Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Dennis Maylin, a prisoner at Westbourne House Approved Premises, on 23 July 2021

A report by the Prisons and Probation Ombudsman

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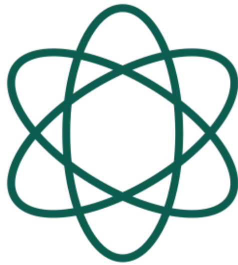
Our vision

To carry out independent investigations to make custody and community supervision safer and fairer



Our values

We are:

Impartial: we do not take sides

Respectful: we are considerate and courteous

Inclusive: we value diversity

Dedicated: we are determined and focused

Fair: we are honest and act with integrity

OGL

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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 Maylin was released from prison on licence on 6 July 2021. He had a long history of drug use but appeared to be drug free when he was released. On 14 July, Mr Maylin told staff at Westbourne House that he had used heroin. Staff put additional monitoring in place but stopped it on 17 July. Six days later, Mr Maylin was found dead in his room.

Mr Maylin had told prison and probation staff that he was worried he would relapse into using drugs following his release. Despite this, Mr Maylin was not drug tested on release or in his first week at Westbourne House. He attended an appointment with the community drug team the day after his release, but they gave him no further appointments and made no further contact with him as his caseworker went off sick. Westbourne House staff made three referrals to the community drug team after Mr Maylin admitted drug use in prison and after release, but these were not actioned.

There was no record by Mr Maylin's home probation area, Lewisham, that they had considered enforcement action after Mr Maylin breached his licence by admitting drug use and subsequently testing positive for drugs.

Supervision by the caretaking probation area, Newham, was poor. Mr Maylin reported to Newham on the day of release and one week later as instructed, but no record was made of the second occasion and he was not given a further appointment. This was a missed opportunity to provide support.

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 **June 2022**

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Summary

Events

1. In August 2017, Mr Dennis Maylin was sentenced to eight years and six months in prison for wounding with intent and robbery. Mr Maylin had a long history of substance misuse but had engaged with substance misuse services in prison and appeared to be drug free by the time of his release. However, he told staff he was concerned he would relapse after release. He asked to be prescribed an opiate substitute, but this was refused.

2. Mr Maylin was released on licence to Westbourne House Approved Premises (AP) on 6 July 2021. The next day, he attended an appointment with the community drug team (Change, Grow, Live – CGL). They carried out a telephone assessment but did not provide a further appointment.

3. On 8 July, Mr Maylin told AP staff that he had been using drugs in prison before his release. They asked CGL to reassess him.

4. On 14 July, Mr Maylin was unwell and told staff that he had taken heroin the day before. Staff started enhanced monitoring and made an urgent referral to CGL, but they never responded. Staff stopped enhanced monitoring on 17 July.

5. On 21 July, Westbourne House staff contacted CGL again to tell them that Mr Maylin's drug test taken on 14 July was positive for cocaine and opiates.

6. On 23 July, during a morning wellbeing check, staff found Mr Maylin unresponsive on the floor of his room. They did not try to resuscitate him as it was clear he was dead.

7. The post-mortem report concluded that Mr Maylin died from multi-drug toxicity (morphine, codeine and cocaine).

Findings

8. Mr Maylin's home probation area was Lewisham, who retained overall responsibility for his case, but Newham took over temporary responsibility for day-to-management of Mr Maylin while he was at Westbourne House. We found that pre-release planning by Lewisham was generally good. However, we would have expected arrangements to have been made to drug test Mr Maylin during his first week of release and this did not happen. Also, when Mr Maylin admitted that he had taken heroin, there was a lack of proper record keeping, particularly around consideration of enforcement action given Mr Maylin had breached his licence.

9. We found the level of supervision by Newham was very poor and this was a missed opportunity to provide support to Mr Maylin. Mr Maylin reported on the day of his release and again a week later, but he was provided with no further appointments. There was no entry on his probation record to say he had reported a second time. Newham carried out an internal investigation and identified several learning points.

10. While Westbourne House started enhanced monitoring after Mr Maylin told them he had taken heroin, there is no record of who was responsible for reviewing Mr Maylin's risk or who authorised observations to be reduced and then stopped.

11. The service Mr Maylin received from CGL was poor. He was not given a further appointment when he attended on 7 July and was never seen or contacted again. The caseworker intended to call him the following week but was off sick between 14 and 30 July. CGL acknowledged the referral made by Westbourne House staff on 8 July but did not respond to the urgent referral made on 14 July, or the contact made on 21 July. CGL carried out their own review and made several changes to working practices to try to avoid similar errors in future. We consider that there should be clear service standards agreed between probation and CGL.

12. Mr Maylin's family picked up his belongings from Westbourne House. They later discovered two wraps of heroin in his clothing. Staff should consider searching belongings before returning them to the family.

13. There were delays in providing evidence to the PPO investigator and there were issues with the arrangement of interviews. Westbourne House needs to improve its PPO liaison arrangements following a death.

Recommendations

- The Head of Service for Lewisham and Bromley should ensure that:
    - residents who have drug testing as part of their licence conditions are tested promptly after release; and
    - where drug use is suspected or confirmed, staff consider enforcement action and record the decisions made.
- The Head of Service for Newham should ensure that the learning points from the internal investigation are fully implemented and in particular that staff:
    - provide sufficiently robust caretaking arrangements for those residing at Westbourne House; and
    - accurately record all contacts.
- The AP Manager for Westbourne House should ensure that all significant contacts and decisions around the management of a resident's risk are accurately and promptly updated on Delius.
- The AP Manager should ensure that staff:
    - know how to escalate concerns about the quality of the service provided by the local substance misuse team; and
    - follow the escalation process if substance misuse referrals are not actioned promptly.

- The Area Manager for Westbourne House should ensure possessions are returned promptly and, where appropriate, property is searched before being returned to a bereaved family.

  - The Area Manager for Westbourne House should, following the death of a resident, identify a single point of contact who will coordinate the response to all the Ombudsman’s requests for information and for arranging interviews with staff.

The Investigation Process

14. The investigator issued notices to staff and residents at Westbourne House AP informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

15. The investigator obtained copies of relevant extracts from Mr Maylin's prison, probation, and medical records.

16. The investigator interviewed eight staff and a resident at Westbourne House and a further three probation staff, two prison staff and three members of staff from the community substance misuse service provider (CGL). She arranged to interview a sessional residential worker at Westbourne House, but she did not attend and made no further contact. She also invited a former resident to interview, but he declined.

17. We informed HM Coroner for Greater London Eastern District of the investigation. We have sent the Coroner a copy of this report.

18. The PPO's family liaison officer contacted Mr Maylin's daughter to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Maylin's family wanted to know why there was a delay in his property being returned and why Mr Maylin's clothes were not checked, as the family found heroin in his pocket.

19. Mr Maylin's family received a copy of the initial report. They did not identify any factual inaccuracies.

20. The Probation Service also received a copy of the report and identified a number of amendments which we have accepted.

Background Information

Westbourne House Approved Premises

21. Approved premises (formerly known as probation and bail hostels) mostly accommodate offenders released from prison on licence and those directed there by the courts as a condition of bail. Their purpose is to provide an enhanced level of residential supervision in the community, as well as a supportive and structured environment. Residents are responsible for their own healthcare and are expected to register with a GP.

22. Westbourne House is an Approved Premises in East London. It has 41 single rooms and is managed by the London Area of the National Probation Service. Each resident is allocated a key worker and an offender manager to oversee their progress and wellbeing and ensure that they adhere to their licence conditions and premises' rules.

23. National Probation Service employees are on duty at Westbourne House 24 hours a day. 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; COVID-19 restrictions meant that for some time, these did not happen routinely, but the exceptional delivery model (EDM) allowed for room searches on a risk basis. There are several CCTV cameras in communal areas which are monitored from the main office. AP staff carry out daily health and safety and wellbeing checks on residents at various times throughout the day and evening.

HM Inspectorate of Probation

24. The most recent inspection of Probation Hostels (Approved Premises) Contribution to Public Protection, Rehabilitation and Resettlement was in July 2017. Inspectors found them to be exceptionally good at protecting the public, and the public can have confidence that risks are being managed well overall, with individuals returned to prison when it is right to do so. Approved premises are not always located where they are most needed, and so many residents are placed away from their home areas. The situation is exacerbated by a general shortage of places, leading to more people being sent to wherever a place is available.

25. Inspectors considered standard out of hours arrangements, where AP managers would be on call to cover several different APs in their area, were an unsatisfactory arrangement which could lead to risk of harm issues or the oversight of serious incidents not being managed sufficiently well.

26. Inspectors included Westbourne House as an example of good practice in respect to substance misuse services. They found Change, Grow, Live (CGL), had developed good working links with the local probation team and through this connected with Westbourne House.

Previous deaths at Westbourne House Approved Premises

27. The last death at Westbourne House prior to Mr Maylin's was in 2016. This death was also due to drug use and we identified the need for prompt drug testing after release from prison.

Key Events

28. In August 2017, Mr Dennis Maylin was sentenced to eight years and six months in prison for wounding with intent and robbery. He was moved to HMP North Sea Camp on 30 March 2020.

29. Mr Maylin had a long history of substance misuse and had completed drug and alcohol awareness work in prison. In June 2021, Mr Maylin told his drug worker that he had not used drugs for some time but was concerned he would relapse when released. He asked if he could be prescribed Subutex (an opiate substitute), but the prison prescriber refused as Mr Maylin had been drug free for some time and they did not want to reintroduce a synthetic opiate. Mr Maylin said he did not want to be prescribed naltrexone (an opiate blocker for those who have stopped using drugs).

30. On 8 June, Mr Maylin was told he had been allocated a bed at Westbourne House Approved Premises (AP) in Newham, East London. His drug worker made a referral to the community substance misuse team, Change, Grow, Live (CGL).

31. On 28 June, Mr Maylin's home probation officer (also known as the community offender manager) in Lewisham, South London, contacted Newham Probation Office, to ask them to caretake Mr Maylin's case while he was at Westbourne House. She was told due to staffing issues it was not possible to allocate a named probation officer.

Westbourne House Approved Premises

32. On 6 July, Mr Maylin was released on licence. (A prison manager had made Mr Maylin aware of his licence conditions before release which included that he was required to live at Westbourne House and that he had to comply with drug tests and any other requirement to address his drug use.) He reported to Newham Probation Office and was given an appointment to report again on 13 July.

33. When Mr Maylin arrived at Westbourne House, a residential worker completed his induction and gave him information about the AP, including the AP's rules and expectations around drug and alcohol testing and room searches.

34. On 7 July, Mr Maylin reported to CGL Newham Rise and prison link lead completed a telephone assessment (she was working from home at the time). She noted that Mr Maylin was anxious about being released from prison and living in a new area, and worried about relapsing, but was engaged and motivated. After the assessment, the prison link lead, the recovery team and a medical prescriber discussed Mr Maylin at a multidisciplinary team meeting. They agreed that Mr Maylin should not be prescribed an opiate substitute for the same reasons as before. The care plan was for Mr Maylin to engage with psychosocial intervention sessions to support him to stay drug free. CGL staff gave Mr Maylin a Naloxone kit (an opiate blocker that aids in preventing opiate overdoses) and training on how to use it. The prison link lead told Mr Maylin she would contact him by telephone the following week.

35. On 8 July, Mr Maylin told his key worker at Westbourne House that he had been using drugs in prison and that he would not be able to control his drug use without an opiate substitute. She emailed a recovery worker at CGL and completed a referral form. The next day, the recovery worker at CGL responded and said that he had forwarded the information to the assessment team, the manager, and clinician to expedite an appointment.

36. On 13 July, Mr Maylin reported to Newham Probation Office. (CCTV footage was not provided to the investigator as it had been overwritten, but the Head of Service in Newham told the investigator that a receptionist had viewed the footage and confirmed that Mr Maylin had attended.) Mr Maylin's attendance was not recorded in his probation record and he was not given a further appointment.

37. That evening, a residential worker recorded in Mr Maylin's probation record that during her night-time wellbeing check at 11.00pm, he said he needed to visit a doctor quite urgently, but no other details are recorded.

38. On the morning of 14 July, Mr Maylin had a swollen, blotchy face and arms, his speech was slurred, and he was confused about his appointments. Staff advised Mr Maylin to seek medical treatment, which he did. His key worker spent some time with Mr Maylin, who told her that he had used heroin the previous day and he became emotional. She contacted a probation officer (who was covering for a colleague while she was on leave), who advised that Mr Maylin should be drug tested, monitored every hour and that staff should 'devise a self-harm monitoring sheet'. The key worker noted that she was concerned Mr Maylin's health would deteriorate if he continued to use drugs. At 1.52pm, she sent another email to the recovery worker at CGL saying that Mr Maylin looked very unwell and that he needed to be assessed urgently.

39. A residential worker completed a concern and keep safe form for Mr Maylin. She noted that Mr Maylin said he felt low, but not suicidal, that it was the first time he had used drugs since his release, and he was struggling to stay away from drugs. She sent an email to two probation officers at 3.23pm, asking for a decision about enforcement as Mr Maylin had breached the conditions of his licence. There is no evidence of a response and no record of an enforcement decision.

40. On 15 July, Mr Maylin asked staff at Westbourne House not to check him every hour as it was disturbing his sleep and he was tired. A residential worker noted on Mr Maylin's probation record that observations would be reduced to once or twice a night and the on-call manager had been notified, but no name was recorded. The next day, Mr Maylin told staff that he was feeling better.

41. On 19 July, during a key work session, Mr Maylin told his key worker that he was feeling better and had not used drugs.

42. On 21 July, a probation officer contacted Newham Probation Office as Mr Maylin had not been given his next appointment. She was told that Mr Maylin should report at 12.00pm on 26 July.

43. The same day, the key worker telephoned CGL to tell them that the drug test taken on 14 July was positive for cocaine and opiates and that he needed to be seen. She noted that she spoke to a secretary but did not record a name (CGL told the

investigator that they do not employ secretaries). She emailed the probation officer and noted that Mr Maylin would not be able to stop using drugs without an opiate substitute prescription, and that she had contacted CGL again but was told that due to the COVID-19 pandemic and impact on staffing levels, there were delays responding to requests.

44. CCTV footage for 22 July shows Mr Maylin and another resident talking in the corridor outside his room for a couple of minutes before Mr Maylin went into his room at 10.55pm. Shortly afterwards the resident knocked on Mr Maylin's door, they spoke briefly, and both went back into their rooms. At 11.00pm, Mr Maylin left his room and went into the toilet next door and returned to his room two minutes later. A sessional residential worker started her welfare checks at around 11.00pm. At 11.31pm she arrived in the corridor where Mr Maylin resided and she checked the residents living next door and opposite, who both opened their doors, but she did not knock on Mr Maylin's door. (An internal investigation found that she did not carry out the wellbeing check. We were told that she was no longer being used as a sessional worker.)

23 July

45. CCTV shows another residential worker started her morning wellbeing checks at around 8.30am. She arrived in the corridor where Mr Maylin lived at 8.43am, and the residents next door and opposite responded. She knocked on Mr Maylin's door several times. She opened the door and saw that his bed was made, and a lamp was on, but she did not see Mr Maylin. She shut the door and checked the toilet and shower rooms next door. She returned to the main office to check to see if Mr Maylin had already left the premises. She checked the keys and the signing out register, which showed Mr Maylin had not left, so she returned to his room.

46. At 9.02am, the residential worker entered Mr Maylin's room and immediately used her radio to ask for assistance and for an ambulance to be called. She found Mr Maylin in the foetal position on the floor between the end of his bed and chest of drawers; he was wearing the same clothes from the previous evening. She described him as cold, stiff and his skin was mottled. She did not get a response over the radio and left the room briefly to get help. Another residential worker heard the request on the radio and ran to room 6. They both entered the room less than a minute after Mr Maylin was discovered. (The investigator viewed CCTV footage and visited the room where Mr Maylin lived. The view into the room was such that it would not have been immediately apparent Mr Maylin was on the floor.)

47. Both residential workers did not try to resuscitate Mr Maylin as it was clear he was dead; he was cold, his lips were blue and rigor mortis was present (stiffening of the body after death). Paramedics arrived and after assessing Mr Maylin, confirmed he was dead at 9.22am.

Contact with Mr Maylin's family

48. Following Mr Maylin's death, the London Ambulance Service contacted Mr Maylin's daughter to tell her that her father had died. An AP Area Manager also contacted Mr Maylin's daughter by telephone to offer her condolences and support. The National Probation Service offered a contribution to funeral costs, in line with national policy.

49. Mr Maylin's daughter visited Westbourne House on 1 August to collect Mr Maylin's belongings. When his family later checked his clothes, they discovered two wraps of heroin in a pocket.

Support for residents and staff

50. After Mr Maylin's death, the AP Area Manager spoke individually to the staff involved in the emergency response to offer support and the Head of Public Protection for London Approved Premises also spoke to those involved. Staff who discovered Mr Maylin were offered specialist trauma support facilitated by an external provider.

51. Other staff who worked closely with Mr Maylin felt less supported. The key worker said she was unaware of Mr Maylin's death until she arrived for work on her next shift and was told during the morning handover. She said she was extremely shocked and upset by Mr Maylin's death and frustrated that there had been no contact from CGL in response to her request for an urgent assessment. A residential worker said when she arrived for her next shift, she was asked by a manager she had never met to clear Mr Maylin's room but did not feel her emotional needs had been considered and that she had no proper guidance on clearing his possessions.

Post-mortem report

52. The post-mortem report concluded that Mr Maylin died from multi-drug toxicity (morphine, codeine and cocaine). Left ventricular hypertrophy (disease of the heart muscle) and cirrhosis of the liver (scarring of the liver caused by long-term liver damage) were listed as contributory factors.

Findings

Probation Service supervision

Lewisham probation area

53. Mr Maylin's home probation area was Lewisham, which retained overall responsibility for Mr Maylin's case management, including specifying licence conditions, updating risk assessments, issuing warnings for breaches, and recalling residents where appropriate.

54. We found that the planning arrangements ahead of Mr Maylin's release were well coordinated and timely. However, there is no evidence of a request to drug test Mr Maylin during the first week of his stay at Westbourne House, despite his history of drug use and drug testing being included on his licence conditions.

55. When Mr Maylin disclosed on 14 July that he had used heroin, staff at Westbourne House contacted Lewisham probation. There is little information recorded on Mr Maylin's probation record as to what risk was considered, when a review should take place and who was responsible for decisions regarding management and the level of observations. There was no information recorded as to what, if any, enforcement action was to be taken given that Mr Maylin had breached his licence conditions. We recommend:

    The Head of Service for Lewisham and Bromley should ensure that:

    - **residents who have drug testing as part of their licence conditions are tested promptly after release; and**
    - **where drug use is suspected or confirmed, staff consider enforcement action and record the decisions made.**

Newham probation area

56. The Head of Service for the Newham area conducted an internal investigation into the lack of information entered on Mr Maylin's probation record and why he was not given weekly reporting instructions as he should have been. He provided the investigator with a summary report dated 5 November 2021.

57. The Head of Service for the Newham area concluded in his investigation that while Newham have a dedicated offender manager to caretake Westbourne House residents, as a result of staff shortages and implementation of the Exceptional Delivery Model, 'the delivery of operations in accordance with this arrangement was compromised'. He stated he found no evidence this impacted on the outcome for Mr Maylin.

58. The Head of Service for the Newham area identified three learning points from his investigation: supervision by the caretaking offender manager should take place at Westbourne House if there are specific difficulties with the resident reporting; all contacts should be recorded; and all staff had been briefed on the importance of promptly updating the contact records. He told us that the offender manager and

senior probation officer involved in Mr Maylin's care have both since left the service. We recommend:

The Head of Service for Newham should ensure that the learning points from the internal investigation are fully implemented and in particular staff should:

- **provide sufficiently robust caretaking arrangements for those residing at Westbourne House; and**
- **accurately record all contacts.**

Westbourne House Approved Premises

59. Staff at Westbourne House started additional monitoring after Mr Maylin told them he had used heroin. However, there was no record of who was responsible for reviewing Mr Maylin's risk or who authorised observations to be reduced and then stopped on the morning of 17 July. We recommend:

    The AP Manager for Westbourne House should ensure that all significant contacts and decisions around the management of a resident's risk are accurately and promptly updated on Delius.

60. Staff told us they felt unsupported when making decisions about residents' care. The permanent manager was on long-term sick leave and other AP managers were on a rota to cover manager duties and respond to out of hours requests from staff. No covering manager visited the premises during this time. We consider that Westbourne House staff did a good job in challenging circumstances. Since Mr Maylin's death, a permanent covering manager who is located at Westbourne House has been appointed to provide consistent support.

61. We found that the AP Area Manager who covered the incident on 23 July, managed it well, including supporting the staff involved.

Engagement with CGL

62. Mr Maylin attended his initial assessment with CGL on 7 July, the day after his release, but he was not given his next appointment. The prison link lead said she intended to contact Mr Maylin by telephone the next week but was off sick between 14 and 30 July. CGL have no policy on minimum levels of contact, but it is accepted best practice to provide the next appointment.

63. Westbourne House subsequently contacted CGL on three occasions: on 8 July, when Mr Maylin admitted to drug use in prison before his release; on 14 July, when Mr Maylin told staff he had used heroin the previous day and AP staff asked for an urgent assessment; and on 21 July, when Mr Maylin's drug test results were received. Apart from an acknowledgement sent on 9 July, nobody from CGL made any further contact, and Mr Maylin was not seen by CGL again before he died.

64. The Service Manager for CGL told the investigator that in response to the lessons learned from Mr Maylin's death, a review of the team's responsibilities identified it was not appropriate to have just one person as the named prison link lead, as in their absence oversights could happen. He said there was now a general inbox for the prison link team, which was monitored daily. In addition, all released prisoners

were now discussed at the daily morning brief (notes of which were circulated to relevant people/teams), which included a prison release tracker detailing when the next contact was due. He said that this should ensure oversights made in Mr Maylin's case should no longer be possible.

65. The Service Manager said that as well as the changes to the prison link team a number of other processes were being reviewed and redrafted to ensure that everyone understood their role and responsibilities at CGL. He said that CGL planned to hold a reflective learning meeting with staff to review the learning from Mr Maylin's case and to review the handbook and processes to support staff training. He said that although it was very clear Mr Maylin had a long history of substance misuse, there had been a gap in service provision by CGL, which they were trying to put right.

66. While we acknowledge the changes made, we are surprised that there is no Service Level Agreement which sets out the expectations for contact between CGL and the Probation Service (including Approved Premises). We recommend:

The AP Manager should ensure that staff:

- **know how to escalate concerns about the quality of the service provided by the local substance misuse team; and**
- **follow the escalation process if substance misuse referrals are not actioned promptly.**

Return of Mr Maylin's belongings

67. Although Mr Maylin's daughter said that it was a number of weeks before Mr Maylin's property was returned, we found that it was returned on 1 August, one week after his death, after she travelled to Westbourne House. The AP Area Manager responsible for Westbourne House said that he did not consider taking Mr Maylin's property to his family to save them the journey at a time when they were grieving but would be more aware of family needs in future.

68. The AP Area Manager said that he was upset and disappointed to hear that drugs had been discovered in Mr Maylin's possessions. He said that it was likely that in order to be respectful, staff did not want to go through his possessions, but accepted this should not have happened. We recommend:

The Area Manager for Westbourne House should ensure possessions are returned promptly and, where appropriate, property is searched before being returned to a bereaved family.

PPO liaison arrangements

69. Annex 23C of Probation Instruction (PI) 32-2014, *Approved Premises Manual*, clearly sets out the expectations following the death of a resident and the information that should be provided to the PPO. Initially the investigator was told by the duty manager for Westbourne House that he would take on the role of liaison. He provided some information but then moved to a different area and did not provide an update on the new liaison arrangements.

70. An administrator from Lewisham Probation Office was appointed as the PPO liaison officer on 6 September, around six weeks after Mr Maylin's death, and the investigator was assured liaison arrangements would improve. However, there were obvious difficulties in a Lewisham-based administrator arranging interviews with staff at Westbourne House, as despite interviews being arranged with seven members of staff there on 5 October, three managers and a residential worker failed to attend. We recommend:

The Area Manager for Westbourne House should, following the death of a resident, identify a single point of contact who will coordinate the response to all the Ombudsman's requests for information and for arranging interviews with staff

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