

**Prisons &
Probation**

Ombudsman
Independent Investigations

**Independent investigation into
the death of Mr Jamie Bennett,
a resident at
Norfolk Park Approved Premises,
on 2 May 2020**

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 Jamie Bennett died from heroin and cocaine toxicity in his room at Norfolk Park Approved Premises on 2 May 2020. He was 33 years old. I offer my condolences to his family and friends.

Mr Bennett was released from HMP Moorland on 1 May and had been at Norfolk Park for less than 24 hours before he was found dead in his room.

While in custody, Mr Bennett had successfully stopped taking opiate drugs, and there was no evidence to indicate that he had recently used drugs in prison. I am satisfied that staff at Norfolk Park had no reason to suspect that Mr Bennett was taking illicit drugs and that they could not reasonably have predicted or prevented his death from a drug overdose.

I do, however, have some concerns.

Staff at Norfolk Park did not discuss Mr Bennett's increased risk of an overdose with him. This is unlikely to have affected Mr Bennett's choices following his release as he had been advised about the risk earlier that day before he left prison, but AP staff should make sure that newly released prisoners understand that their tolerance to drugs is likely to have reduced while they have been in prison.

I am very concerned that staff at Norfolk Park did not perform an adequate welfare check on the morning of Mr Bennett's death and that it was only when another resident raised concerns, that the already delayed midday check took place and Mr Bennett was found. We cannot say whether Mr Bennett was still alive at the time of the morning check and whether a more thorough check might therefore have identified he was unwell and needed urgent medical assistance. However, effective welfare checks are essential and may make a critical difference in a medical emergency.

I am also concerned that the emergency response was poor and that some of the staff on duty in the AP had not received training for their role.

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

November 2021

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Summary

Events

1. Mr Jamie Bennett had no significant health issues, was not prescribed any medication and had no history of self-harm. He had a history of substance misuse in the community, but he had successfully stopped taking drugs while in custody and there is no evidence that he had used drugs in prison in the seven months before his release.
2. On 1 May, Mr Bennett was released on licence from HMP Moorland to Norfolk Park Approved Premises (AP). Mr Bennett left the premises on two occasions that day but complied with his curfew conditions and staff had no concerns about him during the short time that he was at the AP.
3. On 2 May, a member of staff carried out a welfare check of residents at about 7.00am and reported that Mr Bennett was asleep in bed. At 1.30pm, staff found him unresponsive in his room. The emergency services were called but when paramedics arrived, they pronounced that Mr Bennett had died.
4. Evidence of drug use was found in Mr Bennett's room. A post-mortem examination found that Mr Bennett died from heroin and cocaine toxicity and that he had also used cannabis before his death.

Findings

5. Mr Bennett appeared to have been determined to change his lifestyle, including abstaining from drug misuse, on his release from Moorland. He had been at Norfolk Park Approved Premises for less than 24 hours before his death.
6. We are satisfied that staff at Norfolk Park had no reason to suspect that he might be using illicit drugs, and there was therefore no reason for them to conduct a room or bag search. We found that staff at the AP could not have predicted or prevented Mr Bennett's death from a drug overdose.
7. However, we are concerned that Mr Bennett was not told about his likely reduced tolerance to drugs and his increased risk of overdose when he arrived at Norfolk Park and that the AP had no local substance misuse policy.
8. We are also concerned with the quality of the welfare checks on the morning of Mr Bennett's death. We consider it is essential that staff check for signs of life during welfare checks. This did not happen at the 7.00am check and staff at Norfolk Park did not carry out a midday check, as they should have done. We cannot say when Mr Bennett died or whether the outcome might have been different if the 7.00am check had been performed effectively.
9. We also consider that the AP staff showed poor judgement during the emergency response. They did not act with urgency and failed to call an ambulance as soon as they found Mr Bennett unresponsive. We are also concerned that the staff on duty did not have emergency first aid training.
10. Mr Bennett died during the early phase of the COVID-19 pandemic. We recognise that the pandemic caused staffing difficulties at Norfolk Park because

some of the staff who normally worked there were unable to work and were replaced by temporary staff. Nevertheless, we are concerned that some members of staff did not receive adequate training and induction before starting work at the AP.

11. There was also some unfortunate confusion about Mr Bennett's young son visiting Norfolk Park after his father's death. The visit was initially approved but when he arrived at the AP, he was told permission had been withdrawn. Although we do not criticise the decision not to allow the visit, the confusion caused unnecessary distress for Mr Bennett's family.

Recommendations

- **The Approved Premises Area Manager and Approved Premises Manager should ensure that staff have an audited discussion with new residents about reduced drug tolerance post-release during the induction process and that residents receive written information about drug tolerance issues.**
- **The Head of Public Protection for North East Approved Premises Area should ensure that all approved premises have a local substance misuse policy in place, including procedures for requesting substance misuse tests and room searches in line with the requirements of the Approved Premises Manual.**
- **The Head of Public Protection for North East Approved Premises Area and the Approved Premises Manager should ensure that:**
 - **staff understand the importance of welfare checks to ensure the wellbeing of residents;**
 - **guidance is provided on what signs or engagement from the resident would be acceptable to confirm they are safe and well during a welfare check; and**
 - **welfare checks are completed when scheduled.**
- **The Head of Public Protection for North East Approved Premises Area and the Approved Premises Manager should ensure that staff:**
 - **do not leave residents in life-threatening situations;**
 - **call the emergency services immediately in response to life-threatening incidents, including when a resident is found unresponsive; and**
 - **always carry a radio or another form of communication so emergency assistance can be sought promptly.**
- **The Head of Public Protection for North East Approved Premises Area and the Approved Premises Manager should ensure that there is always appropriate cover by staff who are fully trained in first aid and the use of emergency equipment.**

- **The Head of Public Protection for North East Approved Premises Area and the Approved Premises Area Manager should ensure that all staff, including agency staff, are fully inducted before starting work and have signed to confirm they have read the AP's health and safety manual.**
- **The Head of Public Protection for North East Approved Premises Area and the Approved Premises Area Manager should ensure that AP staff know how to dispose of suspected drugs safely.**
- **The Approved Premises Area Manager should ensure that a copy of this report is shared with all staff named in this report and that a senior manager discusses the Ombudsman's findings with them.**

The Investigation Process

12. The investigator issued notices to staff and residents at Norfolk Park Approved Premises, informing them of the investigation and asking anyone with relevant information to contact him.
13. The investigator obtained copies of relevant extracts from Mr Bennett's prison, probation records and medical records.
14. The investigator interviewed seven members of staff at Norfolk Park Approved Premises and one from HMP Moorland. He also wrote to a resident at Norfolk Park, asking to interview him but received no response. He also wrote to a former member of staff, but he declined to be interviewed. (His employment at Norfolk Park was terminated shortly after Mr Bennett's death.)
15. We informed HM Coroner for South Yorkshire (West) District of the investigation. He gave us the results of the post-mortem examination. We have sent him a copy of this report.
16. We contacted Mr Bennett's family to explain the investigation and asked if they had any matters they wanted us to consider. They asked about:
 - the substance misuse support that Mr Bennett received at HMP Moorland;
 - Mr Bennett's movements and interactions with staff at Norfolk Park on the day he arrived and why he was allowed to leave the approved premises;
 - the welfare and health and safety checks that staff carried out at Norfolk Park;
 - the actions of staff when Mr Bennett was found; and
 - the cancellation of his son's visit to Norfolk Park.

We have addressed these issues in this report.

17. Mr Bennett's family received a copy of the initial report. The solicitor representing Mr Bennett's family wrote to us raising a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

Background Information

Norfolk Park Approved Premises (AP)

18. Approved premises (formerly known as probation and bail hostels) accommodate offenders released from prison on licence and those directed to live there by the courts as a condition of bail. Their purpose is to provide an enhanced level of residential supervision in the community, as well as a supportive and structured environment, for offenders who have been released from prison. While residents must comply with their individual licence or bail conditions, curfews and the AP's rules, they are essentially free to come and go from the building.
19. Norfolk Park in Sheffield is the largest of three approved premises managed by the then South Yorkshire Probation Trust. It has accommodation for up to 32 residents arranged over three separate areas and has communal areas for dining and socialising and areas set aside for group work. Residents are provided with breakfast and lunch and can make their own evening meal from food provided by the AP. A curfew operates between 11.00pm and 7.00am
20. Room searches are carried out at random and if staff suspect that residents have stolen property or have illicit drugs or alcohol in their rooms. There are several CCTV cameras in communal areas which are monitored from the main office. AP staff carry out daily health and safety and welfare checks on residents at various times throughout the day and evening.
21. The AP is staffed 24 hours a day by probation employees. Each resident is allocated a key worker responsible for discussing their progress and well-being with them. The key worker also helps to ensure that residents adhere to their individual licence conditions and the rules of the AP.

Previous deaths at Norfolk Park

22. We have investigated three previous deaths at Norfolk Park. The last death was in 2013. One resident had died from natural causes, and the other two involved residents who had used drugs before their death. There were no issues similar to the circumstances of Mr Bennett's death.

Key Events

Background

23. Mr Jamie Bennett had numerous convictions for theft, burglary and possession of drugs, and had served time in prison. In May 2019, he was recalled to prison for breaching his licence conditions.
24. Mr Bennett had a history of substance misuse but completed a methadone detoxification programme in custody.

HMP Moorland

25. On 20 September 2019, Mr Bennett was transferred to HMP Moorland. There is no evidence that Mr Bennett used drugs at Moorland in the seven months before his release. A worker from the substance misuse team knew Mr Bennett from a previous period in custody and said he was completely different during this sentence and had 'turned himself around' and had said he did not want to use drugs anymore.
26. Before his release, it was noted that Mr Bennett showed a willingness to address his offending behaviours and comply with future licence conditions. A recommendation was made for Mr Bennett to live at an approved premises so he could receive closer supervision and community substance misuse support.
27. On 24 February, Mr Bennett told the substance misuse team worker that he intended to remain drug-free when he was released and that he was "sick of coming in and out of prison". He explained to Mr Bennett the substance misuse risks he would face on release, including a low tolerance for drugs after a period of abstinence, contaminated drugs, symptoms of alcohol poisoning and what to do in the event of an overdose. He said that Mr Bennett understood this advice.
28. On 15 April, it was confirmed that Mr Bennett would be released on licence to Norfolk Park Approved Premises (AP). On 1 May, a nurse saw Mr Bennett before his release from Moorland. The nurse raised no concerns about his fitness to be released, noted that he was not taking any medication, and that he reported no mental health issues and had no thoughts of self-harm.
29. The substance misuse team worker also saw Mr Bennett before his release. He again explained the risks of taking illicit substances, gave advice about drug tolerance levels, symptoms of overdose and alcohol intoxication. Although Mr Bennett had declined a referral to community drug support services, the team worker told him where he could access them if he needed them. The team worker also offered Mr Bennett naloxone and explained how the medication should be used in the event of an opiate overdose. Mr Bennett declined to take the drug with him. (Naloxone is a medication used as an emergency antidote for overdoses caused by heroin and other opiates. It is used to counter the life-threatening effects of depressed breathing in an opioid overdose and is administered to provide a window of time in which to seek further emergency assistance. It does not need to be administered by a medical professional.)

Norfolk Park Approved Premises

1 May 2020

30. On 1 May, Mr Bennett arrived at Norfolk Park AP. A residential worker gave him information about the AP, including the AP's rules, and the additional rules during the COVID-19 lockdown (about social distancing and only leaving the AP for specific reasons, such as shopping and medical appointments). Mr Bennett told him that he was "feeling good" about his stay at Norfolk Park and had no thoughts of self-harm.
31. A Probation Service officer introduced herself to Mr Bennett at lunchtime. Mr Bennett told her that he wanted to open a bank account so he could sort out his benefits. She gave him a letter of identification for this purpose. She noted that Mr Bennett had showed a positive and proactive start in wanting to organise his finances on the day of his release. She said that she agreed to help him with his benefit claim after the weekend.
32. At 12.23am, Mr Bennett left Norfolk Park with another resident, who Mr Bennett already knew, and returned at about 2.00pm. A Probation Service officer said that he saw Mr Bennett in the AP's dining area shortly after he had returned to the AP. He said that he and Mr Bennett ate a meal together and talked about the COVID-19 pandemic and how the food at the AP was better than in prison and discussed Mr Bennett's wish to visit his mother's grave the following week. He said that Mr Bennett told him that he was pleased to be out of prison, raised no concerns with him and showed no signs of intoxication.
33. At around 4.00pm, a sessional residential worker introduced himself to Mr Bennett and asked if he had settled in. Mr Bennett raised no issues and the residential worker said there was no indication that he was under the influence of drugs. He said that Mr Bennett appeared bright, cheerful and engaging and that during the afternoon, he left the building several times to go into the AP's grounds.
34. Mr Bennett left the AP again at 6.10pm, telling the sessional residential worker that he was going to buy some toiletries. Mr Bennett returned to the AP at 6.55pm with another resident. After Mr Bennett's death, that resident told police that he knew Mr Bennett from prison, and that he had left the AP with him during the evening and sat on benches in the AP's grounds chatting to him.
35. At 8.00pm, a Sodexo night residential worker started his shift. He said that he was told at the handover that Mr Bennett had arrived at the AP that day, had received an induction and was 'fine'. He said that Mr Bennett did not turn up for his evening meal and that he did not see him that evening, other than on the AP's CCTV.
36. A resident told police that he spoke with Mr Bennett in his room during the evening but that they had left the door open. He said that Mr Bennett did not appear under the influence of drugs but seemed in good spirits. He said that he was aware that Mr Bennett had previously used crack and heroin. He said that Mr Bennett had said nothing about buying drugs.

37. The sessional residential worker checked that Mr Bennett was in the AP at his curfew time of 9.00pm. He noted that Mr Bennett had been in the AP well before the 9.00pm curfew and seemed to have settled well.
38. A sessional residential worker who was in charge that evening, arrived at around 9.30pm for her night shift. She said that at around 9.45pm, she received an oral handover in which she was told that Mr Bennett had arrived earlier in the day, appeared to have settled in, knew a couple of the residents and had raised no concerns. She said that although she did not see Mr Bennett in person that evening, she saw him on CCTV a couple of times, wearing a dressing gown outside his room on the landing of the top floor of the AP.
39. CCTV shows that Mr Bennett left his room to take a shower at around 9.50pm. At 10.20pm, a resident knocked on Mr Bennett's door and, at 10.26pm, Mr Bennett left his room for a cigarette and returned at 10.36pm.
40. At around 11.04pm, the sessional residential worker went to Mr Bennett's room to carry out a welfare check. She knocked on his door and Mr Bennett opened it. She asked him if he was settling in and he told her he was and was fine.

2 May 2020

41. Shortly afterwards, Mr Bennett went to the toilet, and the sessional residential worker saw this on CCTV. CCTV footage shows that Mr Bennett went to the toilet just after midnight and again at around 1.00am, after which he returned to his room. No one entered or left Mr Bennett's room until a welfare check was carried out later that morning. (A sessional residential worker who reviewed the CCTV footage, said that Mr Bennett never seemed unsteady on his feet, under the influence, disorientated or in discomfort at any point.)
42. At 7.04am, the Sodexo night residential worker went to Mr Bennett's room to carry out a welfare check. He said that he opened the door and stood in the doorway. He said he could see that Mr Bennett was lying in his bed, with the bedding pulled up to his neck. He said he thought that Mr Bennett was asleep and saw no sign that he was not breathing or had died. He said he had no concerns, saw nothing suspicious in the room, such as drug paraphernalia, and had not noticed that Mr Bennett had covered the smoke detector with a sock.
43. The sessional residential worker said that when the Sodexo night residential worker returned to the office at about 7.10am, she asked him if everything was okay, and she said he confirmed that it was. She said she and he gave a handover to a residential worker and a trainee probation officer who had volunteered as a sessional support worker during the COVID19 pandemic. They had arrived to start their day shifts at around 7.45am.
44. The residential worker and the trainee probation officer said that it was confirmed at the handover that the 7.00am checks had been completed and that no concerns about Mr Bennett were raised. The night sessional residential worker confirmed the handover in an email and noted that Mr Bennett had raised no issues, appeared to have settled well and knew a few of the residents at the AP.

45. The day residential worker said that he then started to complete the tasks allocated to him. The trainee probation officer had a similar task list, which included carrying out the midday health and safety check.
46. The trainee probation officer said that between 8.00am and midday, she remained in the AP's office answering queries from residents and providing support. She said that she did not see Mr Bennett that morning.
47. The residential worker said that he was surprised to learn from the trainee probation officer that morning that she had not received any training or induction for working in the AP. He said that she told him that she was going to catch up on her offender management work, including watching training presentations, unrelated to the AP.
48. The trainee probation officer said that just before midday, she asked the residential worker if they were to complete the midday health and safety check and welfare check. She said that he told her that it would not be necessary, and she took her lead from him. She said that she had only completed four previous shifts at Norfolk Park and that she did not question him and assumed that his response was in line with COVID-19 procedures. She said that she had previously been on shifts at the AP where checks had not been completed as stringently as she would have expected as residents had presented to the office or had been seen in communal areas.
49. The residential worker said that at around 12.45pm, the trainee probation officer asked him if there was anything that she needed to do. He said he told her that he would add her health and safety check to his tasks if she did not know how to do them and that she thanked him for this. He said he then noticed that she had not moved and was still watching a probation presentation. He said that he intended to complete the checks once he had finished the task he was completing. He said that this did not delay him by more than a few minutes.
50. At 1.30pm, CCTV shows that a resident knocked on Mr Bennett's door but got no response. He left a minute later, went to the AP office and asked the residential worker and the trainee probation officer to check if Mr Bennett was okay. The residential worker said that although the health and safety check was not on his task list, he agreed to do it because the trainee probation officer did not know how to do them. He said that he did not feel supported by the trainee probation officer as she appeared to be unaware of the duties on her task list and this had an impact on him completing his own work.
51. The trainee probation officer said the resident came to the office and told her and the residential worker that Mr Bennett was not answering his bedroom door and that Mr Bennett's sister had also tried to ring her brother but had been unable to get a response. The residential worker told the resident that he would check Mr Bennett first when he started the checks.
52. At 1.33pm, the residential worker went to Mr Bennett's room, opened the door and went in. He said that when he opened the door, he immediately realised that something was wrong as Mr Bennett looked pale and blue in colour. Mr Bennett did not respond when he called his name and he said that when he stepped into

- the room, he could see that Mr Bennett's chest was not moving. He left the room and returned to the office.
53. The trainee probation officer said that she saw on the CCTV footage that the residential worker was looking into Mr Bennett's room. She said that he returned to the office and told her that he could not get a response from Mr Bennett and asked her to go with him to check Mr Bennett again as he did not appear to be breathing.
 54. At 1.36pm, they both went to Mr Bennett's room. CCTV footage shows that both entered the room before leaving a minute later at 1.37pm. The trainee probation officer said that the residential worker tried to rouse Mr Bennett by shaking his leg and that she called out his name, but they got no response. She said that they then noticed pooling of blood on the side of Mr Bennett's face and that his arms were very stiff. She said that from what she could see, she thought that Mr Bennett had already died, although she said neither she nor the residential worker checked for any signs of life.
 55. The trainee probation officer said that they then returned to the office to alert the authorities. The residential worker called the on-call AP manager. She told them to contact the emergency services immediately, to return to the room in full personal protective equipment (PPE) and give Mr Bennett first aid, using the defibrillator if needed.
 56. At 1.41pm, the trainee probation officer called the ambulance service, when the residential worker, who was on the phone to the oncall AP manager, instructed her to do so. She said that they were both in shock and not entirely sure whether to call the police or the ambulance service.
 57. The trainee probation officer told the ambulance service operator that she was unsure if Mr Bennett was breathing as she had been unable to get close enough to him. She said that she would check again as soon as possible. She asked the ambulance service to call her back on her mobile when she had returned to Mr Bennett's room.
 58. Both staff put on PPE (a face mask, gloves and an apron) before they returned to Mr Bennett's room, which the trainee probation officer said took a few minutes. The ambulance service operator called her back. They arrived back at Mr Bennett's room at 1.43pm and went in. The operator told her to put Mr Bennett on the floor and to attach a defibrillator, if one was available. She told the operator that Mr Bennett's body was mottled and stiff.
 59. They were trying to move Mr Bennett from his bed to the floor, when they heard the ambulance arrive. The trainee probation officer left the room at 1.46pm to let the paramedics in, returning to Mr Bennett's room at 1.48pm, with the paramedic.
 60. Having assessed Mr Bennett, the paramedic declared that he had died, and that rigor mortis was present. No attempt to resuscitate Mr Bennett was made. While the paramedics were there, the residential worker noticed that a sock had been put over the room's smoke detector. The trainee probation officer said that there was nothing else untoward about the room and that there was no drug paraphernalia in sight.

61. The police arrived and several items of drug paraphernalia were found in Mr Bennett's room, including rolled-up and burnt foil with a blackened residue and a tobacco tin containing a substance that smelt of cannabis.

Contact with Mr Bennett's family

62. After Mr Bennett was found in his room, a resident spoke to a member of Mr Bennett's family. Members of Mr Bennett's family subsequently rang Norfolk Park several times to ask what had happened. At 3.29pm, the AP's acting manager confirmed to Mr Bennett's family that he had died. He said the news of a death in an AP would normally be broken by the police, but Mr Bennett's family knew something was wrong and was becoming distressed, so he thought it best to break the news himself.

Support for residents and staff

63. At around 7.00pm, the AP's acting manager held a residents' meeting to confirm Mr Bennett's death, explaining what had happened. He offered support to residents who wanted it. We understand that support was also offered to staff working at Norfolk Park.

Further contact with Mr Bennett's family

3 May 2020

64. On 3 May, Mr Bennett's family spoke to the AP's acting manager, who tried to answer the family's questions. He confirmed that items indicating illicit drug use had been found in Mr Bennett's room. He invited Mr Bennett's family to visit the AP to see Mr Bennett's room. He also offered to assist the family with funeral arrangements and costs, in line with Probation Service instructions.
65. Later that afternoon, the AP area manager spoke to Mr Bennett's family to plan for family members to visit Norfolk Park the following day. It was agreed that Mr Bennett's young son could also attend. A dynamic risk assessment concluded that the visit could be managed effectively once parental consent had been sought.

4 May 2020

66. At 9.20am on 4 May, the AP's acting manager tidied Mr Bennett's room in preparation for the family visit. He found a piece of green paper, which he thought might have been impregnated with 'Spice', a psychoactive substance, which he disposed of, along with the remaining contents of the tobacco tin.
67. At 10.00am, a management decision between the AP's acting manager and the AP area manager confirmed that Mr Bennett's family and his son could visit later that day and that parental consent had been obtained. A family visit protocol was completed, setting out how the visit would be managed. This was sent to senior managers at the National Approved Premises Team.
68. That morning, senior managers decided that Mr Bennett's son should not be allowed to visit the AP, regardless of the safeguards that had been put in place, because AP policies do not allow children to visit APs.

69. At 11.00am, the AP's acting manager contacted Mr Bennett's family to tell them that his son could visit Norfolk Park, and went through arrangements for the visit later that day. Just before midday, he was told that the decision to allow Mr Bennett's son to visit Norfolk Park had been reversed and that Mr Bennett's son was not allowed to enter the AP.
70. Just after midday, members of Mr Bennett's family and his son arrived at Norfolk Park. The AP's acting manager told the family that Mr Bennett's son could not enter the building. This caused them significant distress. Mr Bennett's son remained with a family member in their car. Family members spent around an hour in Mr Bennett's room and collected his personal property. The family also met a resident before they left Norfolk Park at around 1.30pm.
71. At 3.23pm, Mr Bennett's family telephoned the AP's acting manager and told him that they had found what they suspected were illicit drugs with his property. They expressed her dissatisfaction that the drugs had not been found earlier during a search of his room. The police later collected the drugs from Mr Bennett's family.

5 May 2020

72. On 5 May, Mr Bennett's family asked the AP's acting manager if a Bluetooth speaker had been left in his room. He told them that no speaker had been found.

Post-mortem report

73. Post-mortem toxicology tests found that Mr Bennett had used heroin, cocaine and cannabis before his death. The post-mortem report concluded that he died because of heroin and cocaine use. The pathologist commented that it was unlikely that the cannabis use had contributed to the death.

Findings

Substance misuse

Information about drug tolerance at induction

74. Mr Bennett had a significant history of substance misuse but had successfully completed a methadone detoxification programme in custody. There is no evidence or intelligence to indicate Mr Bennett had used drugs at Moorland in the seven months before his release and he said he wanted to remain drug-free. Before Mr Bennett was released from Moorland, he was warned about the dangers of taking overdose because his tolerance levels for drugs would have reduced significantly.
75. The risk of relapse for a released prisoner with a history of substance misuse is high. The Approved Premises Manual (APM) 2014 states that one of the main causes of deaths among approved premises residents is from drug overdose. Opioid dependence is a chronic disorder with a high relapse rate, even after prolonged periods of abstinence and among people with a positive mindset. The risk of fatal overdose is also high as, after a period of abstinence, opiate users are particularly vulnerable due to a diminished tolerance, especially in the immediate post-release period.
76. The APM says that lowered drug tolerance levels should always be covered during a resident's induction following release from prison custody. It states that best practice would also include giving residents a leaflet about tolerance levels, including contact details for drug agencies and support groups and that a checklist should be used to ensure that AP staff cover all relevant areas, including drug tolerance, during the induction process.
77. Mr Bennett arrived at Norfolk Park as planned and a residential worker took him through the first stage of the induction process. However, there is no evidence that Mr Bennett was told about drug tolerance levels or that he was provided with written information, such as a leaflet, advising him about his heightened risk or about substance misuse. The induction paperwork signed by Mr Bennett did not have a specific section on reduced drug tolerance levels.
78. In response to a previous PPO investigation in October 2019, the National Approved Premises Team issued a revised version of the nationally-used induction template, with a section on reduced drug tolerance. While we are satisfied that a new template is now in use, we are concerned that it does not appear to have been used with Mr Bennett or that Mr Bennett's heightened risks were discussed with him during his induction at Norfolk Park. We make the following recommendation:

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

79. Once the induction process was completed, Mr Bennett was free to leave the AP, although he was expected to follow the Government guidelines in place at the time during the COVID-19 pandemic.
80. There were no further obligations on AP staff at that stage, and there was no apparent reason for staff to be concerned about Mr Bennett. Mr Bennett said that he was going out to open a bank account and to buy toiletries, both activities that were permitted under the Government guidelines. Staff had no reason to consider that he was leaving the AP to buy drugs (if that is what he did), and staff could not have prevented him from doing so.
81. APs are designed to provide a supportive and structured environment to reduce the likelihood of further offending, but the residents of APs are no longer in custody and are free to make their own choices. Part of the role of AP staff is to monitor residents' behaviour, but if a resident breaks the AP's rules or their licence conditions or uses illicit drugs, AP staff can only inform the resident's offender manager (probation officer) or, in extreme cases, the police, with a view to having the resident recalled to prison. They cannot take physical action to enforce the rules themselves.
82. Mr Bennett had been referred to substance misuse services to help prevent the possibility of relapse, but he died before he had contact with them.
83. Although there is no evidence that Mr Bennett was told about the risks of reduced drug tolerance levels when he arrived at the AP, we are satisfied that he had been told about the risks before he was released from prison earlier that day. We are satisfied that there is nothing that staff at Norfolk Park could have done to prevent Mr Bennett obtaining and using drugs and we do not consider that the AP staff could reasonably have predicted or prevented his overdose.

Drug testing

84. The post-mortem report established the cause of Mr Bennett's death was heroin and cocaine use.
85. Prison records show that before his release from Moorland Mr Bennett had displayed a positive attitude towards change and there was no evidence of drug use. Although staff contact with Mr Bennett at Norfolk Park was more limited than would normally have been the case due to the COVID19 pandemic, none of the staff who had contact with him in the thirteen or so hours leading to his death considered that he was under the influence of any substances and he raised no concerns with staff.
86. Drug testing at Norfolk Park had been suspended at the time due to COVID-19. However, we are satisfied that even if drug testing had been taking place, staff did not have reason to suspect that Mr Bennett may have been using drugs which would have prompted them to conduct a drug test.

Searching

87. Under Norfolk Park's searching policy room searches are only undertaken if staff have good reason to suspect the resident has unauthorised items in their possession. We are satisfied that AP staff had no reason to suspect that Mr

Bennett was bringing illicit drugs into the AP during the short period of time he was there, and they therefore had no reason to conduct a search of his room or bags.

Local substance misuse policy

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

The Head of Public Protection for North East Approved Premises Area should ensure that all approved premises have a local substance misuse policy in place, including procedures for requesting substance misuse tests and room searches in line with the requirements of the Approved Premises Manual.

Welfare checks

90. Staff at Norfolk Park carry out health and wellbeing checks on residents at set times during the day, beginning at 7.00am. Although some aspects of Norfolk Park's daily regime were suspended due to the COVID-19 pandemic, health and wellbeing checks were not affected.
91. At the 7.00am early morning check, the AP's acting manager said that staff should seek a response from the resident to ensure that they are alive and well. The expectation was that if a resident did not respond during a check, staff should enter the room using appropriate personal protection equipment (PPE) to ensure that the resident was safe and well.
92. When the Sodexo night residential worker carried out the early morning welfare check, he assumed that Mr Bennett was asleep and did not seek a response from him. He told the investigator that the check was simply to see if a resident was in their room. This is not correct: the purpose of the 7.00am check is to confirm that all residents are safe and well. He said that residents sometimes became aggressive if they were woken up. He said that he did not wake Mr Bennett because he did not know Mr Bennett or how he might react. The AP's acting manager said that if a member of staff felt unsafe in seeking a response from a resident, the expectation was for them to radio a colleague for assistance.
93. We consider that it is essential that AP staff satisfy themselves that residents are alive and well at the 7.00am welfare check by obtaining a response from each resident.
94. The next wellbeing check is scheduled for midday. A residential worker and a trainee probation officer gave different accounts about why the check did not take place. Whatever the reason, the midday check, which was part of the trainee probation officer's duties that day, did not take place. The staff task list says that

checks must not be delegated, and that a member of staff should tell the AP manager why the scheduled check has not taken place. After Mr Bennett's death, the residential worker said he believed that the midday check could be carried out anytime between midday and 2.00pm. The AP manager confirmed that this was not the case.

95. We are very concerned that this meant that no one checked on Mr Bennett between 7.00am and 1.30pm, a period of six and a half hours, despite staff not having seen him. It was only when Mr Bennett's family contacted another resident and asked him to check on Mr Bennett that the alarm was raised.
96. In November 2017, we published a Learning Lessons Bulletin into deaths in Approved Premises. We concluded that staff undertaking welfare checks of residents must satisfy themselves that the resident is safe and well. We found that the APM did not provide sufficient clarity on what is expected of staff, what constitutes a welfare check or what engagement from the resident would be acceptable to confirm they are safe and well. We said that the National Probation Service should review the guidance on welfare checks to ensure it is clear why the checks are needed and what they should entail. We are therefore very concerned that the Sodexo night residential worker, a residential worker and the trainee probation officer did not understand the importance of the checks or how they should be carried out.
97. We cannot say when Mr Bennett died. Rigor mortis was present when he was found at about 1.30pm, indicating that he had probably been dead for at least two to six hours. We cannot, therefore, know if a more thorough check at 7.00am might have changed the outcome for Mr Bennett.
98. We consider it is likely that Mr Bennett had already died by the time the midday check was due. However, we consider it is essential that staff complete the scheduled wellbeing checks as required to ensure the safety of residents.
99. We make the following recommendation:

The Head of Public Protection for North East Approved Premises Area and the Approved Premises Manager should ensure that:

- **staff understand the importance of welfare checks to ensure the wellbeing of residents;**
- **guidance is provided on what signs or engagement from the resident would be acceptable to confirm they are safe and well during a welfare check; and**
- **welfare checks are completed when scheduled.**

Emergency response

100. The APM provides guidance for AP staff on what to do in the event of an incident of serious self-harm or death. The APM requires AP staff to call an ambulance immediately when a medical emergency occurs. The APM also requires that all AP staff must be trained in first aid and CPR, and that at least one member of staff with up to date first aid training is always on duty. The APM states that

every possible effort must be made to save life and that staff should not leave the resident unattended in such circumstances. The Probation Service's *AP safe working practice* document (dated November 2018) also states that staff must always carry a radio to request assistance during medical emergencies.

101. When the residential worker checked on Mr Bennett at 1.33pm and was unable to get a response, he did not stay at the scene or radio his colleague for assistance or call an ambulance. (It is not clear if he was carrying a radio.) Instead, he returned to the AP office and asked the trainee probation officer to return with him to check on Mr Bennett a second time. When they both returned to the room, neither checked for signs of life as they believed that Mr Bennett had already died. Again, they failed to call an ambulance immediately and instead returned to the office and called the duty manager for advice. It was not until 1.41pm, eight minutes after Mr Bennett was found, that they called an ambulance after the duty manager told them to do so. She also told them to return to Mr Bennett and give first aid. Neither staff were trained in emergency first aid. When they spoke to the ambulance controller, they appear to have struggled to follow instructions.
102. We are concerned that both residential workers showed poor judgement when they found Mr Bennett unresponsive, and they failed to respond effectively. They did not check Mr Bennett for signs of life or immediately call an ambulance.
103. They described Mr Bennett as being stiff when he was found, indicating that rigor mortis was present, and that he had died some time before he was found. It is, therefore, unlikely that their initial failure to act, and the subsequent lack of urgency and effectiveness, affected the outcome for Mr Bennett. However, such delays could be critical in other emergencies, and we are very concerned that staff did not follow mandatory national instructions. We make the following recommendation:

The Head of Public Protection for North East Approved Premises Area and the Approved Premises Manager should ensure that staff:

- **do not leave residents in life-threatening situations;**
- **call the emergency services immediately in response to life-threatening incidents, including when a resident is found unresponsive; and**
- **always carry a radio or another form of communication so emergency assistance can be sought promptly.**

The Head of Public Protection for North East Approved Premises Area and the Approved Premises Manager should ensure that there is always appropriate cover by staff who are fully trained in first aid and the use of emergency equipment.

Staff training

104. The APM states that the induction of staff is of prime importance in ensuring their personal safety, the safety of other staff and residents and the effective running

of the AP. The APM says that managers are responsible for ensuring that staff are adequately inducted to a suitable standard before they work in an AP.

105. The Sodexo night residential worker said he had not received any training on how to perform a welfare check, although he had received training from his employer before starting at Norfolk Park. The day residential worker had completed an induction at Norfolk Park.
106. The trainee probation officer said she had not received any training or induction before starting work at Norfolk Park. She raised her concerns about not receiving any formal training with the AP's acting manager after her first shift at the AP and before the death of Mr Bennett. Norfolk Park acknowledged after Mr Bennett's death that she had not been properly inducted.
107. We also note that the trainee probation officer and several other staff had not signed to confirm that they had read the AP's health and safety manual.
108. The AP estate varies widely in building layout, accessibility and state of repair. It is therefore important that temporary staff are made aware of health and safety information and the unique features of the locations in which they work. We recognise that, at the time of Mr Bennett's death, the COVID-19 pandemic was putting severe strain on staffing levels at APs, and that temporary staff like the trainee probation officer were drafted in at short notice to cover for other staff who were unable to attend work. However, given the potential risks to staff and residents, we consider it is essential that all members of staff receive the appropriate training before starting work. We make the following recommendation:

The Head of Public Protection for North East Approved Premises Area and the Approved Premises Area Manager should ensure that all staff, including agency staff, are fully inducted before starting work and have signed to confirm they have read the AP's health and safety manual.

Family liaison

109. After Mr Bennett's death, his family was invited to visit Norfolk Park and they asked if Mr Bennett's young son could also attend. It was agreed between local and area managers, with advice from the National Approved Premises Team, that the family's request was reasonable if the visit could be operationally managed by putting in place appropriate safeguarding measures. A risk assessment and plan were drawn up.
110. However, on the day of the family visit, senior managers reflected on their decision to allow Mr Bennett's son to visit, considering national policy which states that children cannot visit an AP for any reason. Mr Bennett's family only learnt of the decision not to allow his son to visit when they arrived at Norfolk Park.
111. We understand why Norfolk Park tried to accommodate the family's request to allow Mr Bennett's son to visit on compassionate grounds and in recognition that it was a distressing time for them. However, we also recognise that they were following national policy in not allowing his son's visit. There are sound reasons

for not allowing children to visit APs and we do not criticise the decision not to allow Mr Bennett's son to visit.

112. However, we are concerned that the original decision was reversed so late in the day and we recognise that this will have caused the family additional distress. We consider that AP staff should ensure that they check national policy at the outset before raising the expectations of families.

Removal of evidence of drug use

113. The AP's acting manager said that he tidied Mr Bennett's room before his family visited two days after his death. We are very concerned that in the course of this, he disposed of a piece of paper which he thought might have been impregnated with 'Spice', and the remaining contents of the tobacco tin which smelt of cannabis. We consider that these items should have been handed over to the police. We recommend:

The Head of Public Protection for North East Approved Premises Area and the Approved Premises Area Manager should ensure that AP staff know how to dispose of suspected drugs safely.

Learning Lessons

114. We have identified a significant number of concerns in this report. We consider it is important that staff learn from our findings. We recommend that:

The Approved Premises Area Manager should ensure that a copy of this report is shared with all staff named in this report and that a senior manager discusses the Ombudsman's findings with them.

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