

**Prisons &
Probation**

Ombudsman
Independent Investigations

**Independent investigation into
the death of Mr Daniel Fielding
(also known as Daniel Tutt),
a resident at Meneghy House
Approved Premises,
on 2 September 2022**

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

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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 Daniel Fielding (also known as Daniel Tutt) was found dead on a train on 2 September 2022, while a resident at Meneghy House Approved Premises (AP). He died of cocaine and morphine toxicity. I offer my condolences to Mr Fielding's family and friends.

Mr Fielding had a history of substance misuse. His licence conditions included regular drug testing and a curfew intended to reduce his chances of relapsing into substance misuse. However, he died only eight days after release from prison.

Our investigation found that, although Mr Fielding's probation practitioner and staff at the AP said they discussed reduced drug tolerance and the increased risk of overdose with Mr Fielding, no one recorded this information. Additionally, we found no documentary evidence that he was offered a naloxone kit (medication that can rapidly reverse the effects of opioid drugs).

We have previously made a recommendation to Meneghy House about the need for staff to discuss reduced drug tolerance with new residents and to record they have done so. I have therefore escalated this issue to the Probation Area Chief Officer.

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

May 2023

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Summary

Events

1. Mr Daniel Fielding (also known as Daniel Tutt) was released from HMP Dartmoor on 26 August 2022. His licence conditions included the requirement for regular drug testing and for him to reside at Meneghy House Approved Premises (AP) with a curfew between the hours of 7.00pm and 7.00am.
2. On the day of his release, Mr Fielding's probation practitioner met him at the AP. She talked him through his licence conditions, but she did not record any discussion about substance misuse. He later had an initial induction with AP staff. They noted no concerns about him.
3. The following day, Mr Fielding had his second stage induction with a probation service officer (PSO) at the AP. The PSO again went through Mr Fielding's licence conditions and Mr Fielding signed the AP rules. The PSO did not record that he had discussed substance misuse or associated risk issues with Mr Fielding.
4. On 29 August, Mr Fielding returned to the AP after his curfew time and staff referred the breach to his probation practitioner to consider enforcement action.
5. On 30 August, staff again referred Mr Fielding to his probation practitioner after he was messing around and exposed himself in the garden of the AP.
6. On 31 August, Mr Fielding attended an appointment with his probation practitioner. She warned him about his behaviour at the AP and he apologised. His probation practitioner also carried out a drug test in accordance with his licence conditions. She had not received the results before Mr Fielding died.
7. On 1 September, Mr Fielding again returned late to the AP. He initially apologised to staff but then left the AP again without permission, in breach of his curfew. Staff contacted the recall team and his probation practitioner started recall procedures the following day.
8. On 2 September, at around 9.24pm, Mr Fielding was found unresponsive by staff on a train at Bristol Temple Meads railway station. British Transport Police attempted to resuscitate him, but he was pronounced dead by ambulance staff at 9.52pm. A post-mortem report found that he had died from cocaine and morphine toxicity.

Findings

9. We found no documentary evidence that staff discussed Mr Fielding's reduced drug tolerance or increased risk of overdose with him when he arrived at the AP.
10. We also found no documentary evidence that Mr Fielding was offered a naloxone kit (medication that can rapidly reverse the effects of opioid drugs) when he arrived.

Recommendations

- The Manager of Meneghy House should ensure that staff:
 - tell all new residents about their reduced drug tolerance and increased risk of overdose when they arrive at the AP and record details of this discussion; and
 - encourage all new residents (not only those with a history of substance misuse) to complete naloxone training and accept a naloxone kit, and record the outcome of this discussion, including reasons for refusal of the kit.
- The Regional Probation Director (RPD) should remind probation practitioners and the Residential Head of Public Protection (HoPP) should remind AP staff of the need to record details of discussions about reduced drug tolerance, risk of overdose and naloxone.

The Investigation Process

11. The investigator issued notices to staff and residents at Meneghy House informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
12. The investigator obtained copies of relevant extracts from Mr Fielding's probation records.
13. We informed HM Coroner for Avon of the investigation. The coroner provided us with a copy of the post-mortem report. We have sent them a copy of this report.
14. The Ombudsman's family liaison officer contacted Mr Fielding's parents to explain the investigation and to ask if they had any matters they wanted us to consider. Mr Fielding's parents did not have any questions, but they informed us that Mr Fielding had changed his name from Tutt to Fielding.
15. We shared our initial report with Mr Fielding's parents. They did not raise any factual inaccuracies.
16. We shared our initial report with the Probation Service. The Probation service made some changes to one of our recommendations relating to job roles and responsibilities. They did not raise any other factual inaccuracies with our report.

Background Information

Meneghy House Approved Premises

17. Approved Premises (formerly known as probation and 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 health and are expected to register with a GP.
18. Meneghy House in Camborne, Cornwall, is managed by HM Prison and Probation Service (HMPPS). It has 17 rooms, with capacity for 18 residents. Residents are expected to attend weekly residents' meetings and there is a curfew between 11.00pm and 6.00am. Each resident is allocated a keyworker to oversee his progress and well-being, and to ensure that they adhere to licence conditions and the AP's rules. Probation Service employees are on duty at Meneghy House 24 hours a day.

Previous deaths at Meneghy House

19. There has been one previous death at Meneghy House in February 2019. We made a recommendation in that case about the need for staff to discuss reduced drug tolerance and increased risk of drug overdose with residents during their induction to the AP and to record details of the discussion.

Naloxone

20. Naloxone is a drug that can reverse the effects of opioids, such as heroin, methadone, opium, codeine, morphine and buprenorphine. It is used in emergency situations to reverse breathing difficulties which can occur when a person overdoses on opioids. It can save a person's life if it is used quickly after they have overdosed.
21. Naloxone can be given out by people working in or for drug treatment services if it is being made available to save a life in an emergency. The person giving it out must be trained in recognising and responding to opioid overdose, and how to use naloxone. Training in the use of naloxone is mandatory for staff working in Approved Premises and an agreement is in place which acknowledges that they are 'engaged' in drug treatment services with their local Substance Misuse Provider. Therefore, trained Approved Premises staff can give out naloxone kits.

Key Events

22. Mr Daniel Fielding (also known as Daniel Tutt) was remanded in prison on 21 August 2020, charged with possession of a bladed article and wounding with intent. On 10 February 2021, he was sentenced to 48 months in prison and was moved to HMP Dartmoor on 1 March.
23. Mr Fielding had a history of substance misuse. While he was at Dartmoor, he engaged with substance misuse services, but he was often found to be under the influence of illicit substances. However, there were no records of him being under the influence in the five months before he was released.
24. Mr Fielding was released from Dartmoor on 26 August 2022. His licence conditions included the requirement for regular drug testing and for him to reside at Meneghy House Approved Premises (AP) with a curfew between the hours of 7.00pm and 7.00am.
25. Mr Fielding's probation practitioner met him at Meneghy House on the day of his release. She reminded him of his licence conditions, including his curfew times. She noted that he was unhappy with his curfew times, but she told him she would consider reviewing them. She noted that Mr Fielding was positive about contact with his children, getting a job, going to the gym and linking up with support systems in the community.
26. The probation practitioner did not record if she discussed Mr Fielding's reduced drug tolerance and increased risk of overdose. She told the investigator that she would have this discussion as a matter of course but would not usually record it. She said that she would have referred Mr Fielding to the local drug service who would work with him to reduce his risk. She expected that the drug service would also provide advice and training on the use of naloxone (a medication used to reverse or reduce the effects of opioids) as the probation office did not offer naloxone kits.
27. At 3.30pm, Mr Fielding had a first stage induction, which included a guided tour of the AP. Staff reminded him again of curfew times and noted no other concerns.
28. On 27 August, a probation service officer (PSO) carried out a second stage induction with Mr Fielding. He recorded that he went through his licence conditions again and Mr Fielding signed the AP rules. He provided Mr Fielding with details of the local GP and information on how to apply for benefits. He noted that Mr Fielding was prescribed medication for anxiety and had a history of substance misuse. He told the investigator that he discussed Mr Fielding's reduced drug tolerance and increased risk of overdose and that he offered Mr Fielding a naloxone kit, but he refused it. However, he did not record this information.
29. Mr Fielding later left the AP and returned on time. Staff noted no concerns.
30. On 28 August, Mr Fielding woke before 6.00am and asked if he could leave the AP early. Staff declined his request and, although he was not happy with this, he complied with the instruction. He later left the AP for the rest of the day and returned on time. Staff noted no concerns.

31. On 29 August, Mr Fielding again left the AP all day and returned 15 minutes after his curfew time. He did not offer an explanation to staff or apologise for his lateness. Staff referred his breach to his probation practitioner to consider if enforcement action was appropriate. Around 9.30pm that evening, he asked a member of staff if he could have something to eat, despite knowing that he had returned too late for dinner. She recorded that she refused his request and reminded him of mealtimes, and he accepted this. She said that she engaged in a general conversation with him, and he seemed fine. However, she later had to warn him about taking photographs and making video calls in the AP which is against the rules.
32. On 30 August, Mr Fielding had an appointment scheduled with his probation practitioner at the probation office. However, he failed to attend and said that he thought she was coming to see him at the AP. She accepted this as a misunderstanding and rearranged the appointment to the following day.
33. Later that evening, Mr Fielding was involved in an incident with other residents in the garden where he exposed himself in front of a mobile phone camera. He said that he was joking around, but he apologised to staff. Staff took the incident very seriously and referred it to his probation practitioner, and to the AP Manager.
34. On 31 August, Mr Fielding arrived late to his meeting at the probation office. His probation practitioner warned him about his lateness and breaching his curfew at the AP. She also discussed his inappropriate behaviour the previous evening which staff reported as indecent exposure. She recorded that he appeared embarrassed about his behaviour and again apologised. She decided not to take any formal action but gave a verbal warning. Mr Fielding continued to complain about his curfew times, saying that it felt as though he was being set up to fail and that he might as well be back in prison. She said that she would consider reviewing the curfew but that he needed to show compliance first. She carried out a drug test on Mr Fielding. He told her that he had used cannabis and taken Valium (a sedative). She sent the drug test away for analysis. She said that she told Mr Fielding she would not take any action until she had received the test results.
35. Later that day, the AP Manager gave Mr Fielding a final warning for the indecent exposure incident and breaching AP rules. Staff reported no other significant issues that day and Mr Fielding returned on time for his curfew.
36. It was Mr Fielding's birthday on 1 September. He spent most of the day out of the AP and returned 12 minutes past his curfew time. He apologised to staff for his lateness. However, at 8.45pm, he left the AP without permission and in breach of his curfew. Staff tried to call him on his phone, but he did not answer, so they contacted the out-of-hours recall team. Mr Fielding did not return to the AP.
37. On 2 September, the probation practitioner started recall procedures at 10.00am. She submitted all the required paperwork to the recall team at 3.15pm.
38. On 3 September, at around 9.30am, Mr Fielding's daughter called the AP and told staff that her father had been found dead on a train at Bristol Temple Meads railway station the previous evening. Staff called the British Transport Police, who confirmed this.

39. The account from British Transport Police notes that there was no CCTV on the train, but the train manager who joined the train at Exeter recalled seeing Mr Fielding as he passed through the train inspecting tickets. He thought he was asleep, so he did not wake him. When the train arrived at the final stop, Bristol Temple Meads, he tried to rouse Mr Fielding, but realised he was unresponsive, and staff called for emergency assistance around 9.24pm. British Transport Police carried out cardiopulmonary resuscitation (CPR) while waiting for an ambulance to arrive. At approximately 9.52pm, a doctor confirmed that Mr Fielding was dead.

Information received after Mr Fielding's death

40. Mr Fielding's daughter told staff at the AP that her father had been with a male associate prior to his death. She said she knew this because she called their phone to speak to her father. She believed that this person had left Mr Fielding on the train when he was unwell, and they did not raise the alarm. However, this information cannot be verified as there was no CCTV on the train.
41. The results of Mr Fielding's drug test taken by his probation practitioner on 31 August were received a few days after his death, and showed positive readings for cannabis, cocaine and opiates.

Contact with Mr Fielding's family

42. British Transport Police officers went to Mr Fielding's parents' address on 3 September and broke the news of their son's death.
43. Although Mr Fielding's daughter was not listed as his nominated next of kin, she was the person who informed AP staff that her father had been found dead. The AP Manager contacted her by telephone on 3 September to offer condolences.
44. The AP Area Manager also tried to contact Mr Fielding's daughter on 5 September but was unable to get through to her. On 6 September, he contacted Mr Fielding's mother to offer condolences and explain the processes involved. Mr Fielding's mother was his nominated next of kin, but she requested no further contact from the Probation Service and declined financial assistance towards her son's funeral expenses.

Support for residents and staff

45. On 5 September, the AP Manager chaired a meeting with staff and residents to discuss Mr Fielding's death. He provided the opportunity for staff and residents to speak to him on a one-to-one basis but no one took up the offer.

Post-mortem report

46. The pathologist concluded that Mr Fielding died due to acute toxicity of morphine and cocaine.

Findings

Substance misuse

47. Probation Instruction (PI) 32/2014, Approved Premises, says that one of the main causes of death among AP residents is drug overdose, often due to reduced tolerance after release from prison. The PI says that on the day of release, the offender manager (now known as probation practitioners) should make the offender aware of the risks of overdose if they begin to use drugs again. The PI also says that this topic should always be covered at induction and advice given to all AP residents on reduced drug tolerance following release from custody. There is no documentary evidence that this occurred when Mr Fielding arrived at Meneghy House.
48. The Approved Premises Instruction 'Naloxone Administration in Approved Premises v1.0' says: ... "*Naloxone must be discussed during resident induction*" and "*...Residents will be offered the opportunity and encouraged to complete naloxone training and to accept a kit, reasons for refusal must be documented in line with guidance*".
49. We found no evidence that the probation practitioner discussed reduced tolerance and risk of overdose with Mr Fielding. She told the investigator that she would have this conversation as a matter of course but would not usually record it. However, she said that she understood the importance of recording this information and had done so with other individuals since Mr Fielding's death.
50. The PSO said that he spoke to Mr Fielding at induction about his reduced tolerance to drugs and his increased risk of overdose if he should start using drugs again. He said that he offered him naloxone training and a naloxone kit, but Mr Fielding declined the offer. However, this information is not documented in Mr Fielding's record.
51. We make the following recommendations:

The Manager of Meneghy House should ensure that staff:

- **tell all new residents about their reduced drug tolerance and increased risk of overdose when they arrive at the AP and record details of this discussion; and**
- **encourage all new residents (not only those with a history of substance misuse) to complete naloxone training and accept a naloxone kit, and record the outcome of this discussion, including reasons for refusal of the kit.**

The Regional Probation Director (RPD) should remind probation practitioners and the Residential Head of Public Protection (HoPP) should remind AP staff of the need to record details of discussions about reduced drug tolerance, risk of overdose and naloxone.

Inquest

52. The inquest, held on 5 July 2023, concluded that Mr Fielding's death was drug related.

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