Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ryan Daley, a resident at St Joseph's Approved Premises, on 22 June 2019

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.

Mr Ryan Daley died on 22 June 2019 of cardiac failure at St Joseph's Approved Premises (AP). He was 30 years old. I offer my condolences to Mr Daley's family and friends.

Mr Daley was found dead in bed at the morning check of residents. The post-mortem found that he had used cocaine as well as taking his prescribed medication, although none of the drugs were present in excess. The pathologist gave the cause of death as cardiac failure due to cocaine use.

My investigation into the death of a man at St Joseph's in April 2019 identified learning for the AP about regular drug testing and more urgency in summoning emergency services. I am pleased to see that neither of these issues resurfaced in this investigation. However, I am concerned about the efficacy of the drug testing kits available at St Joseph's and I make a recommendation to support a national review of the quality and reliability of these and a single substance misuse strategy for all APs.

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 **May 2022**

Contents

Summary

Events

1. Mr Ryan Daley had a history of substance misuse, anxiety and depression. In February 2019, a psychiatrist in HMP Manchester diagnosed him with paranoid schizophrenia.

2. On 24 May 2019, Mr Daley was released on licence from Manchester and was required to live at St Joseph's Approved Premises. He was prescribed olanzapine (an anti-psychotic), venlafaxine and mirtazapine (antidepressants), propranolol (for anxiety), co-codamol (a painkiller) and naproxen (an anti-inflammatory).

3. On 25 May, Mr Daley collapsed in his room and was taken to hospital. Staff discovered that he had been overprescribed co-codamol and venlafaxine, and he admitted in hospital that he had taken double his dose of venlafaxine because he was anxious after his release from prison. As a result, Mr Daley was not allowed any medication in possession and was subject to daily room searches. He was also regularly tested for alcohol and drugs.

4. On 1 June, a member of staff found vials of growth hormone and syringes in Mr Daley's room and confiscated them. He received a warning. On 3 June, Mr Daley told the AP's community psychiatric nurse (CPN) that he had stopped taking his venlafaxine because he did not like the side-effects. His medication record indicated he continued to take it.

5. On 11 June, Mr Daley told his psychiatrist that his medication was not controlling his anxiety. On 16 June he tested negative for alcohol. On 17 June, staff suspected Mr Daley had smoked cannabis. He denied doing so and the results of a drug test were inconclusive. On 19 June, staff found evidence that Mr Daley had smoked cigarettes in his room. On 20 June, he told the CPN that he did not think his medication was working.

6. On 21 June, night staff checked Mr Daley at 11.12pm. The next morning at 10.34am, another member of staff found Mr Daley unresponsive in bed during the morning check. Staff did not attempt to resuscitate Mr Daley as he had obviously died and there were signs of rigor mortis. Paramedics attended and at 10.54am, they confirmed that Mr Daley had died.

7. Toxicology results showed Mr Daley had taken cocaine before he died. The pathologist concluded that Mr Daley died from cardiac failure due to cocaine use.

Findings

8. The decision to remove Mr Daley's prescribed medication from his possession after he was found to have taken more than the prescribed dose was appropriate.

9. The decisions to search his room and drug test him regularly were appropriate. He was drug tested and his room searched in line with, or more regularly than, the frequency specified on his probation licence.

10. We are concerned that the drug testing kits at St Joseph's AP are unreliable and not fit for purpose.

11. We consider that the decision not to attempt to resuscitate Mr Daley was appropriate and in line with National Resuscitation Council guidance.

Recommendations

- The National Approved Premises Team should review the quality and reliability of the drug testing kits available in St Joseph's AP and provide them with effective means to test for a wide range of substances including some prescription drugs and psychoactive substances.

The Investigation Process

12. The investigator issued notices to staff and residents at St Joseph's AP informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

13. The investigator obtained copies of relevant extracts from Mr Daley's prison and probation service records. Another investigator took over the investigation after the original investigator left the PPO. The investigator obtained Mr Daley's mental health records, spoke to four staff by telephone and watched CCTV from the AP.

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

15. Our family liaison officer wrote to Mr Daley's mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She had many concerns about Mr Daley's medication and management that we have answered in the report and in separate correspondence. We have sent her a copy of this report.

Background Information

St Joseph's Approved Premises

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. St Joseph's Approved Premises has 29 beds and is one of six approved premises in Greater Manchester. Each resident is allocated a key worker/offender supervisor to oversee their progress and wellbeing and to ensure that they adhere to licence conditions and the premises' rules. Probation Service employees are on duty at St Joseph's 24 hours a day.

18. St Joseph's has an on-site mental health team, employed by Greater Manchester Mental Health Foundation Trust. A mental health worker is on site at St Joseph's, Monday to Friday, during normal office hours, with consultant psychiatrists visiting to see those residents under their care.

Previous deaths at St Joseph's Approved Premises

19. Mr Daley is the fourth resident to die at St Joseph's since 2016. The investigations into the first two of these deaths indicated that illicit drug use had been an issue but was not directly linked to the deaths. In our investigation into the death of a resident in April 2019, we found that when he was suspected of using illicit drugs, he was not tested or challenged. In the same investigation we found that staff did not contact emergency services promptly or attempt basic life support.

Key Events

20. Mr Ryan Daley had a history of steroid, cannabis and amphetamine misuse, social anxiety, depression and attempted suicide and self-harm.

21. On 26 May 2015, he was sentenced to 60 months in prison for sexual assault. He was released on licence from prison in June 2017. In December 2017, he was recalled to HMP Manchester. He worked with the mental health team and was diagnosed with paranoid schizophrenia by a prison psychiatrist in February 2019.

22. On 24 May 2019, Mr Daley was released on licence and was required to live at St Joseph's AP as part of the conditions of his release. He was prescribed olanzapine (an anti-psychotic), venlafaxine, mirtazapine (both anti-depressants), propranolol (for anxiety), co-codamol (a pain killer) and naproxen (an anti-inflammatory).

23. On 24 May, Mr Daley reported to his offender manager at her office at 12.30pm as instructed. She went through the conditions of his licence with him and told him to go straight to St Joseph's. At 5.00pm, St Joseph's informed the offender manager that Mr Daley had not arrived. She said that Mr Daley had some cognitive difficulties and might have been confused by the 9.00pm curfew time. She said that she thought it likely that he had gone to visit his mother. They decided to give him the benefit of the doubt and call the police if Mr Daley did not arrive by the 9.00pm curfew.

24. Mr Daley arrived at St Joseph's at 8.50pm. He received a brief induction and he handed in his medication. A urine test showed he had not consumed alcohol.

25. Mr Daley's AP management and engagement plan included the following requirements:

    - to remain in the AP between 9.00pm and 7.00am;
    - be subject to weekly alcohol testing, alcohol testing on suspicion and random and on suspicion drug testing;
    - have fortnightly room searches (for evidence of drug/alcohol use, misuse of prescription medication and evidence of relationships with females); and
    - attend weekly supervision sessions with his Probation Service Officer.

26. At about 10.00am the next morning a residential worker found Mr Daley on his back on the floor by his sink with a cigarette lighter next to him. She woke him up, checked for signs of injury and found none. She left the room to ask a colleague to call the NHS advice line. When she returned, Mr Daley was standing up wearing his coat and with his bag on his shoulder as if he was about to go out. Mr Daley denied taking any illicit substances.

27. As they were talking, Mr Daley appeared to have a fit and fell backwards hitting his head. The residential worker checked his airway and asked for an ambulance. Mr Daley was unconscious, breathing heavily and bleeding from the

mouth. He regained consciousness after paramedics arrived, but appeared confused, so they took him to Salford Royal Hospital. Staff searched his room and found 24 empty sachets of co-codamol and an empty sachet of venlafaxine that should have contained eight tablets. A subsequent investigation found that the pharmacist had given Mr Daley more than the prescribed amount of his medication, but he had not disclosed this to staff.

28. At 5.45pm, the hospital called St Joseph's to say that they were discharging Mr Daley. They said were concerned at the high level of venlafaxine in his blood and had issued him a new prescription for a lower dose. Mr Daley had admitted to taking double his prescribed dose because he said that he was anxious. Mr Daley's mental health records showed that the hospital referred him to the first fit clinic, but we do not think he had an appointment there before he died.

29. Staff offered to order Mr Daley a taxi back to St Joseph's, but he said he wanted to visit a friend first. He returned to St Joseph's that evening.

30. A Senior Probation Officer (SPO) on duty decided that Mr Daley's suitability for having medication in possession should be assessed and his room should be searched daily.

31. On 26 May, Mr Daley told a residential worker that he had no recollection of the events of the previous day between waking up and being discharged from hospital. He said he had only had fits since beginning venlafaxine. He was unable to give a satisfactory explanation for the empty co-codamol sachets found in his room. The risk assessment requested by the residential worker identified that Mr Daley should not have any of his medication in possession. This meant that AP staff would hold the medication and give it to Mr Daley as required.

32. A residential worker was allocated as Mr Daley's keyworker and met him on 28 May. She issued him with a hostel warning for not handing in all his medication when he first arrived at the hostel. She reminded him that he needed to prioritise registering with a GP and claiming his benefits. Mr Daley said that he was keen to access the mental health support available at St Joseph's and to have home visits with his mother and brother. They discussed the effects of illicit substances on his mental health, and she reiterated that Mr Daley would be subject to regular drug and alcohol tests.

33. On 1 June, a residential worker found vials of human growth hormone and syringes during the daily search of Mr Daley's room. These were confiscated and Mr Daley was issued with a Senior Probation Officer's warning for storing prescription drugs in his room.

34. Mr Daley's hostel medication record showed that he forgot to take all of his medication on 28 May and refused his venlafaxine on 29 May.

35. On 3 June, Mr Daley met the AP's community psychiatric nurse (CPN). She said that Mr Daley was pleasant, quiet, likeable and motivated to work with her. Mr Daley told her he had stopped taking his venlafaxine because of the side-effects. (His medical record only showed he had not taken it on 28 and 29 May.) Mr Daley was tested for alcohol and his results were negative.

36. On 4 June, Mr Daley visited his offender manager as planned. Mr Daley's hostel medication record showed that on 6 and 8 June he fell asleep and forgot to take his olanzapine and mirtazapine. On 9 and 10 June, his record showed he refused to take his venlafaxine because he thought it caused him to have fits. Staff searched his room every day as planned but as they did not find anything illicit, and the searches were reduced to every other day. There is nothing on the record to show that Mr Daley continued to refuse his venlafaxine after 10 June.

37. On 11 June, a consultant forensic psychiatrist reviewed Mr Daley. He said that Mr Daley appeared very anxious and preoccupied. Mr Daley told the psychiatrist that he had ongoing subtle paranoid symptoms and said that he had experienced more significant symptoms in the past. He said his prescribed dose of mirtazapine did not contain his anxiety. The psychiatrist said he thought Mr Daley was under strain because he had just moved to St Joseph's. They spoke about the benefits of ongoing psychological support and the effects of using olanzapine and mirtazapine in combination on weight gain and heart problems. Mr Daley blamed a recent epileptic fit on this combination. The psychiatrist said that Mr Daley appeared to understand the benefits of non-medical interventions to reduce his anxiety.

38. On 12 June, Mr Daley did not attend a scheduled keyworker session. On 13 June his room was searched, and nothing was found. On 16 June, he was tested for alcohol and the test came back negative.

39. On 17 June, staff reported a strong smell of cannabis near Mr Daley's room. A residential worker checked Mr Daley after she heard him have a coughing fit and noted that his room smelled strongly of cannabis. The next morning at 7.30am, she noted that Mr Daley's room smelled of vomit. Mr Daley was awake and said that he was ok.

40. A residential support worker spoke to Mr Daley at 8.30am. He denied having taken anything illicit but there was evidence he had been sick in his room and she said he appeared to be under the influence of something. Two staff spoke to Mr Daley at 9.00am. He again denied he had taken anything illicit. They decided to search his room and test Mr Daley for drugs. They also asked his offender manager to test him at her office because the AP testing kits were not as comprehensive.

41. The drug test at St Joseph's is a six-panel oral swab that tests for opiates, cocaine, benzodiazepines (tranquilisers), methamphetamine and cannabis. Mr Daley's test result that day was "undetermined". On 19 June, staff searched Mr Daley's room again, and found clear evidence that he had been smoking cigarettes, as two Coca-Cola cans had been used as ashtrays.

42. On 20 June, Mr Daley met the CPN again. She said that he appeared fine, had no symptoms of psychosis and was not intoxicated. Mr Daley said he did not like spending time in the communal areas of the AP but had started going to the gym with a friend he had met in prison and was enjoying it. He said that he did not think that his medication was working. She felt he was very focussed on asking for diazepam (a tranquiliser used to treat anxiety and muscle spasms) and pregabalin (used to treat epilepsy and anxiety), both drugs which are abused and illicitly traded. She planned to see Mr Daley again the following week.

43. The AP check sheet for 21 June showed Mr Daley was in the AP for the 11.00am, 8.30pm and 11.00pm checks but was out for the 4.00pm check. (Since Mr Daley's death the AP has introduced an extra check at 2.00pm.)

44. At 9.30pm on 21 June, a residential worker arrived for the night shift. He said two residents were on suicide and self-harm monitoring checks every hour and no concerns were handed over to him about Mr Daley. CCTV showed he checked Mr Daley at 11.12pm. He said that if a resident appeared to be asleep, he made a visual check of their face and neck to check they were breathing. He made landing checks at 2.00am, 4.00am 5.00am and 6.00am. As it was a weekend morning there was no 7.30am residents' check. He handed over to day staff at 7.45am.

Saturday 22 June

45. At 10.30am, a residential worker started the morning check of every resident. CCTV showed that at 10.34am she knocked on Mr Daley's door and went in. Mr Daley was lying on his back on the bed with his head propped up on the wall. She said there was a "purple rash" on his face.

46. The residential worker said she shouted at Mr Daley to try to get a response and shook him. He was cold to the touch. She used her mobile phone to call for an ambulance and pressed her personal alarm to alert other staff. Her colleague arrived a minute later and checked for a pulse. He said that Mr Daley had vomit around his mouth, was very stiff and appeared to have been dead for several hours.

47. Paramedics arrived at 10.54am and confirmed that Mr Daley had died.

48. The patient report form noted rigor mortis and hypostasis (pooling of blood – one of the signs that someone has died) were present. They found white powder on the chest of drawers next to Mr Daley's bed, and said he appeared to have been eating a packet of crisps when he died (as there was a packet in his lap and food in his mouth).

Contact with Mr Daley's family

49. The police, who arrived shortly after the paramedics, told Mr Daley's next of kin in person that he had died. The hostel manager was on leave at the time, but the out of hours Assistant Chief Officer (ACO) contacted Mr Daley's next of kin and invited them to visit the hostel. The family collected Mr Daley's property on 23 June 2019.

Support for residents and staff

50. Residents and staff received support following Mr Daley's death. Staff ensured that staff and residents had the opportunity to talk about what had happened individually or as a group.

Post-mortem report

51. Toxicology tests showed Mr Daley had taken venlafaxine, mirtazapine, propranolol, olanzapine, codeine and paracetamol in amounts consistent with therapeutic use. These drugs were all prescribed to him. Tests also showed Mr Daley had taken cocaine in a concentration consistent with recreational use and not an excess. He had also drunk alcohol, but not to excess, and may have used cannabis. The pathologist concluded that Mr Daley died from cardiac failure due to cocaine use.

Findings

Substance misuse risk management

52. Our Learning Lessons Bulletin, *Approved Premises – Substance Misuse*, published in 2017, discusses the importance of effective testing of AP residents for drug use. The current AP Manual says that testing known drug users on arrival, or when they are suspected of renewed substance misuse, is a targeted and prudent use of resources. It says that staff should have discretion to test residents if there is a reasonable suspicion of substance misuse, and that accepting this regime is a condition of living in APs.

53. We consider that the decision to remove Mr Daley's medication from his possession after he took more than the prescribed dose was appropriate. The decision to test him regularly and search his room was also appropriate. We are satisfied that St Joseph's did everything that they're allowed to do to monitor and manage Mr Daley's medication and ensure he complied with the terms of his licence.

54. We are concerned about the efficacy of the drug testing kits available to St Joseph's. Several staff mentioned that they were ineffective, often failed to work and did not test for some substances that are increasingly prevalent (particularly psychoactive substances). The investigator was told by staff that the tests had sometimes returned negative results even when the resident tested had admitted to taking drugs. In this case, Mr Daley's test result on 18 June was 'undetermined' despite strong evidence that he had smoked cannabis in his room. The hostel manager told the investigator that she and her staff had raised concerns that their drug testing kits were not effective. Sometimes the pink lines that showed the result of the test were not visible and this was the case for Mr Daley's test.

55. In common with other APs, a high number of residents at St Joseph's have substance misuse issues and abstinence from illicit substances is a standard condition of their probation licence and their residence in the AP. APs do not have the same powers as prison staff to search residents and are limited to searching rooms and asking residents to empty their pockets. It is therefore crucial that staff in APs are provided with the means to ensure effective drug testing.

56. The hostel manager told the investigator that the National Approved Premises Team are undertaking a review of drug tests in APs with a focus on quality and reliability. The same team are in the process of devising a single substance misuse strategy for all APs to adhere to. We welcome this initiative and support it with the following recommendation:

    The National Approved Premises Team should review the quality and reliability of the drug testing kits available in St Joseph's AP and provide them with effective means to test for a wide range of substances including some prescription drugs and psychoactive substances.

Resuscitation

57. European Resuscitation Council Guidelines for Resuscitation 2015 say, "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile". The guidelines define examples of futility as including the presence of rigor mortis. The British Medical Association (BMA), the Royal College of Nursing (RCN) and the Resuscitation Council (UK) issued guidance in October 2014 on making appropriate decisions about resuscitation. The guidance says that every decision should be made on the basis of a careful assessment of an individual's situation. Trying to resuscitate someone who is clearly dead is distressing for staff and undignified for the deceased.

58. We are satisfied that Mr Daley showed more than one sign of rigor mortis and the decision not to try to resuscitate him was appropriate. We make no recommendation.

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