Prisons &
Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Lee Longstaff, a resident at Nelson House Approved Premises, on 21 March 2021

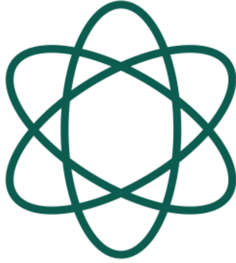
Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

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

T I 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 Lee Longstaff died of heart failure as a result of the combined effects of methadone, mirtazapine, pregabalin and zopiclone on 21 March 2021 at Nelson House Approved Premises. He was 37 years old. I offer my condolences to his family and friends.

Mr Longstaff had been released from prison just over three weeks before he died. He had a history of substance misuse and, despite being warned of the possible consequences, it appears that he continued to use illicit drugs at Nelson House. I am satisfied that staff at Nelson House Approved Premises could not reasonably have done more to have prevented this.

I am also satisfied that staff at Nelson House responded promptly and professionally when they discovered Mr Longstaff unresponsive. Although staff were not carrying emergency safety equipment when Mr Longstaff was found, this had no significant impact and CPR was started promptly.

I consider that staff should have tried to obtain a response from Mr Longstaff when they saw him snoring in bed on the afternoon he was found dead, but I cannot say whether this might have changed the outcome.

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

Elizabeth Moody
Deputy Prisons and Probation Ombudsman **November 2021**

Contents

Summary 1

The Investigation Process...3

Background Information...4

Key Events..5

Findings 10

Summary

Events

1. On 26 February 2021, Mr Lee Longstaff was released on licence from HMP Holme House to Nelson House Approved Premises (AP). He had a history of substance misuse, both alcohol and drugs and was prescribed methadone (an opiate substitute).

2. As part of his induction, AP staff warned Mr Longstaff of the risks of using drugs, explained his licence conditions, the AP rules and the COVID-19 restrictions.

3. Probation records show that two days after he arrived at Nelson House, AP staff were concerned that Mr Longstaff was using illicit substances. AP staff were not able to conduct drug and alcohol testing due to COVID-19 restrictions.

4. On 1 March, Mr Longstaff's offender manager (probation officer) reminded him that his licence conditions required him to abstain from illicit substances or he risked being recalled to prison. Two days later, Mr Longstaff was found under the influence of drugs, and he tested positive for cocaine on 5 March. AP staff subsequently gave Mr Longstaff a warning.

5. On 21 March, AP staff observed that Mr Longstaff appeared to be under the influence of an illicit substance although Mr Longstaff denied this. Staff checked him at about 2.40pm and noted that he was asleep in bed and snoring.

6. At 5.39pm, a residential worker conducting another welfare check found Mr Longstaff lying on his bed, unresponsive and not breathing. He radioed his colleague to call an ambulance and to bring emergency equipment. He started cardiopulmonary resuscitation (CPR), assisted by an AP resident. His colleague arrived and assisted.

7. At 5.55pm, paramedics arrived and took over resuscitation efforts, but Mr Longstaff was pronounced dead at 5.59pm.

8. A post-mortem examination found that Mr Longstaff died of heart failure as a result of taking methadone, mirtazapine, pregabalin and zopiclone.

Findings

9. Mr Longstaff had a long history of substance misuse. AP staff reminded him of the dangers of misusing illicit substances following his release from prison and during his time at the AP. We are satisfied that AP staff could not reasonably have prevented Mr Longstaff's actions.

10. However, drug use was clearly a problem at Nelson House at the time of Mr Longstaff's death, and we await the National Probation Service's revised drug strategy to support approved premises' local drug policies.

11. We are concerned about the welfare check on the afternoon of Mr Longstaff's death. Staff interpreted the fact that he was snoring as a positive sign. However, snoring can be a sign of a drug overdose and, given that they suspected Mr Longstaff may have been under the influence of illicit substances, we consider that

they should have tried to get a response from him after hearing him snoring. We cannot say whether this might have altered the outcome for Mr Longstaff.

12. Probation residential workers acted promptly when they found Mr Longstaff, but staff should carry emergency aids with them when conducting welfare checks.

Recommendations

- The National Probation Service should provide the Ombudsman with an assurance that a revised drug strategy will be implemented by December 2021.
- The National Approved Premises Team should ensure that AP staff know that snoring can be a sign of a drug overdose.
- The Approved Premises Manager should ensure that staff always carry emergency aids with them when conducting welfare checks.

The Investigation Process

13. The investigator issued notices to staff and residents at Nelson House Approved Premises informing them of the investigation and asking anyone with relevant information to contact him. One resident responded.

14. The investigator obtained copies of relevant extracts from Mr Longstaff's probation records.

15. The investigator interviewed five members of staff and three residents. The interviews were completed by video and telephone because of the restrictions imposed due to the COVID-19 pandemic.

16. We informed HM Coroner for Teesside of the investigation. She gave us the results of the post-mortem examination, and we have sent the Coroner a copy of this report.

17. One of the Ombudsman's family liaison officers contacted Mr Longstaff's mother to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Longstaff's mother wanted to know all the circumstances leading to her son's death.

18. Mr Longstaff's mother received a copy of the draft report. She did not wish to make any further comment.

19. The approved premises also received a copy of the report and did not identify any factual inaccuracies.

Background Information

Nelson House Approved Premises

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

21. Nelson House, in Middlesbrough, is managed by the National Probation Service. It can accommodate up to 23 residents. Nelson House is staffed by Probation Service employees who are on duty 24 hours a day. Sodexo provide security staff and cleaners. Staff in reception keep each resident's prescribed medication locked away and administer it as required. Nelson House staff are not clinically trained, other than to distribute medication.

22. Residents are subject to AP rules on top of any licence conditions they have been given. They are not permitted to leave the building between 11.00pm and 6.00am. They are also not permitted to smoke in the building – there is an external smoking area, with a separate covered shed. Due to COVID-19 restrictions, further restrictions were put in place to help to safeguard the wellbeing of staff and residents.

Previous deaths

23. Mr Longstaff's death was the second death at Nelson House since January 2019. The previous resident died of natural causes and there were no similarities between this death and that of Mr Longstaff.

Key Events

24. On Friday 26 February 2021, Mr Lee Longstaff was released from HMP Holme House, having served an indeterminate sentence of Imprisonment for Public Protection (IPP). His licence conditions required him to live at Nelson House Approved Premises (AP) and to address his substance misuse and anger management issues. Mr Longstaff had a daily curfew which required him to be at Nelson House between 8.00pm and 7.00am.

25. Before he arrived at the AP, Mr Longstaff attended his community drug support session appointment with the organisation We Are With You. It was agreed that he needed to attend the support centre once a week.

26. When Mr Longstaff arrived at the AP, a residential worker conducted his induction. He explained the AP rules, including curfew times, and the additional rules and restrictions which applied due to COVID-19. These included that residents were only allowed off the AP grounds for around two hours a day. The AP had arranged for extra food to be delivered due to the limited time residents were allowed out of the AP. Due to social distancing measures, apart from collecting their meals during the day, residents spent most of the time in their rooms. AP staff were also not carrying out drug and alcohol testing or room searches in order to reduce their potential exposure to the virus.

27. Mr Longstaff told the residential worker that he had a history of alcohol and drug misuse. He said he had no thoughts of suicide and self-harm. It was noted that he was on a methadone (heroin substitute) programme and had arranged to receive his medication from the local pharmacy daily.

28. A residential worker spoke to Mr Longstaff on the evening he arrived and had no concerns about him. At the time, Mr Longstaff was having his electronic monitoring tag fitted. He appeared positive and was talking to another resident.

29. The next morning, a residential worker spoke to Mr Longstaff. She noted he was polite and appeared to have settled well into the AP. Mr Longstaff had had his methadone and participated in some exercise. Staff noted no concerns.

30. On the evening of 28 February, a residential worker recorded in nDelius (the probation electronic information system) that Mr Longstaff had red eyes and looked as though he was under the influence of a substance, although it may have been due to his methadone prescription. AP staff could not conduct any drug tests to confirm this due to COVID-19 restrictions.

31. On 1 March, an offender manager (probation officer) visited Mr Longstaff at the AP for his initial appointment. (Prior to COVID-19, this appointment would have taken place immediately after his release from prison.) She discussed his drug treatment and licence conditions, which included an exclusion zone and no contact with his ex-partners. Mr Longstaff said he was settling in and knew some of the residents. Having reviewed nDelius, she was aware that AP staff had suspected that Mr Longstaff had been under the influence of an illicit substance the previous evening. She reminded him to avoid negative influences and not to be recalled to custody by breaking his licence conditions or COVID-19 restrictions. Mr Longstaff said he fully

understood her concerns. He denied taking drugs but said he had had a few drinks since his release from prison.

32. On 2 March, the offender manager arranged a follow-up induction with Mr Longstaff. She said she wanted to ensure that Mr Longstaff was fully aware of the standard of behaviour expected from him.

33. Late that evening, a residential worker checked on Mr Longstaff. She observed that he appeared under the influence of a substance: he was sweaty, he looked flushed, and his speech was slow. Mr Longstaff said he was okay but that he had blisters on his feet. She noted her concerns on nDelius that Mr Longstaff may be using drugs or alcohol and that his appearance and behaviour had deteriorated since his arrival. A resident who lived opposite Mr Longstaff told the investigator that he had known Mr Longstaff for a long time and was aware that he suffered from blisters on his feet.

34. AP staff checked on Mr Longstaff five times that night and left his door open and light on to improve their observations. On most occasions, Mr Longstaff was observed snoring loudly and lying on the floor, although he did get up and try to close his door on one occasion. It was noted on nDelius that Mr Longstaff had befriended another resident who staff were monitoring on suspicion of bringing illicit substances into the AP.

35. On the morning of 3 March, the acting AP Manager contacted the offender manager about Mr Longstaff's recent behaviour. She said that he should be given a warning for not fully adhering to his licence and the COVID-19 restrictions.

36. The offender manager discussed Mr Longstaff with his key worker at We Are With You, the community drugs and alcohol support team. It was agreed that Mr Longstaff would be tested for drugs on 5 March when he attended his next support session.

37. On 5 March, Mr Longstaff attended his appointment at We Are With You and was drug tested. He tested positive for cocaine. On his return to the AP, an AP key worker contacted him by phone. (Each resident at the AP is allocated a key worker. Due to the COVID-19 pandemic, key workers were working from home at that time.) She said she had tried to email Mr Longstaff to explain her role just before his release from prison, but he had not responded.

38. On the morning of 8 March, a residential worker spoke to Mr Longstaff and gave him a verbal warning following his recent poor behaviour. Mr Longstaff accepted it but was unhappy as he believed that his behaviour had improved since 3 March.

39. The offender manager visited Mr Longstaff at the AP that day. She discussed his recent behaviour on 2 March when staff had had to check on him regularly. Mr Longstaff admitted that he had been drinking alcohol at the time and that his behaviour was unacceptable. She also discussed Mr Longstaff's recent positive test for cocaine. She told him that he would probably not be recalled to prison on this occasion but that he should continue to work with the drug support services.

40. On 11 March, the AP key worker completed a key worker session with Mr Longstaff by telephone. They discussed his drug treatment support and accommodation issues.

41. On 15 March, in the absence of the first offender manager, another offender manager checked on Mr Longstaff by telephone. He said that he was well and that his attitude had improved since the previous week. He acknowledged that his earlier behaviour in the AP could have resulted in being recalled to prison. He said he spent most of his time in his room watching television and only left the AP to collect his medication.

42. On 19 March, the AP key worker completed a further key worker session with Mr Longstaff by telephone. She told us that he was more open and talked about his medication. She said he felt anxious about living at the AP and being monitored all the time. He said he had had an appointment with the local GP the day before and had been prescribed mirtazapine (an antidepressant) to manage his anxiety. She reassured Mr Longstaff that he was doing well at the AP.

43. On 20 March, Mr Longstaff remained on the AP premises for most of the day. At around 5.00pm, a residential worker noted that Mr Longstaff said he was leaving the AP to collect his medication. He noted that staff should monitor Mr Longstaff when he returned, in case he and another resident with whom he had left were bringing drugs into the AP.

Events of 21 March 2021

44. When a residential worker checked Mr Longstaff in his room at 10.00am the following morning, he did not initially respond. He was in bed and had to be shaken to wake up. She noted that Mr Longstaff appeared to be under the influence of a substance as he was unable to focus, and his speech was slurred.

45. The AP provided the investigator with data about events recorded on the CCTV footage. It showed that at 12.16pm, Mr Longstaff left his room. He appeared to be unsteady on his feet and went downstairs to collect his lunch. Once downstairs, Mr Longstaff told staff that he was worried that the previous night duty staff and they would think that he had taken an illicit substance. While staff talked to Mr Longstaff, it was noted that he still appeared under the influence of a substance. Mr Longstaff returned to his room shortly after this.

46. During the day, two residential workers told us that they had been very busy dealing with two serious incidents in the AP. They had discovered a resident unconscious in his room after taking an overdose. The resident was taken to hospital by ambulance but later discharged himself and returned to the AP, threatening to take another overdose. Another resident was also threatening to take his own life. During this period, staff continued to check on other residents but were delayed more than usual.

47. When a residential worker checked on Mr Longstaff at 2.41pm (the delayed 2.00pm check), he noted that he was in bed asleep, was breathing normally and snoring.

48. Both residential workers had completed most of the 4.00pm resident welfare checks by 5.30pm. Only four residents remained unchecked at this time. Checks continued to be late due to the earlier incidents. One of the residential workers again had to deal with one of the residents who had had issues that day. The other residential worker therefore continued the welfare checks and found one of the four remaining residents under the influence of an illicit substance.

49. CCTV footage shows that the residential worker knocked on Mr Longstaff's door at 5.39pm to conduct the welfare check. When Mr Longstaff did not respond, he entered his room and saw Mr Longstaff on his bed. He was grey/blue in colour and had a thick, black liquid running from his mouth. He shook Mr Longstaff and called his name several times to get a response, but he remained unresponsive and appeared not to be breathing.

50. The residential worker was not wearing any personal protective equipment or gloves and was not carrying any emergency equipment, including a mobile phone, surgical masks and mini first aid kit. He shouted for help and radioed his colleague. He told her it was an emergency, that she needed to bring a defibrillator and to call an ambulance.

51. Two residents responded immediately to the residential worker's shouts. They helped him to place Mr Longstaff on the floor where cardiopulmonary resuscitation (CPR) could be carried out. The residential worker started CPR. One resident said Mr Longstaff's face and hands were cold. He called the ambulance on his mobile phone.

52. As soon as the other residential worker received her colleague's message, she used the office landline to call an ambulance, collected the emergency bag and defibrillator and went to Mr Longstaff's room. The ambulance service spoke to the residential worker by telephone and gave him instructions on how to support Mr Longstaff.

53. A residential worker set up the defibrillator and attached it to Mr Longstaff. It instructed for CPR to continue. The residential worker continued with chest compressions while his colleague ensured Mr Longstaff's mouth and airways remained opened.

54. When the paramedics arrived at 5.55pm, they took over the care of Mr Longstaff. Another paramedic arrived two minutes later. At 5.59pm, the paramedics declared that Mr Longstaff had died.

55. A residential worker contacted the AP on-call manager, the Acting AP manager and the police to inform them of Mr Longstaff's death.

Contact with Mr Longstaff's family

56. That evening, the police informed Mr Longstaff's next of kin of his death and offered their condolences.

57. On 23 March, the acting AP manager contacted Mr Longstaff's mother and offered her condolences and support. She continued to support Mr Longstaff's mother until his funeral, which she attended, on 7 April. The Probation Service offered to contribute towards its cost in line with national policy.

Support for residents and staff

58. After Mr Longstaff's death, the on-call manager immediately attended the AP, and offered support to the duty staff. The acting AP manager again offered support to all the staff when she attended the AP the following morning.

59. Staff held a meeting and told all the residents that Mr Longstaff had died and offered support. Notices were posted.

Post-mortem report

60. The post-mortem report established that Mr Longstaff had died from acute left ventricular failure due to the combined effects of methadone, pregabalin, mirtazapine and zopiclone.

61. Mr Longstaff was prescribed methadone and mirtazapine. He was not prescribed pregabalin (used for epilepsy, nerve pain and anxiety, but also abused for its euphoric effects) or zopiclone (a tranquiliser).

62. The post-mortem toxicology report noted that although the quantity of each of the drugs used would not have been expected to pose a threat to life on its own, the combination might have been sufficient to induce a degree of central nervous system depression sufficient to explain Mr Longstaff's death.

Findings

Substance misuse

63. Mr Longstaff had a significant history of substance misuse. The risk of relapse for a released prisoner with a history of substance misuse is high, especially for someone like Mr Longstaff who had been in prison for some time. The risk of a fatal overdose is also high due to a diminished tolerance, especially in the immediate post-release period. Probation Instruction (PI) 32/2014 says that a main cause of death among AP residents is drug overdose, and that APs can play a major part in helping offenders not to misuse substances.

64. On release from prison, Mr Longstaff was referred promptly to community drugs and alcohol support services who reminded him of the risks of using illicit substances, especially while taking prescribed medication. This was reiterated by AP staff when he arrived at Nelson House that day.

65. Mr Longstaff attended the community drugs and alcohol support service on a weekly basis, was monitored by AP staff and his offender manager, and had received a warning about his behaviour. Despite this, he continued to use illicit drugs and alcohol. While Mr Longstaff accepted that his early behaviour at the AP was not acceptable and he promised to abstain from using illicit substances, he was again found apparently under the influence of drugs or alcohol.

66. The staff, who had contact with Mr Longstaff before his death recognised that he presented as under the influence of drugs or alcohol and appropriately recorded their observations which were followed up by his offender manager. We are satisfied that staff could not reasonably have done any more to prevent Mr Longstaff taking illicit substances.

Substance misuse at Nelson House

67. AP staff faced many difficulties in managing residents during the COVID-19 pandemic as, under new rules introduced under the Exceptional Delivery Model (EDM), they were not permitted to conduct room searches or drug and alcohol testing. They therefore had to rely solely on their observation and judgement.

68. The Acting AP Manager told us that during Mr Longstaff's time at the AP, staff had recognised that there appeared to be a lot of drugs on the premises and action taken before Mr Longstaff's death had resulted in a number of residents being recalled to custody. Shortly after Mr Longstaff's death, APs were allowed to start drug and alcohol testing and the searching of rooms again, which produced positive outcomes.

69. In several investigations dating back to 2016, we have recommended that the National Probation Service review its drugs strategy for approved premises. We are aware that the National Approved Premises Team had been working on a revised strategy, but its production has been significantly delayed by the COVID-19 pandemic. Urgent action is needed to ensure that the roll out of a national strategy is implemented at the earliest opportunity to help AP staff manage the misuse of illicit drug use in APs. We make the following recommendation:

The National Probation Service should provide the Ombudsman with an assurance that a revised drug strategy will be implemented by December 2021.

Welfare checks

70. When the residential worker checked on Mr Longstaff at 2.41pm on 21 March, he found that he was snoring, and he did not seek a response from him despite the fact that Mr Longstaff had appeared to be under the influence of an illicit substance earlier.

71. We see many drug-related deaths where snoring is taken as a sign that an individual is alive and 'sleeping it off', when in fact it can be a recognised sign of respiratory distress caused by a drug overdose. We are concerned that staff did not recognise snoring as a sign of a possible drug overdose and did not immediately try to establish if Mr Longstaff was unwell or needed assistance, particularly as he had been noted as presenting under the influence of drugs. We cannot say, however, whether the outcome might have been different for Mr Longstaff if this had been done.

72. We recommend:

The National Approved Premises Team should ensure that AP staff know that snoring can be a sign of a drug overdose.

Emergency equipment

73. AP night staff are required to carry emergency equipment with them when completing welfare checks. This includes a mobile phone and other emergency aids.

74. The residential officer who discovered Mr Longstaff was prompt in raising the alarm and radioing his colleague to assist. However, he did not carry emergency aids with him. Although this did not delay CPR or an ambulance being called in Mr Longstaff's case, not having immediate access to emergency aids may cause a delay in responding to a future emergency. We make the following recommendation:

The Approved Premises Manager should ensure that staff always carry emergency aids with them when conducting welfare checks.

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

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T I 020 7633 4100