportive environment, which can facilitate the development of those who live there. PIPEs place particular focus on the importance and quality of relationships and interactions. They aim to approach ordinary situations in a psychologically informed way, paying attention to interpersonal difficulties (such as those issues that might be linked to personality disorder). PIPEs are not a treatment. They are designed to enable offenders to progress through a pathway of intervention, maintaining developments that have previously been achieved and supporting transition and personal development at significant stages of their pathway.

Key Events

40. On 20 November 2008, Ms Georgina Marshall was sentenced to life imprisonment for murder, with a minimum tariff of 12 years, and was sent to HMP New Hall.

41. Ms Marshall was diagnosed with Unstable Emotional Personality Disorder, Borderline Personality Disorder and Anti-Social Personality Disorder. Her offence and her previous offending history were associated with drug and alcohol abuse. She engaged with therapy while in prison.

42. Ms Marshall also suffered from back pain and was prescribed painkillers for this.

HMP Drake Hall

43. In October 2016, Ms Marshall transferred to HMP Drake Hall, where she completed offending behaviour courses and, in May 2019, she progressed to the open unit there. She took unaccompanied day releases under release on temporary licence (ROTL), and from June 2019 she was employed full-time in the community on day release (although this ended when the COVID-19 pandemic began in March 2020). Throughout this time, she maintained enhanced status under the Incentives and Earned Privileges scheme, although she attracted a small number of negative entries for rudeness and not complying with the regime.

44. In November 2020, Ms Marshall was informed that she would be released on parole once a suitable place had been found in a PIPE AP, and in December she was told that she would be released to Crowley House AP on 1 March 2020. As ROTL had been stopped due to the COVID-19 lockdown, she was unable to visit Crowley House, but she began to plan for her release through telephone contact with her new offender manager (probation officer) and her keyworker at the AP.

Crowley House

45. On 1 March, Ms Marshall was released from Drake Hall. She arrived at Crowley House that afternoon and was inducted by staff on duty.

Medication

46. Ms Marshall arrived with a significant amount of medication, including amitriptyline (an antidepressant), nefopam (a pain-killer) and pregabalin (to treat nerve pain), as well as medication to manage her cholesterol and weight. Her medication was held by AP staff and dispensed from the staff office while a medication risk assessment was completed.

47. On 19 March, Ms Marshall was approved to hold all her medication 'in possession' (meaning she could keep it in her room and take it as required) from 21 March. However, she should not have been allowed to have pregabalin in possession as it is a controlled drug. When this was realised, the pregabalin was removed from her room on 29 March (or possibly 4 April – the records are not entirely clear) and was held by staff who dispensed it to her from the office in line with her prescription.

48. The keyworker saw Ms Marshall regularly at the AP and supported her with referrals to support services and a befriending service. She told us that Ms Marshall was happy to have been released but that she was very anxious after spending 12 years in prison. She described her as friendly and bubbly and happy to chat, but said she had mental health issues and often felt 'down'. She said Ms Marshall kept herself very busy with various activities, including support groups, church groups and keep fit classes.

49. The keyworker said she spent a significant amount of time with Ms Marshall trying to get her referred to the community mental health team. This was delayed because of a misunderstanding by Ms Marshall's GP but, on 7 May, she saw Ms Marshall and told her that she had provided the information the community mental health team required, and she hoped Ms Marshall would be contacted for an assessment soon. The assessment does not appear to have happened before she died.

50. Another resident told us that she shared the upstairs flat at the AP with Ms Marshall and another woman for a while, and then she and Ms Marshall moved to the downstairs flat. She said they became very good friends and did everything together. She described Ms Marshall as funny and caring. However, she said Ms Marshall's mood could fluctuate and "she had her off days, her down days", especially when she did not get her own way, and they argued sometimes, although they made up quickly. She said all the staff were very nice to Ms Marshall, but that she had problems with some of the staff and was rude to them.

51. The keyworker said that Ms Marshall's relationship with her flatmate was 'up and down' at times but that it appeared to be beneficial as they supported each other and were both 'on a good path'.

52. By mid-May, Ms Marshall was showing signs of being low in mood. On 11 May, she was abrupt with a residential worker at the AP when she tried to help her with an issue with her bank card.

53. On 13 May, Ms Marshall, the keyworker and a new offender manager met by video-conference. They discussed Ms Marshall's plans for the future after she left Crowley House. The offender manager and the keyworker praised Ms Marshall's proactiveness, but they were concerned that her plan to move to Cornwall (where she knew no one) had challenges and they explored some of the practical challenges, costs and probation processes. Ms Marshall struggled in the meeting. The keyworker told us the meeting was lengthy and quite intense.

54. Afterwards, the keyworker sat down with Ms Marshall to check on her wellbeing. Ms Marshall was tearful and said she felt Drake Hall had let her down, although she could not explain how. She told the keyworker that she was struggling and felt worthless. When the keyworker asked if she had thoughts of self-harm or suicide, Ms Marshall said that she did not.

55. The next day (Friday 14 May), the keyworker saw Ms Marshall for the last time, and they talked about Ms Marshall buying a diary to record her appointments and future plans. On the same day, Ms Marshall told a residential worker that she did not want to talk and said that the only person helping her was a social prescriber at her GP surgery.

56. On 15 May, Ms Marshall sent an email to her work coach at Jobcentre Plus saying that she was at breaking point and was suicidal, worthless and would be better off dead. Her work coach was not at work and did not see the message, and the information was not shared with the probation service until 19 May (after Ms Marshall's death).

57. The flatmate said that Ms Marshall was withdrawn in the week leading to her death. They had fallen out and Ms Marshall did not talk to her and was quiet and, at times, tearful.

Events of 17 May

58. The keyworker was working at home on Monday 17 May and did not see or have contact with Ms Marshall. There were three staff on duty in the AP, Residential Worker A and Residential Worker B, and another keyworker who left at 5.30pm.

59. That afternoon, staff were concerned about another resident, Ms X, who suffered from dementia, and who said she was leaving the AP and was going to travel to the area where her victims lived. Another resident who had a learning disability had arrived at the AP and was being inducted by staff.

60. Ms Marshall went to the staff office to collect her pregabalin medication, and then she and her flatmate left Crowley House and went to the shops, where Ms Marshall bought a large bottle of rum and the flatmate bought a bottle of alcopop, which they mixed and drank. They then bought a large bottle of whisky and a bottle of cola, which they mixed and took back to the AP.

61. They returned around 3.40pm and went to the staff office to collect their room keys. Residential Worker A checked their bags and gave them their keys. Ms Marshall and her flatmate then went to the downstairs flat and the flatmate told us they drank the whisky and cola between them.

62. At around 4.30pm, staff saw Ms Marshall and her flatmate talking to workmen, who were working near the downstairs flat. When staff asked the workmen about the conversation, they told them that Ms Marshall and her flatmate had made sexually suggestive comments to them.

63. As a result, staff turned on the CCTV camera in the sitting room of the downstairs flat to see what Ms Marshall and her flatmate were doing. They watched Ms Marshall and her flatmate dancing and playing music, and around 5.30pm, Ms Marshall and her flatmate started touching each other and kissing. The music was now audible to staff in the main building.

64. At about 6.00pm, Residential Worker A and Residential Worker B left the staff office and went across the courtyard to the downstairs flat. Residential worker A breathalysed Ms Marshall and her flatmate, and the flatmate gave her an empty bottle of alcohol.

65. At 6.18pm, CCTV shows Residential Worker B left Ms Marshall's room with a medicine box in her arms. She told us that she had found Ms Marshall's 'in possession' medication, including her amitriptyline, in many boxes and dossette boxes spread across her bed and on the floor. Ms Marshall followed her down

the corridor of the downstairs flat, visibly swaying, and Residential Worker B noticed that she was struggling to stand and slurring her words.

66. At 6.19pm, CCTV shows that Ms Marshall shouted and waved her fist at the staff as they left the flat. At 6.30pm, Ms Marshall and her flatmate entered the main building via the back door. There was then a confrontation between them in the corridor outside the staff office. It is not fully captured on the CCTV footage, but it appears that the flatmate tried to move Ms Marshall away from the staff office. She closed an internal door and put her weight against it to prevent Ms Marshall from going further. Both then went into the residents' lounge. At 6.38pm, they both left the lounge, and they appeared to be struggling with each other.

67. In interview, the flatmate said that Ms Marshall was behaving aggressively towards staff and that she intervened to prevent Ms Marshall reaching them. She said she placed herself between Ms Marshall and staff, at which point Ms Marshall grabbed her around the neck.

68. In interview, both residential workers said that Ms Marshall was verbally aggressive towards them and that Ms Marshall tried to reach through the hatch of the staff office to hit Residential Worker A. Residential Worker A also said that Ms Marshall had got her hands around her flatmate's throat and had her up again a door. Residential Worker B said that the 'tussling' between Ms Marshall and her flatmate, and Ms Marshall's aggression towards staff lasted around 15 minutes.

69. Residential Worker B said in interview that Residential Worker A wanted to call the police, but she felt that they need to speak to the off-site duty manager first.

70. At 6.43pm, Residential Worker A rang the duty manager and told her that Ms Marshall and her flatmate had been drinking and that Ms Marshall had been aggressive to towards staff. The duty manager assessed that the imminent harm had passed. In interview, she said she advised Residential Worker A to keep Ms Marshall and her flatmate separated; to call the police if Ms Marshall was violent; to keep the staff area secure; and to control Ms Marshall's access to the main building. She also asked the Residential Worker A to ring her back at 7.15pm, to let her know if the other resident, Ms X, had returned to the AP.

71. In interview, both residential workers said that the duty manager advised them to stay in the office and observe Ms Marshall via the CCTV.

72. Meanwhile, Ms Marshall had left the main building and returned to the downstairs flat. CCTV footage shows her staggering between the two buildings, hitting both the wall of the main building and then the wall of the flat as she reached the doorway. As she entered the flat, she tripped and fell face down onto the floor at about 6.40pm. Only her legs are visible on the CCTV. After she fell, there was some movement in her legs but, at 6.46pm, her legs stopped moving. The front door to the downstairs flat remained open.

73. At 6.50pm, CCTV shows that the flatmate returned to the downstairs flat. She kicked the sole of Ms Marshall's shoe and then went into her room. In interview, she said that she kicked Ms Marshall in frustration because feared that her actions would get them both recalled to prison. She said she thought Ms

Marshall had passed out from the drink and that she did not know that Ms Marshall had taken her medication.

74. Residential Worker B told us that just before 7.00pm she received a call from someone who identified themselves as from West Midlands Police. They told her they had received a report that Ms Marshall was lying on the floor of the downstairs flat and that the flatmate was going to the leave the AP. The flatmate told us she had rung 999 and called the police and ambulance service as she was concerned for Ms Marshall.

75. At 7.01pm, CCTV footage shows that both residential workers arrived at the flat. They looked through the windows and then through the doorway, where they saw Ms Marshall on the floor. Residential Worker A entered the flat and squatted down next to Ms Marshall. She said that when they checked Ms Marshall, she was not responsive and could only "moan". She said was lying on her front on the floor but was breathing. There were no visible signs of injury, no blood and no vomit. She said she moved Ms Marshall's head to one side. Residential Worker B said that they checked Ms Marshall's airway and she was breathing and "making sounds". She said they tried to move her but could not and then they moved her head to one side and left the door open.

76. Although much of the staff action cannot be seen due to the lack of CCTV coverage, the CCTV does show that Ms Marshall did not move and was not moved by staff. The assessment and intervention by staff was short, lasting not more than 90 seconds.

77. At 7.03pm, both residential workers left the flat and closed the door behind them. They spoke to the flatmate through her window for a minute before they returned to the main building.

78. At 7.08pm, CCTV footage shows that the flatmate left the flat, leaving Ms Marshall alone on the floor. From the available CCTV footage, no-one entered or left the downstairs flat after this. At 7.20pm, CCTV footage shows that Ms Marshall's legs appeared to spasm for around 10 seconds before stopping. This was the last time Ms Marshall can be seen moving.

79. After she left the flat, the flatmate went to the AP's secure entry gate. At interview she said she planned to abscond because the situation had become too much for her and she wanted to go back to prison. Residential Worker A went out to talk to her and, following a long conversation, she persuaded her not to leave.

80. At 7.31pm, the duty manager rang the AP, as she had not received the call back she had requested at 7.15pm. There was no answer. She rang again at 7.33pm without success, but finally got through to Residential Worker A at 7.34pm.

81. The duty manager said Residential Worker A told her that the flatmate was trying to leave the AP and Ms Marshall was asleep in the corridor of the downstairs flat but was conscious and responsive. She said that Ms X had not returned. The duty manager said she told the Residential Worker A to prioritise Ms Marshall and go to check on her. The duty manager said the call lasted a couple of

minutes. CCTV shows that staff did not go over to the downstairs flat for another 12 minutes.

82. At 7.45pm, the flatmate returned to the downstairs flat. She stepped over Ms Marshall and went into the bathroom. At 7.48pm, CCTV shows she bent over Ms Marshall, apparently trying to rouse her. She then called staff via the landline phone in the flat and told them that Ms Marshall was not breathing.

83. Both residential workers immediately went to the downstairs flat. They assessed Ms Marshall and tried to move her into the recovery position but could not do so due to her size and the narrowness of the corridor. Residential Worker A made a 999 call to the ambulance service. At 7.52pm, Residential Worker A and the flatmate started CPR, but the flatmate stopped moments later, and Residential Worker A took over.

84. The flatmate left the downstairs flat and reached the AP entry gate as night staff arrived. As Residential Worker B opened the gate, the flatmate slipped through the gate and left. She was subsequently recalled to prison.

85. At 7.56pm, the AP night staff arrived at the downstairs flat. Residential Worker B took over CPR and then one of the night staff took over from her.

86. At 7.59pm, ambulance paramedics arrived and took over CPR. They removed vomit from Ms Marshall's mouth and administered naloxone (medication used to reverse an opioid overdose) and adrenaline (medication to treat a cardiac arrest). Ms Marshall did not respond to treatment. At 8.32pm, the paramedics confirmed that Ms Marshall had died.

87. The police, who had been called by ambulance staff, arrived and took charge of Ms Marshall's body. They were initially concerned that there were suspicious circumstances but, after reviewing the CCTV footage, they concluded that this was a sudden death. During a search of Ms Marshall's body, police officers found an unidentified white tablet in her bra.

Contact with Ms Marshall's family

88. The police contacted Ms Marshall's next of kin. The AP arranged for him to visit Crowley House on 25 May to meet with the manager who was on duty that night, to see Ms Marshall's room and collect her belongings.

89. There is no evidence that the Probation Service contributed to the costs of Ms Marshall's funeral.

Support for residents and staff

90. After Ms Marshall's death, the duty manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The AP manager continued to offer support in the following days and staff were referred to the employee welfare support service.

91. The next morning, the AP manager led a support session for the Crowley House residents. The AP also posted notices informing other residents of Ms Marshall's death, and offering support.

Post-mortem report

92. During the post-mortem examination a small number of tablets were found in Ms Marshall’s clothing and stuck to her thigh.

93. Post-mortem toxicology tests found that the level of amitriptyline in Ms Marshall’s blood was nearly seven times higher than the therapeutic level and was suggestive of an overdose, while the level of pregabalin was between five and thirteen times higher than the therapeutic level and was suggestive of a “significant” overdose.

94. The level of alcohol in Ms Marshall’s blood and urine was 180mg/dL and 210mg/dL respectively. The UK ‘driving limit’ for alcohol is 80mg/dL and alcohol levels of above 200mg/dL are associated with slurred speech, unsteadiness and loss of consciousness.

95. The pathologist found that Ms Marshall died of pregabalin, amitriptyline and ethanol (alcohol) toxicity. He concluded that the concentrations of the prescription medications were lethal and that the effects of the drugs and alcohol together likely led to respiratory depression (ineffective breathing) and death.

Findings

96. Ms Marshall had spent 12 years in prison and had been at Crowley House for 11 weeks before she died. Although she had initially been very nervous about life outside prison, she seemed to settle at the AP and kept herself very busy. There were problems arranging her mental health support in the community, but she received support from other sources.

97. We are satisfied that probation staff had no reason to be concerned about her wellbeing until a few days before her death when there appears to have been a downturn in her mood and she told her keyworker she was struggling and felt worthless. However, she denied any thoughts of suicide and we do not consider that staff had any reason to consider she was at imminent risk of suicide or self-harm. (She disclosed suicidal thoughts to her job coach two days before her death, but probation staff did not know this at the time.)

98. Having said that, we think that there was an unfortunate combination of staffing issues that may have meant that staff were less likely to have noticed any deterioration in Ms Marshall's mood or mental health than might normally have been the case.

99. Because of the pandemic, Ms Marshall's key worker was working at home for part of the week and did not always see Ms Marshall in person. She last saw Ms Marshall on Friday 14 May. She does not work at weekends and she was working at home on the day of Ms Marshall's death.

100. The AP manager changed while Ms Marshall was at the AP. The last AP manager's (who happened to be the duty manager on the day of Ms Marshall's death) last day was 19 March and although the new AP manager took up post on 1 April, she was still involved in the management of her previous AP until 1 June. This meant that, through no fault of staff locally, there was reduced management capacity.

101. In addition, Ms Marshall had three different offender managers over this critical period. The offender manager she had known in prison left on 1 February (a month before Ms Marshall's release), and her new offender manager also moved after only eight weeks and was replaced on 1 April. This meant that Ms Marshall had not established a relationship with her new offender manager, who she met for the first time on 13 May by video-conference at the difficult meeting to discuss her future plans.

102. We do not know when Ms Marshall took the large quantities of pregabalin and amitriptyline that contributed to her death on 17 May. However, it seems likely that she took the amitriptyline, and possibly the pregabalin, before 6.18pm, when her 'in possession' medication was removed from her flat, and she must have taken both before she collapsed at about 6.40pm. Although the flatmate said that they drank the same amount of alcohol, it appears from CCTV that Ms Marshall was significantly more under the influence than the flatmate from at least 6.18pm.

103. Nor can we say why Ms Marshall took the drugs or whether she intended to kill herself when she did so. The flatmate said that after they tested positive for alcohol at about 6.00pm, Ms Marshall was worried that she would be recalled to

prison (although the flatmate herself thought they would just get a warning until Ms Marshall became violent and aggressive after 6.30pm). It is possible that the fear of being recalled prompted the drug use.

104. What is clear from the toxicology tests is that Ms Marshall took a “significant” overdose of pregabalin. She had not had pregabalin ‘in possession’ after 29 March (or possibly 4 April). We consider how she obtained such a large quantity of the drug, and whether staff took appropriate action in relation to the ‘in possession’ drugs, later in this report.

Actions on 17 May

105. Although we are satisfied that staff could not have foreseen the events of 17 May, we consider that there were a number of failings in the way staff responded that evening and that the outcome might have been different for Ms Marshall if they had acted differently.

Failure to seek medication advice

106. When Ms Marshall and her flatmate were found to be drunk at about 6.00pm, staff acted appropriately by breathalysing them and then removing their ‘in possession’ medication (because of the obvious dangers of mixing drink and drugs).

107. However, Residential Worker B said that Ms Marshall’s medications were in several boxes and dossette boxes spread across her bed and the floor. Staff did not know how much medication should have had in her room and did not, therefore, know how much she might have already taken. Once the medication had been removed, no further action was taken.

108. We consider that staff should have realised there was a possibility that Ms Marshall had taken at least some of her ‘in possession’ medication before they removed it and should have sought advice from NHS 111 about whether this might put her at risk.

Calling the police

109. After she had been breathalysed, Ms Marshall became aggressive and attempted to hit Residential Worker A and put her hands around her flatmate’s neck and pushed her against a door. Residential Worker A had wanted to call the police but was dissuaded from doing so by her colleague. We consider that they should have called the police at this point.

110. In interview, we were told that this type of incident would not be reported to the police unless the victim of the offence wanted to give a statement, and that the police had not responded quickly to similar incidents in the past. We do not find these persuasive arguments for not calling the police.

111. Ms Marshall had been assessed as a high risk of harm to others and many of her previous offences were committed while under the influence of alcohol. Her most recent OASys assessment reported that her risk to others would increase if her wellbeing deteriorated or she misused drugs or alcohol. Staff were sufficiently

concerned to have locked themselves in the office and at this point they could not have known whether Ms Marshall would commit further violent acts.

112. We note that the Crowley House *Safe Working Practice Policy* (dated May 2021) says that the police must be called immediately if a resident draws a weapon to threaten or attack another person. However, we can see no guidance on how to respond to violence or threatened violence where no weapon is used. We think this is an omission.

113. We make the following recommendation:

The AP Manager should ensure that staff know how to respond if a resident is violent to staff or other residents.

Failure to observe Ms Marshall after she collapsed on the floor

114. At about 7.00pm, both residential workers saw Ms Marshall lying face down, unmoving on the floor of the downstairs flat. In interview, Residential Worker A said Ms Marshall was non-responsive and moaning and Residential Worker B said Ms Marshall was making sounds. CCTV shows that Residential Worker A made some attempts to speak to Ms Marshall but, although they said they tried to move Ms Marshall into the recovery position, it is not clear from the CCTV that they did.

115. We are very concerned that they then left Ms Marshall on the floor for 45 minutes until the flatmate called them and said Ms Marshall was not breathing. They assumed she was drunk and would 'sleep it off'. We also consider that they should have contacted the duty manager again to update her.

116. The local AP policy says that where there are concerns about drug misuse, residents should be observed five times an hour to check on their wellbeing, and "if an unconscious, non-responsive person is found, immediate help should be called, and CPR commenced. … it is not acceptable to assume someone is 'sleeping' if they are breathing, as they could be unconscious".

117. We were told that local practice, although not written down in the local policy, was to manage an intoxicated resident by placing them in the recovery position, bringing or keeping them in the main building and placing them under observation. None of this happened.

118. Although both residential workers said they monitored Ms Marshall on CCTV from the office after they left her in the flat, only Ms Marshall's legs can be seen on the CCTV. It was not possible to see if she had vomited or if she was breathing. This was not a safe or effective way to observe her, and we consider that they should have checked her in person. They only returned to see her at 7.49pm after the flatmate told them Ms Marshall was not breathing. By this time, she had not obviously moved since 7.20pm when her legs spasmed briefly.

119. We recognise both residential workers had been subject to verbal abuse and threatening behaviour by Ms Marshall. Retreating into the secure office was a sensible and defensible decision at 6.40pm. However, after Ms Marshall collapsed, we consider that they should have recognised that the situation had changed from managing a potentially violent resident who posed a risk to others,

to a potential medical emergency involving an unconscious or semi-conscious resident who was heavily intoxicated and had collapsed.

120. We cannot say whether earlier intervention would have resulted in a different outcome, but it may have done.

121. We make the following recommendations:

The AP Manager should ensure that all staff know what they should do if they find a resident unresponsive after suspected drug or alcohol misuse.

The AP Area Manager should commission an investigation into the actions of Residential Worker A and Residential Worker B on 17 May 2021, with a view to considering whether disciplinary action is appropriate.

Emergency response

122. When the flatmate phoned both residential workers to tell them Ms Marshall was not breathing, we consider that they should have rung for an ambulance before going to the flat to check for themselves. Although they could not be sure that the flatmate was right, they knew that Ms Marshall had been lying on the floor for 45 minutes. They should also have taken the AP's defibrillator with them. Although Residential Worker A rang 999 and started CPR promptly when she reached Ms Marshall, the defibrillator was never used.

123. We asked if the AP had an emergency response policy. We were told that as staff were first aid trained, no such policy was necessary. However, the National Probation Service *Approved Premises Safe Working Practice Document* (dated May 2021) includes sequential emergency response guides on violent incidents, fires, self-harm and new psychoactive substances. We consider a similar guide on medical emergency responses would provide useful step-by-step guidance for staff.

124. We make the following recommendations:

The AP Manager should ensure that:

- **staff have clear guidance on how to respond to a medical emergency; and**
- **all staff are trained to use a defibrillator and know they should always take a defibrillator to any medical emergency response.**

'In possession' medication risk assessment

125. The *Midlands Division Approved Premises Medication Practice* document (dated November 2018) sets out the policy for managing drugs classified as 'controlled' under the Misuse of Drugs Act 1971. It says that no controlled medication will be allowed 'in possession' and that it should be stored securely under supervision. In April 2019, pregabalin was made a controlled drug under the Misuse of Drugs Act.

126. However, under the risk assessment completed by Ms Marshall's keyworker and countersigned by a line manager, Ms Marshall was incorrectly allowed to have pregabalin 'in possession' from 21 March until at least 29 March (and possibly until 4 April, when a note on the weekly medication audit states "returned in cabinet").

127. We are concerned that AP staff did not know that pregabalin was a controlled drug a year after it was made one and that as a result Ms Marshall had the drug in her possession for at least a week.

128. Ms Marshall took a substantial amount of pregabalin on the day she died. We do not know how she collected this amount. She may have obtained it illicitly or she may have stockpiled it when it was dispensed to her by staff each day, but errors in the management of controlled medication obviously increase the risk of misuse, including hoarding, diversion and overdose.

129. We make the following recommendation:

The AP Manager should ensure that staff are appropriately trained in completing 'in possession' medication risk assessments.

Staffing levels

130. The standard minimum operating level for Crowley House is two residential workers. They are the most junior grade of staff working in APs. Residential workers at Crowley House, work 12 hour shifts, and at weekends and during night shifts they are the only staff on duty.

131. On the day of Ms Marshall's death, there was one keyworker and two residential workers on-site. The keyworker left around 5.30pm (before Ms Marshall was breathalysed and became aggressive).

132. The two residential workers were therefore dealing with the escalating issues with Ms Marshall and her flatmate (their drinking, the altercation and violence that followed, and then Ms Marshall's collapse and the flatmate's threat to abscond), and they were also involved in the case of another resident with dementia who had gone missing. They appear to have been overwhelmed by the complexity of the issues they faced.

133. All APs accommodate people assessed as high risk of harm to others. As a PIPE site, Crowley House is also tasked with supporting and managing individuals with complex needs. We question whether the staffing levels at Crowley House the resilience have required to meet the needs and challenges of providing care in this complex operating environment. This is particularly the case during the COVID-19 pandemic when other staff were working at home part of the time, leaving the residential workers alone on-site more often.

134. We recommend:

The Probation Service should review:

- **whether evening and weekend staffing levels at APs are sufficient to support residents safely; and**

- **whether remote working is appropriate in an AP setting.**

Funeral contributions

135. Probation Instruction (PI) 32/2014, the *Approved Premises Manual*, sets out the policy on probation contributions to the cost of funerals for AP residents. It says, “Trusts are required to offer to pay reasonable funeral costs of up to £3,000”.

136. No contribution was offered to Ms Marshall’s next of kin and none of the probation staff we spoke to knew who was responsible for making such an offer. We recommend:

The AP Area Manager should ensure that:

- **when a resident dies in an AP, an offer of financial assistance with funeral expenses is made to the next of kin, in line with policy; and**
- **an offer of financial assistance is now be made to Ms Marshall’s next of kin if this has not already happened.**

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