Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Daniel Varndell, a resident at Dickson House Approved Premises, on 12 May 2020

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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

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 Daniel Varndell died from mixed drug toxicity on 12 May while unlawfully at large from Dickson House Approved Premises. He was 30 years old. I offer my condolences to Mr Varndell's family and friends.

Mr Varndell had a number of challenging mental health issues and was assessed as presenting high risk to himself and others. On 10 May, he attacked another resident at Dickson House and left the premises soon afterwards. He was found dead at a private house two days later.

Overall Mr Varndell was well managed at Dickson House. I am concerned that the system in place for staff to summon urgent police assistance did not work as it should have done. As a result, the police arrived at the Approved Premises after Mr Varndell had left. Had they been there sooner they would have arrested Mr Varndell, he would have been returned to prison and the outcome might have been different. There were also deficiencies in family liaison that led to further distress for Mr Varndell's next of kin at an already difficult time.

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

Sue McAllister CB
Prisons and Probation Ombudsman **October 2021**

Contents

Summary

Events

1. On 4 January 2019, Mr Varndell was sentenced to 18 months for battery and five counts of assault. He was released on licence from HMP Winchester to Dickson House Approved Premises (AP) on 9 August 2019 but was recalled to prison on 16 August after probation staff decided they were unable to manage his risk in the community.

2. On Thursday 7 May 2020, Mr Varndell was released on licence to Dickson House at his sentence expiry date.

3. On 8 May, staff suspected that Mr Varndell might be under the influence of an illicit substance but were unable to undertake suspicion drug testing due to restrictions imposed during the COVID-19 pandemic. (What they thought was a pipe for smoking crack cocaine later turned out to be a vaping device.)

4. After initially appearing resistant to cooperating with staff, Mr Varndell became more settled, and there were signs of a developing trust.

5. At 5.35pm on 10 May, staff witnessed Mr Varndell attack another resident. Mr Varndell left Dickson House at 5.50pm and did not return. On 12 May, the police informed the AP that Mr Varndell had been found dead at a private house.

6. A post-mortem and toxicology report showed he had died from inhaling his vomit due to mixed-drug toxicity.

Findings

7. Overall, Mr Varndell received good care at Dickson House AP.

8. The personal alarm system in place did not work as it should have done when Mr Varndell attacked the other resident on 10 May. There appears to have been a delay between staff activating their alarms and the message being received by the security company monitoring them, and Mr Varndell left the AP before the police arrived.

9. The AP did not appoint a family liaison officer in line with guidance in place at the time. The issue was confused by the fact that Mr Varndell died outside the AP and had been recalled to prison in his absence. This led to a delay in Mr Varndell's next of kin receiving his property and added to their distress.

Recommendations

- The Manager of Dickson House should ensure that in case of future deaths, the AP appoints a dedicated family liaison officer and that their responsibilities are set out in local guidance.

- The National Probation Service should amend the guidance in the Approved Premises Manual (Annex D) to ensure that staff are aware of their responsibilities when an AP resident dies in the community.

The Investigation Process

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

11. The investigator obtained copies of relevant extracts from Mr Varndell's probation service records and CCTV from 10 May 2019. Further information on the alarm system was obtained from the Ministry of Justice (MOJ) Area Facilities Manager for South West/Hampshire.

12. Due to restrictions in place during the COVID-19 pandemic, the investigator interviewed three members of staff by telephone and spoke at length to the AP manager, also by telephone.

13. We informed HM Coroner for Hampshire, Portsmouth and Southampton of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

14. Our family liaison officer wrote to Mr Varndell's mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Varndell's mother asked:

    - Was Mr Varndell prescribed medication for schizophrenia while in prison?
    - What was the prison's assessment of his mental state when he was released from prison?
    - Did he get early release?
    - Was he released early due to the coronavirus? (If so, she does not think that this was appropriate, given his mental health issues.)
    - What support did he get for his mental health when he was at the AP?
    - Had there been an incident that made him leave the AP? (She had been told there was by unofficial sources.)
    - What happened to his property at the AP? (On the day he died, she was told by the AP manager that the police had taken his property away that day. The police said they did not remove his property, and that it was still at the AP. She was still trying to get it back.)
    - Why was she not told until 10.00pm that he had died?

15. We have answered these questions in this report and in separate correspondence.

16. In response to our initial report, Mr Varndell's mother contacted us to say that her son did not want to be released into an AP but wanted to be moved to a mental health unit.

Background Information

Dickson House AP

17. Dickson House is an Approved Premises (AP – formerly known as a probation hostel) in Fareham, near Portsmouth, managed by the National Probation Service. It provides accommodation for up to 19 adult males.

18. Each resident is allocated a key worker, with whom the resident discusses their progress and well-being. The key worker also ensures that residents adhere to their individual licence conditions and the rules of the AP. Dickson House is staffed 24 hours a day by probation employees.

19. A Clinical Nurse Specialist from the Offender Personality Disorder (OPD) Pathfinder team works in Dickson House for half a day a week.

20. Dickson House staff are provided with personal attack alarms monitored by OCS Group UK Ltd under contract from Custodian. When staff trigger their alarms, OCS are alerted and are required to call the police immediately using a direct line that by-passes the 999 call process. They should then call the AP and establish whether the emergency is genuine and update the police.

21. In the year to February 2021, Dickson House staff triggered their personal alarms twice.

Previous deaths at Dickson house

22. In 2004 we investigated the death of a resident by drug overdose while off the premises. In 2013 we investigated the death of a resident from natural causes. There are no similarities between either of these deaths and Mr Varndell's death.

Multi-agency public protection arrangements (MAPPA)

23. MAPPA is a set of public protection arrangements to ensure the successful management of violent and sexual offenders in the community by the police, probation trusts and prisons working together.

Key Events

24. Mr Daniel Varndell had a history of drug misuse, violence, anxiety, attempted suicide, self-harm and severe mental illness. He was diagnosed with dissocial personality disorder and paranoid schizophrenia in 2009 and admitted to Broadmoor high secure psychiatric hospital for several months before progressing to medium secure psychiatric units. Mr Varndell had a number of convictions for assaulting police officers and members of staff from different agencies and for possession of weapons. He was at high risk of suicide and severe self-harm and in 2018 he was placed on life support in hospital after taking an overdose of different drugs.

January 2019 – April 2020

25. On 4 January 2019, Mr Varndell was sentenced to 18 months for battery and five counts of assaulting a police officer. In July 2019, he was assessed as presenting a very high risk to himself and others at a multi-agency public protection arrangements (MAPPA) level 3 meeting.

26. On 9 August, Mr Varndell was released on licence to Dickson House Approved Premises (AP). Because of his risk to others, probation services and the police had developed a trigger plan for AP staff, with instructions about what to do if Mr Varndell breached the conditions of his licence.

27. On 15 August, Mr Varndell's Offender Manager applied for his licence to be revoked on the grounds that his risk was no longer manageable in the community. Mr Varndell was returned to prison, HMP Lewes, on 17 August.

28. Mr Varndell was discussed at MAPPA meetings in April 2020, as the end of his prison sentence approached. A bed was again found for him in Dickson House. As before, a trigger plan was agreed between Mr Varndell's offender manager and the local police.

5 – 9 May 2020

29. On 5 May an officer told Mr Varndell that he would be returning to Dickson House on release and had an appointment with a forensic psychologist from the personality disorder service the same day. Mr Varndell replied that he "might not make it there". He said he had explained before that he was "not going to live with sex offenders".

30. Mr Varndell was released to Dickson House at his sentence expiry date on Thursday 7 May. He was given a five-day supply of medication (instead of the more usual seven-to-ten-day supply) because of concerns that he had misused his medication in prison, and a discharge letter for his GP.

31. Mr Varndell arrived at Dickson House at 12.15pm. A residential worker completed his induction. He said that Mr Varndell was not happy to be there. Mr Varndell said he would not come back to the AP that night and would cut one of his arteries so he would be sent to hospital. Mr Varndell refused to sign most of his admission paperwork, including next of kin details, and to hand over his medication. (Mr

Varndell was not allowed to keep his medication with him because of his history of self-harm and previous problems managing medication.)

32. The AP manager completed a 'risk to self, assessment and management plan'. Mr Varndell said he had been monitored under suicide and self-harm monitoring procedures in prison and had not wanted to be released. The manager assessed Mr Varndell as borderline between raised and imminent risk of self-harm based on his history and his threat to cut an artery. The plan included regular room searches in Mr Varndell's presence, and regular welfare checks throughout the day and every one to two hours overnight to check for signs of life. Mr Varndell was allocated a room close to the stairs to reduce staff response time in case of an incident. Staff made up packs of first aid material for Mr Varndell in case he cut himself.

33. The AP manager emailed Mr Varndell's offender manager about Mr Varndell's threat to break his curfew and harm himself. He also emailed the pharmacist at HMP Lewes to ask what medication Mr Varndell had been released with.

34. The forensic psychologist from Lewes rang while Mr Varndell was out during the afternoon and she said she would ring back the following Monday, 11 May (the first working day after the Bank Holiday weekend).

35. Mr Varndell arrived nine minutes late for his mandatory 5.00pm sign in. A residential worker asked to search his bag, and Mr Varndell handed over a razor blade that he said he was going to declare. He said that he was worried that AP staff were looking for a reason to recall him to prison because of his experience on his previous release. Mr Varndell again refused to hand over his medication. He threatened to "slice" or "string up" and said that it had needed three prison staff to control him and that it would need five AP staff to do the same.

36. Mr Varndell said three of his seven medications were "PRN" (to take as necessary) and would not hand them over. He left the hostel again (breaking restrictions under the COVID-19 lockdown) but said he would be back for the 9.00pm curfew. The AP manager updated his area manager, and they agreed to speak again if Mr Varndell was late for the 9.00pm curfew.

37. The AP manager rang his area manager at 9.13pm when Mr Varndell did not return to Dickson House. The area manager agreed to instigate emergency recall procedures, but Mr Varndell arrived back during their conversation. Recall procedures were put on hold pending Mr Varndell's behaviour between then and 11.00pm when the AP shut for the night.

38. Mr Varndell allowed a residential support worker to search his bag, and she found nothing illicit. He then realised one of the other residents was a friend who he had known in Broadmoor Hospital and began chatting to him.

39. At 10.50pm, the AP manager called his area manager and reported that Mr Varndell had appeared "spaced out and under the influence" but had not been aggressive or confrontational. He still refused to hand over his medication. Staff were unable to undertake a suspicion drug test as these were suspended because of COVID-19 lockdown measures. They agreed that staff should make welfare checks throughout the night to check Mr Varndell was breathing.

40. Between about 11.00pm and 2.00am, Mr Varndell spoke to a residential support worker and the AP manager in the AP office. He talked about the issues he had

had in prison, his mental health, his post-traumatic stress disorder (PTSD), how he felt his diagnosis of personality disorder was wrong, the sexual abuse he had suffered as a child and his self-harm.

41. Mr Varndell also showed them poetry he had written and agreed staff could display it in the AP. Mr Varndell asked for a razor because he had not been allowed one in prison. He shaved and said he would get his hair cut at his father's house the next day. He eventually went to bed at about 3.00am.

42. During the night, the AP manager emailed Mr Varndell's trigger plan to the AP staff, together with some information from the forensic psychologist on the best way of working with Mr Varndell. He briefed them on the events of 7 May and said Mr Varndell had agreed to hand over his medication when he got a new prescription on Monday 11 May. He said that if Mr Varndell tried to leave the AP, they should try to persuade him to stay but, if he became aggressive, they should allow him to leave and contact the duty manager.

43. At the 5.00am welfare check on 8 May, a member of staff suspected that Mr Varndell was hiding something. His speech was slurred but he denied taking anything illicit. At the 7.00am welfare check a residential worker thought she saw a pipe for smoking crack cocaine under his arm. He denied taking crack and refused to show her the object. She reminded him that drugs were not allowed in the AP. She said she did not want to push the issue due to concern over Mr Varndell's history of violence to staff. (It later transpired that the object she had seen was a vaping device.)

44. At 9.40am, Mr Varndell told staff he had not slept well, and spent most of the day in bed. He left the AP at about 7.30pm for his hour of exercise and returned by 8.30pm. He ate with the other residents and a residential worker showed him his poetry typed up and ready for display. He said Mr Varndell was very pleased, thanked him and even joked with him. Mr Varndell did not appear under the influence during the day.

45. Mr Varndell ate his meals with the other residents on 9 May and there were no recorded incidents. The AP manager updated his area manager and said he felt that they had made a positive start and had started to build trust with Mr Varndell.

10 May 2020

46. The next day, 10 May, Mr Varndell appeared quiet and polite at all of the morning welfare checks. In the afternoon he completed his GP registration forms and signed a consent form allowing the AP to request his medical details and for his medication to be sent direct to the AP from his GP.

47. At 5.35pm, Mr Varndell attacked another resident in the TV room. Staff, who were based in the AP office, saw Mr Varndell on top of the other resident hitting him violently. Residents tried to defuse the situation and Mr Varndell went and sat in the dining room, although he remained apparently agitated. Mr Varndell then left the AP at 5.50pm.

48. A residential worker said that she was working in the office when she heard a fight. She watched what was happening on CCTV and made the decision, as the most experienced member of staff present, not to intervene. She said she took into

account Mr Varndell's MAPPA risk level, the police trigger plan, his history of violence and the number of other residents present.

49. The residential worker said that she activated her personal alarm at 5.38pm, to summon help from the police via the security company. She said that she understood that the alarm company was supposed to contact the police and ring the AP back immediately to confirm assistance was needed. In her experience, on the couple of occasions she remembered, there had been an issue with the speed of the response. (The investigator established that the personal attack alarms were activated twice between 21 February 2020 and 21 February 2021 including during this incident.)

50. When no one from the security company rang back immediately, the residential worker called 999 and asked for the police. The security company rang back at 5.50pm, during this phone call. Two police officers arrived at about 5.55pm, after Mr Varndell had left the AP.

51. The Ministry of Justice Area Facilities Manager for South West and Hampshire obtained details about the incident from the security company for the investigator. The security company said the emergency call from Dickson House came through to them at 5.49pm and they called the police 22 seconds later. They called the AP at 5.50pm who confirmed the police were needed. The security company contacted the police again to confirm they should attend the AP.

52. The Area Facilities Manager subsequently told the investigator that a new integrated CCTV, panic alarm and access control system was due to be installed at Dickson House from 12 April 2021.

Events after Mr Varndell left Dickson House

53. The police looked for Mr Varndell in the area but were unable to find him. They returned to the AP and searched his room but did not find anything to indicate where Mr Varndell had gone. The resident involved in the fight told AP staff later that he had asked Mr Varndell and another resident to talk somewhere else because he was trying to watch TV. In response Mr Varndell had attacked him.

54. Another resident who had known Mr Varndell in Broadmoor, told an AP worker that Mr Varndell had confided in him that a drug dealer outside the AP had been bothering him and threatening his family and that he was considering assaulting him.

55. Mr Varndell did not return to Dickson House. At 7.05pm, the AP were told that he had been recalled to prison and to call 999 if he returned.

56. On 12 May, police told the AP manager that Mr Varndell had been found dead in a private house.

Contact with Mr Varndell's family

57. The police informed Mr Varndell's next of kin that he had died before they informed the AP.

58. Mr Varndell's mother attempted to collect his property from the AP later the same day, but the AP manager told her he was waiting for the police to confirm whether they needed it for their investigation and was unable to release it.

59. On 11 June, Mr Varndell's mother told our family liaison officer that she had still not received her son's property and was distressed by the delay. When the investigator contacted the AP manager about this, he realised that he had missed an email from the police confirming they did not need Mr Varndell's property. He subsequently contacted Mr Varndell's mother and she collected her son's property.

Support for residents and staff

60. The other resident involved in the fight on 10 May and the resident who knew Mr Varndell from Broadmoor, received individual support from staff. AP staff received support from the AP manager. Both residents and staff were reminded of the support services available to them. Staff interviewed were happy with the support they had received.

Post-mortem report

61. The pathologist concluded Mr Varndell died from inhaling his vomit due to mixed drug toxicity.

62. A toxicology report showed Mr Varndell had cocaine, heroin and amphetamines in his system when he died, as well as three of the medications prescribed to him.

Findings

Overall care for Mr Varndell at Dickson House

63. Mr Varndell's severe personality disorder meant he was a very challenging man to manage, and he had a significant history of violence towards those in authority. We consider that, overall, Dickson House managed Mr Varndell very well during his short period with them. Contingency measures in the form of a risk and trigger plan were in place in case support was needed from police and probation services.

64. An open channel of communication was kept with senior probation staff and Mr Varndell's offender manager. When staff suspected that Mr Varndell was under the influence of an illicit substance, they were unable to drug test him under restrictions imposed during the COVID-19 pandemic, but adopted sensible precautionary measures including checking him more frequently during the night.

65. There was good evidence that some trust was developing between staff and Mr Varndell – he was evidently pleased to have his poetry displayed, he opened up about some personal issues and he agreed to let staff have his medication when he received a new prescription.

66. It was unfortunate that Mr Varndell was not in the AP when his psychologist rang on 7 May but, given the circumstances in which Mr Varndell left the AP, we do not consider this affected the outcome for him.

The Emergency Response

67. The AP manager provided all staff with Mr Varndell's trigger plan and information from his psychologist on the best way of working with him. On 7 May, he advised them that, if Mr Varndell tried to leave the AP, they should attempt to persuade him to stay but, if he became aggressive, they should allow him to leave and contact the duty manager. We consider that the decision taken by staff who witnessed Mr Varndell attack another resident on 10 May not to intervene but to activate their personal alarms, was reasonable given Mr Varndell's history of violence and in line with advice given to them.

68. It was clear from interviews that staff had little confidence in their personal attack alarms and the system underpinning it. On this occasion, from the evidence we have seen, it appears that about ten minutes elapsed between staff activating their alarms and the security company registering the call. The decision to adopt that alarm system is historic and beyond the scope of this investigation.

69. It is fundamental that AP staff, who work with challenging and violent people, have an effective means of summoning emergency help. Most crucially in this case, the delay meant that Mr Varndell managed to leave the AP before the police arrived. Mr Varndell's violent behaviour to another resident would have resulted in his arrest and did result in his recall to prison and, had this happened, the outcome might have been different.

70. We are satisfied that the alarm system is about to be replaced with a completely new system from 12 April 2021 and we make no recommendation.

Family liaison

71. The Approved Premises Manual Annex D, which was in force at the time Mr Varndell died, required APs to appoint a responsible member of staff to act as family liaison officer. Although Mr Varndell did not supply details of his next of kin when he arrived at Dickson House, the AP became aware of his mother's details when she went there on the day he died.

72. The AP manager said he did not appoint a family liaison officer in this case because he felt shift patterns meant it would not be possible for them to provide consistent support. He said the expectations of the AP were confused by fact that Mr Varndell had not died on the premises and, technically, was not a resident because he had been recalled to prison.

73. Deaths in APs are rare and the previous death at Dickson House was in 2013. As a result, AP managers and staff are often unfamiliar with the death in custody reporting process and their responsibilities following a death. In fairness to the AP manager, the AP manual does not specifically address what to do when a resident dies off the premises. However, one interpretation of this omission is that the location of the death does not make a difference to the family liaison expected of the AP.

74. Our view, and the spirit of the guidance in force at the time, is that responsibility for family liaison falls most naturally to the AP. They know what happened up the point the person left the premises – which is typically the sort of information that next of kin want to know – and they hold the remainder of the person's property.

75. The problem of shift patterns is not unique to APs. Prisons also have to work around shift patterns when they appoint a family liaison officer and do so by appointing a deputy to ensure there is always someone available for the family to contact.

76. The AP manager's decision not to appoint a family liaison officer led to a lack of focus and ultimately added to the distress of Mr Varndell's next of kin at a very sad time. We make the following recommendations:

    The Manager of Dickson House should ensure that, in case of future deaths, the AP appoints a dedicated family liaison officer and that their responsibilities are set out in local guidance.

    The National Probation Service should amend the guidance in the Approved Premises Manual (Annex D) to ensure that staff are aware of their responsibilities when an AP resident dies in the community.

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