Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ross Vaughan, on 22 March 2022, following his release from HMP Cardiff

A report by the Prisons and Probation Ombudsman

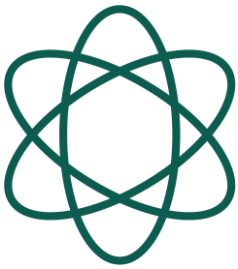
Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

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

Summary

1. 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.

2. Since 6 September 2021, the PPO has investigated post-release deaths that occur within 14 days of a prisoner's release.

3. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

4. Mr Ross Vaughan died on 22 March 2022, a day after his release from HMP Cardiff. The cause of his death was unascertained. He was 41 years old. I offer my condolences to his family and friends.

5. Mr Vaughan had a long history of alcohol dependence. His Prison Offender Manager and Community Offender Manager appropriately prepared for his release and ensured that he had accommodation in place on the day of his release. Although Mr Vaughan declined to take medication for alcohol dependence in prison, arrangements were made for him to resume his prescription on release.

6. We found no issues of concern.

The Investigation Process

7. The PPO investigator obtained copies of relevant extracts from Mr Vaughan's prison and probation records. On 26 August 2022, he interviewed a member of healthcare staff at HMP Cardiff.

8. We informed HM Coroner for Worcestershire of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

9. The Ombudsman's family liaison officer wrote to Mr Vaughan's sister to explain the investigation and to ask if she had any matters she wanted us to consider. She asked if Mr Vaughan had been diagnosed with autism while in HMP Cardiff. We have addressed her question in this report.

10. We shared the initial report with the Prison Service and the Probation Service. There were no factual inaccuracies.

11. We shared the initial report with Mr Vaughan's sister. She did not respond.

Background Information

HMP Cardiff

12. HMP Cardiff is a medium security prison holding up to 779 adult male prisoners who have either been remanded into custody or have been sentenced.

13. Physical and mental healthcare services are provided by Cardiff and Vale University NHS Health Board. Substance misuse services are provided by Cardiff and Vale University NHS Health Board with the Dyfodol consortium.

HM Inspectorate of Prisons

14. The most recent inspection of HMP Cardiff was in July 2019. Inspectors reported that contact between prisoners and prison offender managers had improved with the introduction of a new model, although risk management planning for prisoners' release needed to be improved. Inspectors reported that nearly half of prisoners were released without any accommodation. Most prisoners said that they received help to prepare for release.

15. Inspectors reported that prisoners receiving substance misuse treatment received good through-the-gate care.

Probation Service

16. The Probation Service work with all individuals subject to custodial and community sentences. During a person's imprisonment, they oversee their sentence plan to assist in rehabilitation as well as prepare reports to advise the Parole Board and have links with local partnerships to which, where appropriate, they refer people for resettlement services. Post-release, the Probation Service supervises people throughout their licence period and post-sentence supervision.

HM Inspectorate of Probation

17. The most recent inspection of the National Probation Service in Wales was in April 2019. Inspectors reported that in some cases, supervision was not sufficiently focused on addressing factors related to offending. There were extremely lengthy delays before individuals could start offending behaviour programmes which inspectors found was unacceptable.

Key Events

18. On 4 December 2021, Mr Ross Vaughan was recalled to HMP Cardiff, having been released from custody in October. Mr Vaughan was alcohol dependent. He had previously used drugs and had been diagnosed with anxiety and depression. There is no record that Mr Vaughan was ever diagnosed with autism. On arrival in prison, Mr Vaughan was prescribed diazepam and thiamine for alcohol dependence syndrome. Mr Vaughan engaged with Dyfodol (South Wales' prisons and community drug and alcohol recovery services).

19. Mr Vaughan was allocated a community offender manager (COM) and a prison offender manager (POM).

20. On 10 January 2022, a prison GP prescribed Mr Vaughan disulfiram. (Prescribed for chronic alcoholism. It works by making the user unwell should they drink alcohol and needs to be built up over a period of time).

21. On 10 February, Mr Vaughan was sentenced to six months in prison for breaching a restraining order and criminal damage.

22. On 25 February, the COM held a video link call with Mr Vaughan. She noted that Mr Vaughan was motivated to comply with all aspects of his licence and restraining order. He said that he was prescribed disulfiram and that this would be a safety net for him when he was released. She told Mr Vaughan that she had received a Bail Accommodation Support Services (BASS) application for accommodation, which she would support. (BASS provides accommodation for people released from custody and to those referred by courts and Community Rehabilitation Companies.)

23. On 4 March, the COM explained to Mr Vaughan his additional licence conditions. She told him that he would have to attend a Building Better Relationships (BBR) Programme (a programme for male perpetrators of violence and abuse within relationships). She noted that she had completed a review plan to reflect Mr Vaughan's further sentence for breaching his restraining order.

24. On 7 March, the COM asked Mr Parry to complete a BASS referral for home detention curfew (a scheme that enables eligible prisoners to be released before they have completed half their sentence, subject to an electronically monitored curfew). Three days later, she assessed Mr Vaughan's risks and needs in the community in preparation for his release. Mr Vaughan's release date was 21 March.

25. On 14 March, a BASS referral coordinator wrote to Mr Parry and told him that Mr Vaughan had been accepted to live at BASS accommodation in Worcester.

26. On 18 March, a Dyfodol keyworker at Cardiff, emailed a probation service officer in the Worcester probation office, who was allocated Mr Vaughan's case. She explained that there was no community prescriber in Worcester to prescribe disulfiram. (Disulfiram is not prescribed by community GPs but community drug and alcohol services.) She said that if Mr Vaughan engaged with drug services on release, he could provide a blood test which she could forward to the drug service to restart the prescription promptly. The probation service officer said that she could liaise with Cranstoun (a registered charity which provides services for those

facing difficulties, including with drugs and alcohol) and could complete a referral to them to prescribe the medication.

27. The keyworker then emailed the COM and explained the arrangement she had made with the probation service officer. She said that because Mr Vaughan had refused to see her that day, healthcare staff at Cardiff were unable to give him a new prescription for disulfiram because there was no record that he had taken it since he had last collected it in February.

28. That day, a worker from the Department for Work and Pensions made an appointment for Mr Vaughan to attend the Jobcentre Plus in Worcester, to make a claim for Universal Credit.

29. A POM saw Mr Vaughan and explained the terms of his licence. He showed Mr Vaughan on a map the location of the BASS hostel in Worcester and highlighted the route for him to get there. He explained that Mr Vaughan would be given a travel warrant on the morning of his release.

30. On 21 March, Mr Vaughan was released from HMP Cardiff on home detention curfew. He did not receive any prescribed medication before his release. Mr Vaughan's licence conditions required him to report at 2.00pm to a probation officer at the Worcester probation office.

31. Mr Vaughan's licence conditions required him to live at BASS accommodation in Worcester, where he had to remain between 7.00pm and 7.00am each day. On the day of his release, Mr Vaughan was required to be at the address from 3.00pm so that a contractor could fit an electronic tag.

Post-release

32. Mr Vaughan did not report to the Worcester probation office as required.

33. At 6.28pm, a member of staff from Electronic Monitoring Services (EMS) went to the BASS accommodation to fit Mr Vaughan's electronic tag. EMS records show that Mr Vaughan was not available.

34. At 7.27pm, a BASS service lead received a telephone call from the BASS frontline team who said that Mr Vaughan had arrived at the hostel. However, Mr Vaughan was not at the BASS hostel listed on his licence, but at a different hostel in Worcester. Mr Vaughan telephoned the police several times because he was concerned that he might be immediately recalled to prison.

35. At 9.09pm, the BASS service lead telephoned Mr Vaughan, who told him that he was now outside the correct BASS hostel. The service lead gave him the key safe code for the front door to the property and told him how to access his room key. (The service lead told the investigator that BASS hostels do not have an office and that staff visit the premises on an ad hoc basis and when necessary.)

36. At 9.15pm, a staff member emailed the COM and told her that Mr Vaughan had arrived at the property.

37. At 9.42pm, a member of staff from EMS went back to the hostel. Their records show that Mr Vaughan was not available to fit the tag. The EMS worker noted that Mr Vaughan was in breach of his licence conditions for not being available for installation of the tag and the monitoring equipment. It is not clear where Mr Vaughan was at the time.

38. At 10.00pm, the COM initiated an out-of-hours licence recall to recall Mr Vaughan to prison. She completed the licence recall report the following day. She noted that Mr Vaughan did not report to the Worcester Probation Office or the BASS accommodation as required. She noted that Mr Vaughan had not made any contact with Probation Service staff.

Circumstances of Mr Vaughan's death

39. At 9.02am on 22 March, a BASS support worker went to the hostel to meet Mr Vaughan. She found the door to Mr Vaughan's room propped open with a duvet. She went to the ground floor bathroom and found the door locked. She managed to open the door and saw Mr Vaughan lying in the bath. She thought that he was dead. She telephoned for an ambulance, which arrived shortly afterwards.

40. At 9.15am, an ambulance paramedic confirmed that Mr Vaughan had died.

Post-mortem report

41. The post-mortem report concluded that the cause of Mr Vaughan's death was unascertained.

42. Toxicology tests showed that Mr Vaughan had consumed alcohol at a level consistent with mild to moderate drunkenness. Mr Vaughan also tested positive for pregabalin (an anticonvulsant/antiepileptic drug which can be prescribed for anxiety). Mr Vaughan had not been prescribed pregabalin at Cardiff.

Support for staff

43. The POM told us that he was not offered support from his line manager after Mr Vaughan's death, but that he had received an email from the support team with information about how to contact support services. The COM was offered support from her manager and PAM Assist (an employee support programme).

Contact with Mr Vaughan's family

44. On 23 March, South Wales Police told Mr Vaughan's father that he had died.

Findings

Pre-release planning

45. Mr Vaughan had a history of alcohol dependence. During his time at Cardiff, he completed an alcohol detoxification programme and engaged with the substance misuse service. While he was prescribed disulfiram in advance of his release from custody and said that this would be beneficial to him on release, Mr Vaughan did not collect his medication in prison which meant that he would have needed it to be restarted in the community. We are satisfied that probation staff also made appropriate arrangements for Mr Vaughan to restart his prescription of disulfiram in the community.

46. The toxicology report indicates that Mr Vaughan had drunk alcohol and taken unprescribed medication before he died. However, we are satisfied that he received appropriate support in prison and was referred to appropriate support agencies on release. We are also satisfied that probation practitioners arranged suitable release accommodation for Mr Vaughan.

Events of 21 March

47. We do not know where Mr Vaughan went on the day of his release. Nevertheless, we are satisfied that prison staff did all that they could to ensure that he arrived at the Worcester probation office on time and knew when and how to get to the correct BASS accommodation.

48. We make no recommendations.

Kimberley Bingham
Acting Prisons and Probation Ombudsman **March 2023**

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