

**Prisons &
Probation**

Ombudsman
Independent Investigations

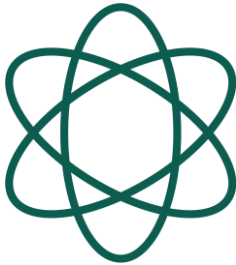
Independent investigation into the death of Mr Stephen Bottomley, a resident at Wordsworth House Approved Premises, on 15 September 2020

A report by the Prisons and Probation Ombudsman



Our vision

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



Our values

We are:

Impartial: we do not take sides

Respectful: we are considerate and courteous

Inclusive: we value diversity

Dedicated: we are determined and focused

Fair: we are honest and act with integrity

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 Stephen Bottomley died in hospital on 15 September 2020, after taking psychoactive substances (PS) at Wordsworth House Approved Premises (AP). He was 39 years old. I offer my condolences to Mr Bottomley's family and friends.

Mr Bottomley arrived at Wordsworth House on 14 August 2020. Although he had a history of substance misuse, he had engaged well with substance misuse services in prison and appeared to have stopped using drugs and alcohol by the time of his release. Within a few days of arriving at Wordsworth House, Mr Bottomley complained to staff that residents were taking PS and said that he wanted to move elsewhere. However, he remained at the AP.

I am very concerned that it appears very little was done to address residents' drug use at the AP, even when it was brought to the attention of staff.

I am pleased to note that the new manager who took over at Wordsworth House in early September 2020 has introduced a zero tolerance drugs policy and reintroduced drug testing. However, the AP does not test for PS. I am concerned that there is still not an effective strategy and testing regime to deal with suspected PS use.

I am also concerned that, although AP staff suspected Mr Bottomley was using drugs on two occasions, they did not report this to his offender manager or carry out a room search.

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

Kimberley Bingham
Acting Prisons and Probation Ombudsman

June 2021

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Summary

Events

1. In November 2019, Mr Stephen Bottomley was sentenced to 18 months in prison for common assault and grievous bodily harm. On 14 August 2020, he was released on licence to Wordsworth House Approved Premises (AP).
2. Mr Bottomley had a history of substance misuse but had engaged with substance misuse services in prison and was alcohol and drug free when he was released.
3. On 18 August, Mr Bottomley told a probation worker that he had taken a photograph of an AP resident who was “off his head” on drugs, suspected to be psychoactive substances (PS), and that AP staff had taken no action. He said he was concerned about the level of drug use at the AP and wanted to move elsewhere (though he later said he was strong enough to resist drugs and alcohol). He remained at Wordsworth House.
4. On the evening of 24 August, during a routine check, staff found Mr Bottomley on his bed covered in vomit. Staff checked on him throughout the night but took no further action.
5. On 8 September, Mr Bottomley missed his 8.00pm curfew and when he arrived at the AP at 10.45pm, he appeared to be under the influence of drugs. Staff monitored him overnight but took no further action.
6. On 12 September, during the 11.00pm welfare check, staff found Mr Bottomley collapsed in a bathroom. They called for an ambulance and Mr Bottomley was taken to hospital. He died three days later.
7. The post-mortem report concluded that Mr Bottomley died from the toxic effects of PS.

Findings

8. We are very concerned that drug use appeared to be widespread when Mr Bottomley arrived at Wordsworth House and that there is no evidence that staff were taking action to address this.
9. At the time Mr Bottomley was at Wordsworth House, there was no drug testing. Although a new AP manager took up post on 7 September and reintroduced drug testing soon afterwards, staff still do not test for PS. We have flagged this as an issue in several previous AP deaths. We note that PS testing of AP residents is not legally allowed at present and that the National Probation Service is looking to introduce legislation to change this. We recommend that the strategy for tackling PS in APs is reviewed, including developing mechanisms for PS testing once legislation allows.
10. We are concerned that staff did not report the incidents of suspected drug use on 24 August and 8 September to Mr Bottomley’s offender manager.

Recommendations

- The National Probation Service should review its strategy to reduce the supply and demand for PS in Approved Premises, including developing mechanisms to test for PS use.
- The National Probation Service should ensure that AP staff report any suspicions of substance misuse to the resident's offender manager.
- The National Probation Service should ensure that AP staff carry out room searches when they suspect that alcohol or illicit drugs are present within the AP.
- The AP Manager should share this report with the interventions facilitator and both residential workers and discuss the Ombudsman's findings with them.

The Investigation Process

1. The investigator issued notices to staff and residents at Wordsworth House Approved Premises informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
2. The investigator obtained copies of relevant extracts from Mr Bottomley's prison and probation record.
3. We informed HM Coroner for Lincolnshire of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
4. One of the Ombudsman's family liaison officers contacted Mr Bottomley's family to explain the investigation and ask if they wanted to raise any issues. They raised no issues but asked for a copy of our report.
5. We shared our initial report with the National Probation Service. They pointed out a factual inaccuracy which has been amended in this report. They provided an action plan which is annexed to this report.
6. We provided Mr Bottomley's next of kin with a copy of our initial report. They did not raise any issues or comment on the factual accuracy of the report.

Background Information

Wordsworth House Approved Premises

11. Approved premises (APs), 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.
12. Wordsworth House Approved Premises is in Lincolnshire and is managed by the National Probation Service. It can house up to 20 men. Each resident has a key worker to oversee their progress and wellbeing and see that they adhere to their individual licence conditions and the premises' rules. Staff are on duty at Wordsworth House 24 hours a day.
13. During the COVID-19 pandemic, staff and residents were unable to meet for their key work sessions and group meetings. This restriction was lifted shortly before Mr Bottomley died.

Previous deaths

14. Mr Bottomley was the second resident at Wordsworth House to die since September 2018. The previous death (in December 2019) was also drug-related, although the resident had only been at Wordsworth House for a day when he collapsed and died in the street and there was no evidence that he had used drugs in the AP.

Key Events

15. Mr Stephen Bottomley (who was known by his middle name, Dan) was sentenced to 18 months in prison on 15 November 2019, for common assault and attempted grievous bodily harm. On 14 August 2020, he was released on licence to Wordsworth House Approved Premises (AP).
16. Although Mr Bottomley was pleased to have been released from prison, he did not want to live at Wordsworth House, and wanted to relocate to Grimsby to be closer to his family. He was keen to find accommodation and a job in Grimsby.
17. Mr Bottomley was inducted into the AP on 14 August. He signed his induction booklet acknowledging his licence conditions, which included attending all meetings with probation and key workers, adhering to the AP's curfew and attending drug and alcohol testing when required. Staff told Mr Bottomley about the AP rules and consequences of breaking them and explained to him that people released from prison can have a reduced tolerance to drugs or alcohol, which could result in death. Mr Bottomley had a 7.00pm curfew, which was occasionally extended, with prior AP agreement, to 8.00pm, to enable him to travel back from Grimsby where he visited family and friends.
18. Key work sessions were suspended at the AP due to COVID-19. AP staff put televisions in residents rooms, provided an X-Box, and gave residents activity packs, newsletters and information on coping strategies, such as mindfulness, to occupy them. We Are With You (WAWY), a drug service, was supposed to visit the AP weekly to test residents who were already engaged with them but this was suspended due to COVID-19.
19. On 18 August, an interventions facilitator (a probation worker), spoke to Mr Bottomley on the telephone (she had been unable to run any groups in person due to COVID-19). He told her that he was shocked at the prevalence of drugs at the AP. He had taken a photograph of a resident who was just outside the AP and appeared under the influence of drugs. He said he had told staff, but they took no action. She said he must not take photographs of residents and noted their conversation on Delius (probation case management system).
20. Mr Bottomley told the interventions facilitator that drug and alcohol testing formed part of his licence conditions, but the AP did not test residents. She told him he would need to engage with WAWY, and emailed his probation officer, about this. Mr Bottomley said he was worried about the use of drugs at the AP, and that it was not an environment he wanted to live in, particularly given his history of alcohol misuse. Mr Bottomley said he needed to leave the AP as he was concerned that he might start to drink alcohol again to enable him to cope. However, he then said he was strong enough to resist alcohol and drugs. The interventions facilitator suggested Mr Bottomley speak to the AP Manager about these issues.
21. On 19 August, Mr Bottomley failed to attend an appointment with his offender management team. Mr Bottomley had asked staff for a travel warrant, but the AP had no record of this meeting so did not issue one. Mr Bottomley visited his family instead. The AP contacted the probation officer colleague, about the confusion surrounding Mr Bottomley's appointment. She said he had had an appointment and

agreed to keep the AP updated about forthcoming appointments. Mr Bottomley's appointment was rebooked for 26 August.

22. On 24 August, during the 11.00pm routine curfew check, staff found Mr Bottomley lying on his bed covered in vomit. He was incoherent but told staff, "You know why I'm like this." There was no smell of alcohol. Staff put Mr Bottomley on increased welfare checks throughout the night. Later, Mr Bottomley attributed his sickness to indigestion and cleaned up his room. There is no evidence that staff carried out a room search or reported this incident to Mr Bottomley's offender manager.
23. Mr Bottomley failed to attend another appointment with the offender management team on 26 August. Grimsby Probation Office issued him with a formal warning on the same day. It said that Mr Bottomley had failed to attend a meeting on 19 August, and on 26 August, he had failed to meet a police officer who was part of his offender management team. The warning said if Mr Bottomley failed to comply with any of the requirements on his licence he could return to prison.
24. On 27 August, Mr Bottomley missed his 8.00pm curfew by 40 minutes. He blamed the delay on trains. AP staff noted this on Delius and told Mr Bottomley's offender manager team. They also noted that his curfew had been altered to 8.00pm permanently.
25. The interventions facilitator spoke to Mr Bottomley on the telephone on 1 September. She reiterated that it was important that Mr Bottomley attended appointments and was not late for his curfew. Mr Bottomley said he had a job opportunity on a fishing boat and would discuss this with the police officer. She noted that Mr Bottomley seemed upbeat and in good spirits.
26. Mr Bottomley telephoned the police officer on 2 September. He said he had a job interview at Grimsby Fish Market. Mr Bottomley still seemed in good spirits. He said things had improved at the AP as several residents had left. Mr Bottomley said he kept himself to himself and spent most of the time away from the AP.
27. On 4 September, Mr Bottomley missed his 8.00pm curfew by 15 minutes. No reason was recorded, and there is no record of any action taken. He missed his curfew two days later, by six minutes. AP staff recorded this on Delius.
28. On 8 September, Mr Bottomley missed his 8.00pm curfew again. He telephoned the AP to let them know he had missed his train and would have to catch a later one. He kept in touch with the AP and his offender management team by telephone. They said he was very apologetic and did not sound under the influence of substances. However, when he arrived at the AP at 10.45pm, he appeared to be under the influence of an illicit substance. The night staff on duty monitored his safety and wellbeing for the rest of the night but there is no record that any other action was taken.
29. Mr Bottomley did not attend his first key work session with his key worker the next morning (this was the first face-to-face key worker session scheduled for Mr Bottomley following their suspension during the pandemic.). Mr Bottomley said he did not care about the key work appointments and that it did not matter as he had not seen anyone "for weeks" anyway. Mr Bottomley was reminded this was due to COVID-19 restrictions and it was important he attended these sessions. The keyworker issued him a warning letter (on behalf of the AP manager) which said he

had breached Rule 6, *'I must take part in the Approved Premises programme, including any group or individual activities that form part of my personal sentence or supervision plan'*, that attending these activities was a condition of his licence, and that if he continued to breach his licence conditions, he risked having his place at the AP withdrawn and being recalled to prison.

30. The key worker wrote to the probation officer to let her know about Mr Bottomley's first AP warning. The probation officer agreed to speak to Mr Bottomley about his behaviour and the need to attend key work sessions, when they next met.
31. On 10 September, the interventions facilitator spoke to Mr Bottomley on the telephone, about missing his curfew on several occasions. She reminded him that his curfew was now 8.00pm, and failure to adhere to his curfew might result in his recall to prison.
32. The probation officer emailed the AP and the interventions facilitator on 11 September, informing them that Mr Bottomley would be starting work on Sunday 13 September, at Grimsby Fish Market. Mr Bottomley was pleased to have the job and began to talk about finding somewhere to live in Grimsby.

12 September 2020

33. At approximately 7.00pm on 12 September, a resident spoke to Mr Bottomley, who was returning to the AP after spending the day in Grimsby. Mr Bottomley said he had met a woman in Grimsby who he had been speaking to online. The resident said that they spoke for about half an hour and that Mr Bottomley seemed very happy.
34. Staff saw Mr Bottomley at approximately 10.00pm, when he went to speak to them through the office window. They chatted generally and they said Mr Bottomley seemed fine. Mr Bottomley was pleased to have found a job and would start working at Grimsby dockyard the next day. He also took his prescribed medication, codeine phosphate (a painkiller).
35. CCTV shows residents leaving and returning to their rooms from 9.32pm onwards. At 10.36pm, Mr Bottomley, wearing just boxer shorts and socks, walked unsteadily and knocked on two residents' doors, before going into the second-floor bathroom. At 10.52pm, the two residents went into the bathroom, and a third resident joined them a minute later. A few seconds later, the first two residents left the bathroom, followed by the third resident a few seconds after that, leaving just Mr Bottomley in there alone.
36. One of the first two residents who was seen going into the bathroom, made a statement to police. He said he went to the bathroom just before 10.55pm. He said that one of the two toilet cubicles in the bathroom had the door closed, but he did not hear anything from it.
37. At 11.00pm, two residential workers began the first of three routine curfew checks to ensure residents are in the AP and are safe and well. A residential worker knocked and opened Mr Bottomley's door on the second floor but he was not in there. They checked the other residents, who were all in their rooms. A residential worker then went upstairs to check the bathroom on the third floor, as it was the only bathroom with hot water at that time, but Mr Bottomley was not in there either.

The residential worker re-joined their colleague at 11.05pm, and they both checked the second-floor bathroom.

38. The residential workers noticed that a toilet cubicle in the bathroom was shut and locked from the inside. They called out and knocked, but got no reply, so they decided to unlock the door from the outside using a coin. Mr Bottomley appeared to have fallen forward from the toilet seat; his bottom was in the air, his head was on the floor, and his shorts were pulled down. There appeared to be some urine on the floor, and he was breathing heavily. They shouted and tried to rouse Mr Bottomley but got no response, so a residential worker immediately telephoned for an ambulance.
39. A residential worker said that Mr Bottomley's head was underneath his shoulders and wedged between the toilet and the wall, so he did not want to move him in case he injured him. A residential worker noticed Mr Bottomley was holding a lighter tightly in his right hand. Both residential workers said they could hear Mr Bottomley breathing and see the rise and fall of his back.
40. One residential worker passed the telephone to the other residential worker so he could speak to the ambulance operator. They asked if he could move Mr Bottomley, but the residential worker said he could not due to his size and the position he was in. They said an ambulance was on its way and one residential worker went to the front door to let them in when they arrived. Throughout this time the ambulance operator asked the other residential worker to describe Mr Bottomley's breathing, which he did.
41. A transcript of the telephone conversation confirmed that the residential worker said he could not move Mr Bottomley, but he was breathing. They discussed the possibility that he may have taken illicit drugs, possibly PS. During the conversation, it was noted that Mr Bottomley was breathing differently and very slowly (six breaths a minute) just as two paramedics could be heard arriving in the bathroom at 11.17pm.
42. The paramedics said Mr Bottomley needed to be moved, and they and the residential worker managed to pull him free and lay him down outside the toilet. The paramedics then checked Mr Bottomley. He felt warm, looked pale and had no pulse and had, by this time, stopped breathing. The paramedics asked whether he had taken anything, for example illicit drugs, but the residential worker did not know. The other residential worker went to look in his room for any evidence of this. She returned and said she could not see anything obvious.
43. The paramedics started cardiopulmonary resuscitation (CPR), and the residential worker took over at one point while they set up their equipment. A second ambulance crew arrived and set up an automatic defibrillator to shock Mr Bottomley. At 12.34am, they took him to Lincoln County Hospital,
44. After they left, staff checked the toilet and saw a small cigarette butt and what looked like remnants of tobacco on the floor. Police collected this evidence.
45. During a search of another resident's room on 16 September, following suspicions he was dealing drugs at the AP, staff found an empty strip of painkillers and a set of scales with white powder residue on them. The police were informed, and the

resident was recalled to prison. This resident was one of the three seen on CCTV on 12 September.

Contact with Mr Bottomley's family

46. The police officer informed Mr Bottomley's family of his death.
47. The AP Manager wrote to Mr Bottomley's brother, but did not receive a response. The Probation Service offered to contribute to Mr Bottomley's funeral, in line with national guidelines.

Post-mortem report

48. The post-mortem report concluded that Mr Bottomley died from hypoxic brain injury (lack of oxygen to the brain) and a cardiac arrest, caused by the toxic effects of synthetic cannabinoids (PS).

Findings

Substance misuse at Wordsworth House

49. Mr Bottomley died as a result of taking psychoactive substances (PS). During the period Mr Bottomley was at Wordsworth House, the use of PS among residents appeared to be rife and Mr Bottomley raised concerns with his interventions facilitator that residents were under the influence of PS and that staff were taking no action.
50. Our Learning Lessons Bulletin *Approved Premises – substance misuse* published in 2017, discusses the challenges in managing the risks posed by PS in APs. It recommended that the National Probation Service should revise the AP manual to provide up to date guidance on managing PS use. The current AP manual says that testing known drug users on arrival, or when they are suspected of renewed substance misuse, is a targeted and prudent use of resources. It says that staff should have discretion to test residents if there is a reasonable suspicion of substance misuse. If staff are unable to test, they should try to find out what substance a resident has taken by asking them, should monitor them and seek medical advice if they become unwell. Since our bulletin, the NPS have introduced a PS handbook and have made Naloxone (an emergency antidote for overdoses caused by heroin and other opioids) available in many APs. However, this is not effective for PS use.
51. During the period that Mr Bottomley was at Wordsworth House, no drug testing took place. The new AP manager on 7 September and he arranged training for AP staff so that they could carry out drug testing. This resumed from October 2020. However, AP staff are not currently legally allowed to test residents for PS, though the National Probation Service are looking to bring in legislation to permit this.
52. We are very concerned that PS use appeared to be going unchallenged at Wordsworth House during Mr Bottomley's time there. We consider that the lack of testing for PS is hampering the ability of AP staff to tackle PS use effectively. This is an issue we have raised before in several previous investigations. While we note that a change in legislation is needed before APs can lawfully test residents for PS, we repeat our previous recommendation:

The National Probation Service should review its strategy to reduce the supply and demand for PS in Approved Premises including developing mechanisms to test for PS use.

Mr Bottomley's suspected drug use

53. Prior to 12 September, there were two occasions, on 24 August and 8 September, when Mr Bottomley appeared to be under the influence of illicit drugs. Although AP staff monitored his welfare, we are concerned that we found no evidence that they told his offender manager. It is important that information is shared between AP staff and the offender manager to ensure that the resident's licence is managed appropriately.

54. The AP manual says that room searches should be carried out where it is suspected that alcohol or illicit drugs are in the AP. We saw no evidence that a room search was carried out after Mr Bottomley photographed a resident under the influence of PS. Also, on 24 August, when Mr Bottomley was found covered in vomit, no room search was carried out. We make the following recommendation:

The National Probation Service should ensure that AP staff report any suspicions of substance misuse to the resident's offender manager.

The National Probation Service should ensure that AP staff carry out room searches when they suspect that alcohol or illicit drugs are present within the AP.

Emergency response

55. Mr Bottomley was still breathing when he was found. The investigator listened to the call to the ambulance operator, and the residential worker described Mr Bottomley's breathing to them, which changed a few seconds before paramedics arrived. The residential worker said Mr Bottomley was a large man who was in an awkward position, and he did not want to cause an injury by moving him. He was also aware Mr Bottomley was breathing. The residential worker said that if Mr Bottomley had not been breathing, he would have moved him despite risking an injury, and started CPR.
56. It is difficult to criticise the emergency response as staff felt they were doing what was best for Mr Bottomley by leaving him where he was. While understanding why the residential worker did not want to move him, we conclude that it would have been more helpful for Mr Bottomley to have been moved into the recovery position in anticipation of the paramedics' arrival and to enable staff to keep a closer eye on his breathing.

Learning lessons

57. We consider it important that staff should learn from our investigations. We therefore recommend:

The AP Manager should share this report with the interventions facilitator, both residential workers and discuss the Ombudsman's findings with them.

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