Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Luke Dowdle, a resident at Brigstocke Road Approved Premises, on 18 February 2022

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk
T l 020 7633 4100

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 Luke Dowdle died of a gastrointestinal bleed and acute liver failure in hospital on 18 February 2022, after taking an overdose of paracetamol while a resident at Brigstocke Road Approved Premises (AP). He also had chronic liver disease which contributed to but did not cause his death. He was 46 years old. I offer my condolences to his family and friends.

We found that Brigstocke Road staff provided meaningful support to Mr Dowdle during his time at the AP. They implemented a care plan and regular welfare checks when Mr Dowdle's risk of suicide and self-harm increased. However, the plan was not updated or reviewed after significant events and there was no ongoing record of actions taken. There was also confusion among staff about alcohol testing requirements in the AP, which led to inconsistent practice.

After Mr Dowdle was hospitalised, AP staff had difficulty in obtaining information from the hospital to help manage his risk following discharge. While these factors did not impact on Mr Dowdle's death, they must be addressed in order to ensure that the AP can appropriately manage AP residents' safeguarding and offending risks.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Kimberley Bingham
Acting Prisons and Probation Ombudsman **October 2022**

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Summary

Events

1. In 2014, Mr Luke Dowdle was sentenced to eight years in prison for violent offences. He had a range of needs, including cancer, mental health and substance misuse issues. His son and mother died during his time in prison.

2. In 2019, Mr Dowdle was recategorised as suitable for open conditions and transferred to HMP Leyhill in preparation for his release. He struggled to cope with the new regime and was transferred back to closed conditions at HMP Channings Wood on July 2021. Mr Dowdle told staff he was nervous about his eventual transition into the community.

3. On 31 January, Mr Dowdle was released from prison and made his way to Brigstocke Road AP. He told his community offender manager in the Probation Service that he had had an alcoholic drink on the way to calm his nerves after getting lost. When he arrived, his breathalyser test result was negative, and staff noted that he did not seem intoxicated. Staff completed a Support and Safety Plan, which was a standard procedure for all AP residents when they arrived. Staff recorded that Mr Dowdle's risk of self-harm was low at the time.

4. On 3 February, Mr Dowdle asked his GP to change his antidepressant but this was declined. He was upset but discussed it with staff and seemed to accept the decision.

5. On 6 February, Mr Dowdle missed his curfew and failed a breathalyser test when he returned to the AP. Staff made welfare checks on him during the night.

6. On 7 February, Mr Dowdle said that he was "feeling down" but that he had no thoughts of harming himself. Staff discussed his presentation and his social isolation and decided to "keep an eye on him".

7. On 9 February, Mr Dowdle returned to the AP with several bottles of water and a vitamin drink and said that he felt very dehydrated and "wiped out". A member of staff made a GP appointment for him for the following day.

8. At 2.35am on 10 February, Mr Dowdle telephoned the AP office and told staff that he had taken an overdose of paracetamol on 8 February. A member of staff called an ambulance and went to his room to provide support. They stayed with Mr Dowdle until the ambulance arrived at 3.52am and took him to hospital. He remained there until he died in the early hours of 18 February.

Findings

Risk of suicide and self-harm

9. Mr Dowdle was given the appropriate support to prepare for his release from prison. Staff referred him to relevant services and information about him was shared appropriately between agencies.

10. Staff implemented welfare checks on Mr Dowdle when they had concerns about his increasing risks. They encouraged him to engage and offered support. However, they did not update Mr Dowdle's Support and Safety Plan, which meant there was no ongoing record of his changing needs and risks and how these were to be managed.

Mr Dowdle's alcohol use

11. Mr Dowdle told staff that he had drunk alcohol on two occasions while in the community. There was no licence condition requiring him not to do so. He drank the alcohol outside the AP and therefore did not breach AP rules. Staff were aware of the potential effect of alcohol on his risk and discussed this with him. However, the AP's policy on alcohol testing was unclear. While there is no evidence of a direct link between Mr Dowdle's alcohol use and his death, inconsistent practice might impact on the management of risks for future residents.

Healthcare

12. AP staff were sensitive to Mr Dowdle's health and provided appropriate support and assistance. They supported him to register with a GP and they made an appointment on his behalf when he showed signs of illness.

13. Mr Dowdle did not collect his medication during his time in the AP. When he arrived and was inducted, staff made it clear that it was his responsibility to do so. Staff organised appointments on his behalf, where necessary.

14. When Mr Dowdle was taken to hospital, AP staff shared key risk information with hospital staff, specifically, that he had threatened to discharge himself from any stay in hospital and kill himself. When they asked the hospital to share information about his condition and discharge, hospital staff were reluctant to do so. While we recognise that AP staff appropriately tried to obtain information about Mr Dowdle's care needs on discharge from hospital, it is important that they are able to obtain information about a person under probation supervision before they are discharged from hospital into their care.

Recommendations

- The Manager of Brigstocke Road AP should ensure that significant changes in risk are recorded in a residents' Support and Safety Plans (SaSP).

- The Manager of Brigstocke Road AP should clarify the policy on alcohol testing and ensure that staff are aware of expectations.

- The Approved Premises Area Manager for the South West should liaise with the local NHS Trust to explore whether a local protocol can be established to enable the sharing of information about hospitalised offenders under supervision, where this is required for safeguarding or risk management purposes.

The Investigation Process

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

16. The investigator obtained copies of relevant extracts from Mr Dowdle's probation service records. He interviewed six members of Brigstocke Road AP staff and Mr Dowdle's community offender manager (probation officer). He obtained information from South West Ambulance Service.

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

18. The Ombudsman's family liaison officer contacted Mr Dowdle's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They asked a number of questions, including if there had been any indication of why Mr Dowdle took his own life. We have addressed these concerns in this report and by way of separate correspondence.

Background Information

Brigstocke Road Approved Premises (AP)

19. Approved premises provide accommodation for offenders released from prison on licence and those directed there by the courts as a condition of bail or community orders. Their purpose is to provide an enhanced level of residential supervision in the community, for the purpose of risk management, as well as a supportive and structured environment. Residents are responsible for their own healthcare and are expected to register with a GP.

20. Brigstocke Road AP in Bristol is one of around 100 approved premises in England and Wales. There are rooms for 25 adult male residents, 12 with full board accommodation and 13 for self-catering residents. Most of the residents are assessed as posing a high risk to the public.

Previous deaths at Brigstocke Road AP

21. The last death at Brigstocke Road was in January 2021. The cause of that death was not determined by a post-mortem examination, but we found that AP staff provided effective support and there are no similarities in our findings across the two investigations.

Key Events

Background

22. In 2014, Mr Luke Dowdle was sentenced to eight years imprisonment for wounding, with intent to cause grievous bodily harm. It was not his first time in prison. He had a history of violent behaviour and of drug and alcohol misuse. In his early days in prison, Mr Dowdle failed a drug test, was found with fermenting liquid in his cell, and was suspected of diverting prescribed medication.

23. Mr Dowdle had been diagnosed with cancer in 2010. He was in remission but required further treatment in prison. At the time of his death, he was not receiving cancer care.

24. In 2016, Mr Dowdle's son took his own life. He engaged with the mental health team to address depression and anxiety. He was supported by suicide and self-harm prevention procedures, known as ACCT, on three occasions between September 2015 and November 2019. Mr Dowdle was monitored under ACCT procedures again in July 2021 when his mother died shortly after his transfer to an open prison. He struggled to cope with the news of his mother's death in a new environment. He tied a ligature around his neck and was returned to a closed prison.

Release planning

25. Mr Dowdle engaged with support from prison and probation staff as he prepared for release. His risk assessment noted that drug and alcohol use were linked to his risk of harm to himself and others, which could increase if his mental health was poor or if he did not use his medication appropriately. It also highlighted that the pressure of leaving prison might lead to substance misuse. It was decided that he would initially live in an Approved Premises (AP), where he would have the support of probation and AP staff and where his risk could continue to be monitored.

26. On 19 January 2022, a probation service officer from Brigstocke Road AP spoke to Mr Dowdle to provide information about the AP and what to expect. She explained the rules of the AP including the expectation that he would have a weekly drug test. Also, he was encouraged to engage with the mental health team and the Offender Personality Disorder Pathway programme (OPD). (The OPD is a national initiative that provides services to offenders with complex personality disorders.) She explained that offenders were expected to register with a GP in the community. She recorded that Mr Dowdle was anxious but was pleased that he would not be sharing a room and said that he was encouraged by the support he would get from staff.

27. The licence also contained exclusion zones to where Mr Dowdle was prohibited from travelling. This meant that he would be unable to visit his home area offender manager. Arrangements were made for the area offender manager to continue as his offender manager but for Mr Dowdle to have another offender manager to report to in person in his release area. The expectation was that she would continue to manage his risk assessments and make decisions but that, a community offender manager, would provide day-to-day support and share information.

Brigstocke Road Induction

28. On 31 January, Mr Dowdle was released from Channings Wood. He reported to his community offender manager for his first supervision appointment and then left to go to the AP. Shortly afterwards, he telephoned the community offender manager, and said that he was lost. The offender manager found him and escorted him to the AP. Mr Dowdle told him that he had had an alcoholic drink to calm his nerves.

29. A sessional residential worker completed Mr Dowdle's initial induction. He told her that he had had a drink on his way to the AP to calm his nerves. She did not observe that he seemed intoxicated but gave him a breathalyser and the result was negative. She explained that alcohol was not allowed in the AP and that residents were tested each day. She advised him to discuss any alcohol misuse issues with his offender manager. The information was noted on his electronic probation record and brought to the attention of AP staff and of his home area offender manager.

30. Channings Wood had given Mr Dowdle a printout of his medical records to ensure continuity in his healthcare when he registered with a GP in the community. He asked staff for help with the registration. He had been given seven days' worth of his antidepressant which he gave to the sessional residential worker, as required. He told her that he had been experiencing negative side effects, including sleeping issues, and was considering not taking it. He said that he had been prescribed pregabalin in the past and hoped to be able to use it again because it had helped. She advised him to discuss this with the GP when he registered.

31. Mr Dowdle said that overall, he felt well and was glad to be out of prison. However, his mood was low and when he was at his lowest, he thought suicide was inevitable. He was open about his suicide attempt the previous July and said he was planning to build up his coping mechanisms and move forward. He said the AP was nicer than he had expected and he was grateful to have a bed there. He did not like eating with other people so would not use the communal dining area. He was in touch with a cousin, an aunt and a friend who provided support.

32. On the basis of the sessional residential's worker note of her interview with Mr Dowdle, a probation service officer completed a Support and Safety Plan (SaSP, which provides individualised information on types of risk, needs and triggers for AP residents and provides a support structure for them). There was a standard template for all residents which assessed needs and risks and set out a management plan. She recorded Mr Dowdle's history of self-harm and substance misuse, as well as his depression/anxiety and cancer treatment. She noted that he had been made aware that the AP was a supportive environment, with staff available at all hours. She noted that Mr Dowdle was planning for the future, expressing positivity, and was engaging with medication management processes. She assessed his risk of self-harm as low, to be monitored and reviewed, as appropriate, on an ongoing basis.

33. Staff made standard wellbeing checks through Mr Dowdle's first night in the AP and raised no concern.

1 – 2 February

34. On 1 February, Mr Dowdle completed the second part of his induction with the probation service officer. He had completed an application to register with a GP. He said that he needed to sign up for universal credit. He agreed to work with the OPD programme, and with the local drug and alcohol service. She made the respective referrals. Later that day, Mr Dowdle took his GP registration form to the local surgery. He complied with his curfew, and his alcohol test showed a negative reading that night.

35. On 2 February, Mr Dowdle telephoned the community offender manager for a planned supervision appointment. He was polite and grateful for her support. They discussed him having had a drink, which was a concern given his previous substance misuse issues but they agreed that it was positive that he had told staff. He said that he could write an essay on why he should abstain from drink and drugs, which she suggested that he should do as a reminder to himself. She said that she would call him the following week for an Initial Supervision Plan interview. That evening, Mr Dowdle complied with his curfew, and his alcohol test was negative. He did not collect his medication.

3 February

36. On 3 February, Mr Dowdle had a telephone appointment with his doctor to discuss medication. He told one of the AP's residential support workers that it had not gone well. He had asked to be prescribed pregabalin for his anxiety but the doctor declined. She explained that doctors are reluctant to prescribe pregabalin to people with substance misuse issues due to the risk of addiction. Mr Dowdle engaged with the conversation and said he understood.

37. A doctor who was an OPD pathway clinical psychologist was allocated to Mr Dowdle. She contacted Mr Dowdle by telephone for their first appointment due to COVID-19 restrictions. He was upset that his GP had not prescribed him pregabalin. He told the doctor that he had anxiety and had a cancer diagnosis. The doctor made an appointment to see Mr Dowdle again on 14 February.

38. Later that day, the residential worker made a note on the AP's handover record for night staff that Mr Dowdle looked grey and unsteady on his feet. She added a request for him to be tested for drugs the following day. He went out of the hostel but returned within his curfew. An alcohol test was negative.

4 - 5 February

39. On 4 February, Mr Dowdle asked staff how much he owed in rent to the AP. They advised that he did not owe anything at that time but he said that he was worrying about it and wanted to borrow it from family and pay in advance. Staff advised what the costs would be if he paid in advance and he paid the sum later that afternoon. He complied with his curfew. His record notes that he did not go to the office to take an alcohol test.

40. On 5 February, Mr Dowdle was drug tested and the result was negative. His records note that he did not take an alcohol test that day.

6 February

41. On 6 February, Mr Dowdle telephoned the community offender manager. He had no specific concerns or requests. The community offender manager observed that Mr Dowdle wanted someone to talk to. In the evening, as his curfew approached, he telephoned the AP to clarify when he needed to be back. He told the residential worker that he thought his curfew was 10.00pm but wanted to check because he could not understand the 24-hour clock. She told him that he should return by 8.00pm.

42. At 8.11pm, he telephoned again to say that he would be late. The residential worker thought that he sounded as if he might be intoxicated. She noted this in the handover for night staff. Mr Dowdle arrived back at the AP at 8.15pm, saying that he did not know the area and had got lost. One of the AP's residential workers conducted an alcohol test, which showed 68 micrograms of alcohol per 100 millilitres of breath. (The drink drive limit is 35.) This was reported in probation records.

43. The relief residential worker made a wellbeing check at 11.35pm. Mr Dowdle was looking at photographs of his son, who had died in 2016. He talked about his regrets about not being there for him while in prison but was trying to stop dwelling on difficult topics. Mr Dowdle declined her offer of independent bereavement support. She invited him to sit with staff in the office but Mr Dowdle said he wanted to sleep before his probation appointment the following morning. She said that staff would conduct wellbeing checks during the night. Mr Dowdle replied that he had no thoughts of harming himself and did not think it necessary but did not object. She updated Mr Dowdle's notes and informed the duty manager.

44. Through the night, staff conducted welfare checks as planned. She noted in the electronic record that Mr Dowdle's risk of self-harm should be reviewed.

7 – 8 February

45. On 7 February, Mr Dowdle met the community offender manager and a police officer who joined the meeting for a progress check. Police involvement was required as part of Mr Dowdle's multi-agency public protection arrangements (MAPPA) monitoring as a violent offender. Mr Dowdle said that he had booked an appointment with a different, private doctor to get a second opinion on his request for pregabalin. The community offender manager suggested that Mr Dowdle discuss this with the doctor in the OPD team at their next appointment. If she thought it appropriate, she could speak to his GP. The community offender manager asked Mr Dowdle about drinking alcohol at the weekend. Mr Dowdle said that he had only had one can of cider, and he would not do it again. When the community offender manager pointed out that he would not have given such a reading on a single can, he said that he had had two cans. He said that they could offer help if he was having problems. They discussed him eating alone in the AP, his low self-confidence, and how he could improve it. He asked him to write down how he was feeling and the issues he was facing so they could work through them at their next appointment.

46. That afternoon, Mr Dowdle had a telephone meeting with a community offender manager. He had cancelled his private doctor's appointment and planned to discuss his medication with the doctor when they next met. They discussed his self-image, his emotions about his son's suicide and how he could discuss these areas of his life with the doctor. The community offender manager encouraged him to interact with others, perhaps starting by talking to AP staff.

47. Mr Dowdle had a key work session with the probation officer about his release into the community. She reiterated the support that was available to him during his time at the AP. He repeated that he did not like dining communally, and she said that staff would continue to bring his meals to his room to ensure that he was eating. Mr Dowdle said that he was "feeling down" but that he had no thoughts of harming himself. The probation officer sent an email to staff, asking them to "keep an eye" on Mr Dowdle following her meeting with him. She exchanged emails with the AP manager, expressing concern at Mr Dowdle's presentation and asking whether his SaSP should be reviewed. The AP manager said that AP staff should monitor whether Mr Dowdle was taking his prescribed medication.

48. On 8 February, Mr Dowdle told staff that he was "fine" but tired so was resting. He complied with his curfew. His records show that he did not attend the office for an alcohol test.

9 and 10 February

49. On the morning of 9 February, Mr Dowdle returned to the AP with several bottles of water and a vitamin drink. A residential worker asked if he was okay. He said he felt very dehydrated and "wiped out". She asked if he was in pain or whether it was psychological, and he said the latter and attributed it to the shock of coming out of prison. She asked if he would like to see his GP. He agreed and she contacted the surgery and made an appointment for the following morning. She told the doctor that Mr Dowdle was unsure of the stage of his cancer treatment so the GP agreed to refer Mr Dowdle to the local oncology department.

50. That evening, Mr Dowdle told the residential worker that he felt unwell and wanted a COVID-19 test. The result was negative. She asked if he was still drinking fluids and he said he was. She said that if he felt unwell, staff could get him anything he needed. He gave her some money and asked for some fruit the following morning. They spoke for some time, and Mr Dowdle said that he wanted to get the support he needed to live his life, before going up to his room.

51. At 2.35am on 10 February, Mr Dowdle telephoned the office and told the residential worker that he had taken an overdose of paracetamol and wanted to die. She called for an ambulance and went to his room while speaking to operators. Mr Dowdle was pale and had been sick. The Ambulance Service asked questions through her, and Mr Dowdle said that on 8 February, he had bought several packs of paracetamol from different shops, gone to a park and taken them all. He said that he wanted a fast way out but it had not worked. He said that he did not want to be alive anymore and could not cope.

52. The residential worker sat with Mr Dowdle while waiting for the ambulance. Mr Dowdle said that if he was discharged from hospital, he would not return to the AP but would go elsewhere and take his own life. Mr Dowdle became more unwell and

at 3.10am, she made a follow-up call to the Ambulance Service. At 3.51am, Mr Dowdle vomited blood, and she made a further call to the Ambulance Service. An ambulance arrived at 3.56am and transferred Mr Dowdle to Bristol Royal Infirmary.

53. The residential worker advised the ambulance staff of Mr Dowdle's threat to take his own life if discharged and asked for the AP to be kept updated.

After Mr Dowdle's hospitalisation

54. Mr Dowdle's care plan noted that in an emergency, staff should contact his aunt as his next of kin. The residential worker telephoned and left a voicemail message asking her to contact the AP. She also provided his aunt's contact details to the hospital. She then went to Mr Dowdle's room and removed items that would increase his risk such as razors and paracetamol.

55. Staff made contingency plans in the event that Mr Dowdle was discharged from hospital. AP staff asked for updates about his condition and prognosis, and when he might be discharged but hospital staff were reluctant to pass on details because of patient confidentiality.

56. On 18 February, at approximately 3.00am, Mr Dowdle had a significant internal bleed. He died at 4.50am.

Contact with Mr Dowdle's family

57. AP staff stayed in contact with Mr Dowdle's aunt while he was in hospital. After he died, they arranged to pass his property to her when she felt ready. In line with national guidance, the Probation Service offered a contribution to the cost of Mr Dowdle's funeral.

Support for residents and staff

58. Managers spoke to staff after Mr Dowdle was hospitalised, offering support and signposting to sources of further support. After Mr Dowdle died, this support was offered again. AP staff informed the other residents that Mr Dowdle had died and offered support.

Post-mortem report

59. There was no post-mortem examination or toxicology test for Mr Dowdle. A hospital doctor concluded that Mr Dowdle died from a gastrointestinal bleed, acute liver failure and acute paracetamol intoxication, with chronic liver disease as a contributory factor. The Coroner accepted this cause of death.

Findings

Risk of suicide and self-harm

60. Prison, AP and probation staff supported Mr Dowdle to prepare for his release from prison. They made the appropriate referrals to support services, based on his identified needs and risk factors, and shared information appropriately between agencies to ensure the risks were managed.

61. On arrival at the AP, the probation officer completed a standard SaSP assessment. She had not seen him personally but based the assessment on notes of Mr Dowdle's induction meeting with another member of staff. She also reviewed his records and risk assessments. She noted his known risk factors and his forward-looking attitude at that stage and recorded that he presented as posing a low risk of suicide or self-harm. The sessional residential worker's notes addressed the appropriate issues, which were then reflected in the SaSP. The AP manager reviewed and countersigned the probation officer's assessment. Based on the circumstances, we are satisfied that this was a reasonable approach.

62. SaSP guidance says that the plan should be updated or reviewed in response to any changes "and especially when there is evidence of increased risk or distress". On 6 February, when a residential worker had concerns about Mr Dowdle, she recommended an SaSP review the following day. On 7 February, the probation officer asked the AP manager if Mr Dowdle's SaSP should be reviewed, and sent a message asking staff to "keep an eye" on Mr Dowdle. On 9 February, he accepted the offer of a GP appointment as he felt "wiped out". There is no evidence that Mr Dowdle's plan was reassessed or updated during his time in Brigstocke Road AP, despite a clear escalation in Mr Dowdle's risk factors and wellbeing concerns. When he tested positive for alcohol, this was not recorded on the plan, even though it was an identified risk factor.

63. Staff implemented welfare checks on Mr Dowdle when they had concerns about him. They encouraged him to engage with them and with other residents. Information was recorded on his electronic record and in handover notes, and at interview, we heard of verbal discussions about Mr Dowdle's risks. We are satisfied that staff were alert to Mr Dowdle's risks and responded appropriately. This information was not, however, recorded on an updated SaSP form. Nor was consideration given to whether Mr Dowdle needed to be supported under Collaborative Assessment of Risk and Emotion procedures (which is the process to support residents thought to be at risk of self-harm). We make the following recommendation:

    The Manager of Brigstocke Road AP should ensure that significant changes in risk are recorded in residents' Support and Safety Plans.

Substance misuse

64. Mr Dowdle had drunk alcohol on his journey from Channings Wood to Brigstocke Road AP, and he disclosed this to AP staff on arrival. He was open with them about drinking alcohol on 6 February, after a breathalyser test was almost double

the drink drive limit. He changed his claim to have had only one drink when challenged.

65. Mr Dowdle's licence contained no requirement for alcohol testing. However, it was clear in his probation risk assessments that his offending risks increased when he drank alcohol. On both occasions that Mr Dowdle drank alcohol, it was outside the AP, and therefore did not break any rules or breach his licence. However, staff took appropriate action to manage the risks. AP and probation staff shared information on both occasions and the community offender manager discussed alcohol use with Mr Dowdle at a supervision meeting.

66. Alcohol was prohibited in the AP, in line with national policy requirements. National policy required testing on an intelligence basis, as opposed to consistent and planned testing, with the purpose of ensuring individuals could not circumvent the system. There was no consistency in the testing undertaken on Mr Dowdle but this does not appear to be due to it being an intelligence-led system on every occasion. We found evidence that staff misunderstood the local requirements about alcohol testing.

67. While there is no evidence to suggest that this impacted on the outcome for Mr Dowdle, it might have an impact on future outcomes. Where alcohol consumption is linked to an increase in the risk of offending, or other risks, there must be a clear policy in place, understood by all staff, to ensure that risks are managed or reduced effectively. We make the following recommendation:

The Manager of Brigstocke Road AP should clarify the policy on alcohol testing and ensure that staff are aware of expectations.

Healthcare

68. When Mr Dowdle gave his medication to AP staff, he mentioned that he was considering stopping taking it. Staff reminded him that it was his responsibility to attend the office to request his medication, and that he could discuss any issues about the medication itself with his GP, once he was registered. During his time in the AP, Mr Dowdle did not collect his medication. Staff noticed this, and on 7 February, the AP manager sent a reminder to staff to check on future collections.

69. Residents in APs are responsible for their own healthcare. Mr Dowdle had spent a long time in prison, in which healthcare is provided automatically when it is needed. When Mr Dowdle felt unwell, a residential worker provided a COVID-19 test for him, and arranged an urgent appointment with the GP on his behalf to ensure his risks were reduced. Mr Dowdle told her that he was unsure of the current stage of his cancer care, which she reported to the GP surgery and asked them to address it during the appointment. We are satisfied that staff worked to ensure continuity in Mr Dowdle's healthcare.

70. When Mr Dowdle was taken to hospital, a residential worker appropriately cleared his room of any unsafe items and identified and contacted his next of kin.

71. Mr Dowdle was a high-risk offender, subject to enhanced monitoring under MAPPA. He was required to live in an AP following his release from prison because his risks could not be managed in the wider community. AP staff developed a contingency

plan in the event that he was discharged to ensure the risk of harm to himself and others was appropriately managed.

72. AP staff shared information with the hospital about Mr Dowdle's previous threat to take his own life if discharged. When they contacted the hospital for updates about Mr Dowdle, hospital staff were reluctant to pass on details about his condition. The hospital were also unwilling to share information about whether Mr Dowdle had been or would be discharged.

73. Mr Dowdle's condition worsened, and he died in hospital, which meant the contingency plan was never implemented. However, he was a high-risk MAPPA offender, subject to enhanced monitoring due to the risk of violence he posed. He was also identified as at risk of harming himself. If he had been discharged without notification to AP staff or his community offender managers, these risks could not have been managed and this might have resulted in harm to Mr Dowdle or the public. We accept that patient confidentiality regulations might have prevented the sharing of information about Mr Dowdle's health. While we recognise that AP staff appropriately tried to obtain information about Mr Dowdle's care needs on discharge from hospital, it is important that they are able to obtain information about people on probation before they are discharged from hospital into their care. We consider that information on discharge was integral to public protection and the safeguarding of Mr Dowdle, and should be able to be shared where necessary for risk management purposes. We make the following recommendation:

The Approved Premises Area Manager for the South West should liaise with the local NHS Trust to explore whether a local protocol can be established to enable the sharing of information about hospitalised offenders under supervision, where this is required for safeguarding or risk management purposes.

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 020 7633 4100