

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Christopher Ames, a resident at Meneghy House Approved Premises, on 10 February 2019

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 Christopher Ames died of cocaine toxicity in a hotel room on 10 February 2019. He was a resident at nearby Meneghy House Approved Premises (AP). Mr Ames was 38 years old. I offer my condolences to Mr Ames' family and friends.

Mr Ames was released from HMP Garth in December 2018 to live at Meneghy House. He settled well and appeared to be an extremely well-motivated and focused resident who was determined to change his lifestyle. Staff did not suspect that he was using drugs and were all extremely shocked at his death.

I make only one recommendation, that Mr Ames should have been informed on arrival at the AP about his reduced tolerance to drugs and the increased risk of overdose. This should have been recorded, as should later conversations which staff had with him on the subject. However, I am satisfied that this did not impact Mr Ames' death and staff did all they could in the circumstances to support him.

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

October 2019

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Summary

Events

1. On 27 December 2018, Mr Christopher Ames was released on licence from HMP Garth to live at Meneghy House Approved Premises (AP). Mr Ames was serving a prison sentence of 12 years for wounding and robbery.
2. Mr Ames had no health issues, was not prescribed any medication and had no history of self-harm. While in custody, he had successfully completed offending behaviour programmes and engaged in a voluntary drug testing programme. His behaviour had improved throughout his time in prison.
3. Mr Ames settled well at the AP and staff commented that he was the most motivated and focused resident they had met. He completed a forklift truck driver course, volunteered at a food bank, attended the gym regularly and applied for a university course. Mr Ames engaged regularly with his keyworker. Staff had no reason to suspect Mr Ames was not being honest about his whereabouts when he left the AP and they did not have any reason to suspect he was using drugs or drinking alcohol.
4. On 9 February 2019, Mr Ames left Meneghy House at 7.45am saying he was going to the gym. He did not return to the AP in line with his curfew at 11.00pm and staff started recall procedures when they were unable to contact him.
5. On 10 February, police rang AP staff to say that Mr Ames had been found dead in a nearby hotel room.
6. A post-mortem examination found that the cause of Mr Ames' death was cocaine toxicity.

Findings

Substance misuse

7. Mr Ames appeared to be a highly motivated individual who was determined to change his lifestyle, including abstaining from drug misuse and offending.
8. We found that staff could not have been expected to suspect Mr Ames was not being truthful about either his whereabouts or his drug use.
9. However, we are concerned that there is no written evidence that Mr Ames was told about his likely reduced tolerance to drugs and his increased risk of overdose.

Recommendation

- The Manager of Meneghy House should ensure that all new residents are told about their reduced drug tolerance and increased risk of overdose on arrival at the AP. This must be documented during induction, by the offender manager and when discussed during key-working sessions.

The Investigation Process

10. The investigator issued notices to staff and prisoners at Meneghy House, informing them of the investigation and asking anyone with relevant information to contact her. No one responded. She obtained copies of relevant extracts from Mr Ames' probation records.
11. The investigator interviewed three members of staff at Meneghy House on 12 March. She also asked to speak to residents but they did not want to be interviewed.
12. We informed HM Coroner for Cornwall of the investigation. She gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
13. One of the Ombudsman's family liaison officers contacted Mr Ames' parents to explain the investigation and to ask whether they had any matters they wanted the investigation to consider. They asked how Mr Ames had been in the days before his death. We have addressed their question in this report.
14. Mr Ames' parents received a copy of the initial report. They did not make any comments.
15. The initial report was also shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Background Information

Meneghy House Approved Premises (AP)

16. 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.
17. Meneghy House in Camborne, Cornwall, is managed by HM Prison and Probation Service (HMPPS). It has 17 rooms, with capacity for 18 residents. Residents are expected to attend daily compulsory residents' meetings and there is a curfew between 11.00pm and 6.00am. Each resident is allocated a keyworker to oversee his progress and well-being, and to ensure that they adhere to licence conditions and the AP's rules. Probation Service employees are on duty at Meneghy House 24 hours a day.

Previous deaths at Meneghy House

18. Mr Ames' death was the first to occur at Meneghy House.

Key Events

19. In December 2012, Mr Christopher Ames was arrested and remanded into custody for offences of wounding and robbery. In June 2013, he was convicted and sentenced to 12 years in custody. He first became eligible for parole on 26 December 2018.
20. Mr Ames had a long history of drug misuse and was prescribed methadone and subsequently subutex (a synthetic opioid drug) in prison. Mr Ames was also initially prescribed medication for anxiety in prison but subsequently stopped taking this, and used meditation and yoga to improve his mental health.
21. On 16 March 2017, Mr Ames tested positive for cannabis. He later enrolled on the voluntary testing drug programme. There is no evidence that he used drugs in prison after that time. Mr Ames had been working towards an undergraduate degree with the Open University since 2013. His behaviour improved throughout his time in prison.
22. On 27 December 2018, Mr Ames was released on licence from HMP Garth. His licence conditions required him to live at Meneghy House, to comply with appointments with his offender manager, to address his drug use as directed and to comply with drug testing. He arrived at Meneghy House AP at 7.00pm. Mr Ames told staff that he had no medical conditions and had never had thoughts of suicide or self-harm.
23. The Approved Premises Manager said that Mr Ames also received an induction that evening, although this was not recorded. He said that there was no evidence that staff discussed Mr Ames' reduced tolerance to drugs and increased risk of overdose with him, as he would have expected.
24. The next day, staff gave Mr Ames details of local Buddhist centres and Narcotics Anonymous meetings, as he had requested. Mr Ames settled well and was proactive around the AP, assisting with chores. On 31 December, Mr Ames spent the day with his family.
25. On 2 January, an offender manager telephoned Mr Ames. He told her that he was pleased he had resisted drinking alcohol over the New Year. They discussed his plans to attend university. The Approved Premises Manager recalled meeting Mr Ames around this time. They found a suitable gym for him to join, which he attended regularly. Mr Ames also volunteered at the local foodbank.
26. The Approved Premises Manager told the investigator that Mr Ames was the most positive resident he had ever met, and was both focused and well-motivated. He said this continued throughout Mr Ames' time at Meneghy House. He told the investigator that the only concern he had about Mr Ames was whether he was trying to accomplish too much in too short a space of time. He said he never had any concerns that Mr Ames was using drugs or consuming alcohol.
27. On 9 January, Mr Ames met his keyworker for the first time, a probation support officer. This was Mr Ames' keyworker's first day back at work, following leave.

He told the investigator that, as Mr Ames' keyworker, he aimed to meet with him weekly to check on his welfare, make plans for the future and complete any offending behaviour work. He recorded that Mr Ames seemed very motivated not to return to prison. He told the investigator that he discussed Mr Ames' reduced tolerance to drugs with him, although this was not recorded. Mr Ames said he was trying to get a job and wanted to train as a forklift truck driver while he was studying. Mr Ames refused to complete a form about his risk to himself. He told the investigator this was not uncommon due to the personal nature of the questions and he said that he had no concerns that Mr Ames was a risk to himself.

28. On 11 January, an offender manager telephoned Mr Ames and recorded that he was progressing well, volunteering at the foodbank, going to the gym and completing a computing course. On 16 January, Mr Ames' keyworker met with Mr Ames who had completed his application to Falmouth University and was still looking for employment.
29. On 17 January, the offender manager visited Mr Ames. He said that he had not been to a Narcotics Anonymous meeting yet as he had not been tempted to use drugs. She encouraged Mr Ames to attend the meeting while he was feeling positive.
30. On 22 January, Mr Ames told his keyworker that he was enjoying his IT course and was "really happy" with his progress. On 24 January, the offender manager phoned Mr Ames. He had recently spent the day with his family and was happy that his parents were giving him a second chance. Mr Ames said he was not tempted to use drugs or consume alcohol.
31. Mr Ames' keyworker told the investigator that Mr Ames remained focused and increasingly positive during his time at the AP. He never suspected that Mr Ames was drinking alcohol or using drugs. He said he spoke to Mr Ames about his reduced tolerance to drugs and risk of overdose on several occasions, although this was not recorded. Mr Ames was aware of the substance misuse services available in the area and at the AP.
32. On 4 February, the offender manager met Mr Ames. She noted that he remained focused on his goals. Mr Ames told the offender manager that he had been in contact with another prisoner he had met at HMP Channings Wood but they only discussed maths, and that he was a positive influence. Over the following days, Mr Ames continued to go to the gym and finished his forklift driver qualification. On 8 February, a residential worker saw Mr Ames around the AP and recalled nothing out of the ordinary.

Events of 9 February

33. On 9 February, a residential worker saw Mr Ames having breakfast in the dining room. Mr Ames left the AP to go to a shop at 7.20am and returned at 7.40am (residents must sign in and out when they leave the AP). Mr Ames left the AP again at 7.45am. He told the residential worker that he was going to the gym. The residential worker recorded that Mr Ames seemed "absolutely fine". The residential worker told the investigator that he had no concerns about Mr Ames, who had been a very positive resident at the AP and one of the most motivated

he had met in his twelve years working there. The residential worker had no concerns that Mr Ames was drinking alcohol or using drugs and had no reason to question where he was going that morning.

34. A residential worker started work at 8.00am and noted Mr Ames had already left the AP. Mr Ames did not return during his shift. He did not consider this unusual as Mr Ames had left early for the gym the previous weekend and had sometimes stayed out until after 9.00pm.
35. A sessional worker started work at 8.00pm. He noted that Mr Ames had been out of the AP since he left for the gym at 7.45am, which he thought was unusual. When his colleague, a residential worker began work at 10.00pm he mentioned this to her. She suggested that Mr Ames may have spent the day with friends from the gym.
36. Mr Ames had not returned to the AP by 11.00pm in line with his curfew. Staff telephoned his mobile several times over the next 30 minutes but there was no reply. They informed the out-of-hours manager, a senior probation officer. Staff checked with police that Mr Ames was not in their custody and phoned the local hospital to check he was not there. At 11.45pm, as Mr Ames had not adhered to the terms of his curfew, staff started recall procedures.

10 February

37. On 10 February at 2.45pm, police telephoned the AP to inform staff that Mr Ames had died. Mr Ames had been found in a room in a hotel opposite the AP at 1.10pm when he had failed to check out. The member of staff who found him told the 999 operator that Mr Ames was cold and stiff, indicating that he had been dead for some time. Paramedics attended at 1.16pm and pronounced Mr Ames dead. Police also attended. They recorded that a small plastic bag containing white powder was in the room, together with an empty plastic “wrap” in the bin. There was also an empty whisky bottle near Mr Ames.
38. Police watched CCTV at the hotel from 9 February. This showed Mr Ames arriving at the hotel reception at 7.30am and booking a room for two people. He then returned at 8.00am with a holdall. After Mr Ames entered his room, the electronic key records show that no one went in or out of the room. There is no CCTV on that floor of the hotel. When the member of staff tried to open the door at 1.10pm, he found the door of the room had been manually locked on the inside and had to fetch a key to open the door.
39. Police searched Mr Ames’ room at the AP but found nothing of any concern.

Contact with Mr Ames’ family

40. Police in Exeter went to Mr Ames’ mother’s address and broke the news of her son’s death. She told police that she had seen Mr Ames on 8 February and that he had seemed happy and was making plans for the future.
41. On 11 February, the Area Approved Premises Manager telephoned Mr Ames’ mother. He offered his condolences and offered a contribution to Mr Ames’ funeral costs in line with Probation Service policy. He stayed in contact with Mr

Ames' parents over the next few days. On 21 February, Mr Ames parents visited Meneghy House.

Support for residents and staff

42. On 10 February, a senior probation officer, telephoned the AP to check on staff welfare. Residents were also informed of Mr Ames' death.
43. On 14 February, the Area Approved Premises Manager chaired a meeting with staff and residents to discuss Mr Ames' death. Staff and residents were shocked and saddened. the Area Approved Premises Manager offered support and encouraged staff and residents to talk to each other. They discussed an appropriate memorial to Mr Ames. Staff were also offered individual and group counselling.

Information received after Mr Ames' death

44. After Mr Ames' death, a woman told police that she had started an intimate relationship with him in early January after they had met at the gym. She said that Mr Ames had started supplying cocaine to assist with her financial difficulties. Mr Ames told her that he had got some cocaine to sell a week before he died and had taken a small amount himself to test it. She told police that she had spent a day in the Travelodge with Mr Ames in the fortnight before his death but did not know that he had booked a hotel room on 9 February.

Post-mortem report

45. The post-mortem report found that the cause of Mr Ames' death was cocaine toxicity.

Findings

Substance misuse

46. AP staff were unanimous in their praise for Mr Ames and the considerable efforts he was making to change his lifestyle. Mr Ames had a keyworker who he met regularly and several staff tried to assist him with his plans. No one the investigator spoke to had concerns that Mr Ames was consuming drugs or alcohol. All were extremely shocked by his death.
47. The only person who was aware of Mr Ames' cocaine use was his partner at the time. AP staff were both unaware he had a partner (it was a licence condition that he should inform his offender manager if he began an intimate relationship) or that he was allegedly supplying drugs.
48. We are satisfied that staff could not have reasonably been expected to suspect Mr Ames was using drugs or that he was not always honest about his whereabouts when he left the AP. Mr Ames' keyworker said that when residents returned to the AP they had to sign in and there was always someone on the front desk. If staff had any concerns about Mr Ames having consumed alcohol or used drugs, they would have tested him.
49. Probation Instruction (PI) 32/2014, *Approved Premises' Manual*, says that one of the main causes of deaths amongst AP residents is drug overdose, often due to reduced tolerance after release from prison. The PI instructs that on the day of release, the offender manager should make the offender aware of the risks of overdose if the offender returns to using drugs at the same level as before they went into custody. There is no evidence that this occurred.
50. The PI also instructs that this topic should always be covered at induction and advice given to all AP residents on reduced drug tolerance following release from custody. The AP manager told the investigator that he was not convinced this had happened in Mr Ames' case.
51. Mr Ames' keyworker first met Mr Ames on 9 January. He told the investigator that he spoke to Mr Ames several times about his reduced tolerance to drugs and increased risk of overdose. This was not documented.
52. The AP manager told the investigator that he planned to create a checklist for people who arrived at the AP, to ensure they had been given all the necessary information including that about reduced tolerance to drugs and the risk of overdose.
53. Aside from this, staff spoke to Mr Ames several times about his past substance misuse and how he was feeling about it at the time. Mr Ames told them that he was not tempted to use drugs but staff encouraged him to attend the local Narcotics Anonymous Group anyway. He was also made aware of the alcohol support services provided at Meneghy House.
54. We make the following recommendation:

The Manager of Meneghy House should ensure that all new residents are told about their reduced drug tolerance and increased risk of overdose on arrival at the AP. This must be documented during induction, by the offender manager and when discussed during key working sessions.

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