Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael Pinkney, a resident at The Crescent Approved Premises, on 26 November 2022

A report by the Prisons and Probation Ombudsman

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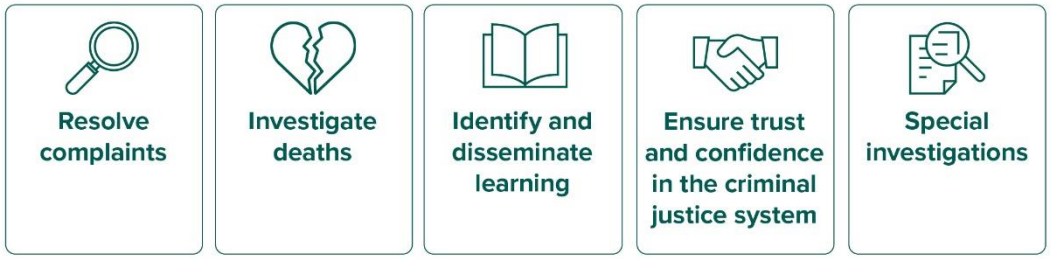
OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

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.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Michael Pinkney died after overdosing on methadone, an opioid substitute, at The Crescent Approved Premises on 26 November 2022. He was 39 years old. I offer my condolences to Mr Pinkney's family and friends. Mr Pinkney was the first resident to die at The Crescent in three years.

We found that Mr Pinkney's risks were generally well managed at the AP. He appeared to settle in well, complying with rules and engaging positively with staff. There was no evidence to suggest that AP staff could have foreseen Mr Pinkney's death and we make no recommendations.

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

Adrian Usher
Prisons and Probation Ombudsman **September 2023**

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Summary

Events

1. On Friday 11 November 2022, Mr Michael Pinkney was released to The Crescent Approved Premises (AP), after serving 18 months in prison. He had a history of substance misuse, for which he had engaged with support services in prison.

2. Mr Pinkney settled into the AP well. He engaged with staff and appeared compliant. He bought and handed in some paracetamol, which he said he used to treat pain from a historic car accident. He was compliant with his methadone prescription (a synthetic opioid used to treat heroin dependence) and routine room searches found nothing inappropriate. Mr Pinkney met a member of the drug strategy team and talked in detail about his plans for long-term recovery.

3. On 24 November, Mr Pinkney told his offender manager about plans to further his rehabilitation. He also had a session with his key worker, who completed a drugs test. The results were negative.

4. On 25 November, Mr Pinkney was out during the day and later went for a walk with another resident. He returned to the AP at 9.10pm, appearing grey and clammy, which he put down to the walk and becoming unfit in prison. He went out again and returned to his room within curfew, chatting to another resident before closing his door for the night.

5. Staff completed a welfare check at 11.00pm and reported no concerns. At 12.50am, another resident spoke to Mr Pinkney at his door and raised no concerns. When staff carried out a welfare check at 6.00am, they found Mr Pinkney lying on the floor, unresponsive. Staff called an ambulance, but Mr Pinkney could not be revived and paramedics pronounced his death at 10.15am.

Findings

Assessment and management of risk

6. Since October 2022, mandatory drugs tests are required for all AP residents, at least twice during their stay. Residents may also be tested if AP staff have a suspicion that they are using illicit substances. A condition of Mr Pinkney's licence was that he should undergo drug testing required by his probation practitioner. This had not yet been implemented when Mr Pinkney died.

7. When Mr Pinkney arrived at The Crescent, staff were implementing a new process for drug testing on arrival (as part of the two tests residents were required to complete during their stay). Due to an oversight, Mr Pinkney was not drug tested on arrival. However, staff checked him for signs of illicit drug use and did not have any concerns. In response to the learning, the AP manager issued a notice to staff reminding them to test residents on arrival.

8. Mr Pinkney was tested for drugs on one occasion in the AP, on 24 November. The result was negative. The next day, he returned from a walk with another resident

and staff noticed he was grey and clammy. When they asked Mr Pinkney about his presentation he said it was due to walking in the cold weather, his general health issues and lack of fitness following his time in prison. When we interviewed staff, they explained there were no obvious signs of illicit substance misuse and they had no immediate concerns.

9. We are satisfied that staff managed the risks effectively.

The Investigation Process

10. We were notified of Mr Pinkney's death on 28 November 2022.

11. The investigator issued notices to staff and prisoners at The Crescent informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

12. The investigator obtained copies of relevant extracts from Mr Pinkney's probation records. He interviewed three members of staff in April 2023.

13. We informed HM Coroner for Hartlepool 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. The Ombudsman's family liaison officer contacted Mr Pinkney's mother to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Pinkney's mother had no specific questions.

Background

Approved Premises

15. Approved Premises (APs) accommodate offenders released from prison on licence and those directed to live there by the courts as a condition of bail. Its 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.

16. The Probation Service manages The Crescent Approved Premises which is based in Middlesbrough and accommodates up to twelve men. The accommodation is catered and there is a communal area for eating and socialising. Each resident has a key worker to oversee their progress and well-being and see that they adhere to their individual licence conditions and the premises' rules. AP staff are on duty 24 hours a day. During the night, staff only check on residents if there is a specific need to do so (such as a resident at risk of self-harm being under procedures to support them, or a resident with a medical issue that requires night-time care).

Previous deaths at The Crescent

17. There were no other deaths at The Crescent in the three years before Mr Pinkney died.

Key Events

18. Mr Michael Pinkney was remanded to HMP Durham in April 2020, charged with robbery. It was not his first time in custody. In November, Mr Pinkney was sentenced to five years and two months imprisonment.

19. In December 2020 Mr Pinkney transferred to HMP Holme House. Staff identified that Mr Pinkney had a history of mental ill-health, for which he was prescribed medications. They also identified long standing substance misuse issues and made a referral to the substance misuse service to support Mr Pinkney's withdrawal. Mr Pinkney engaged with mental health and substance misuse services while at Holme House. Staff did not record any concerns, other than Mr Pinkney's concerns about being released homeless.

20. On Friday 11 November 2022, Mr Pinkney was released from Holme House with a licence condition that he should reside at The Crescent Approved Premises (AP). He had a curfew which meant he must be in the AP between 11.00pm and 6.00am and would need to report to AP staff at midday.

21. Mr Pinkney received an induction briefing on arrival, which included information on AP rules and support available to residents. He handed in his antidepressant medication, as required by AP policy.

22. On 12 November, staff recorded that Mr Pinkney had settled into the AP. He went out and visited a friend, then went to the pharmacy for his prescription of methadone (a synthetic opioid used to treat heroin dependence). Mr Pinkney was on a supervised prescription of methadone, which meant that he went to the pharmacy daily and would be given his dosage in view of the pharmacist. 12 November was a Saturday and the pharmacy would be closed the following day, so after taking his daily dosage they gave Mr Pinkney the following day's dosage. He returned to the AP and handed it in to staff. He said that he felt well and had no concerns.

23. On 13 November, Mr Pinkney went out to local shops. When he returned, in line with the policy on medication, he handed in some paracetamol that he had bought and asked for two tablets. He told staff that he experienced pain from injuries sustained in a car accident before he was in prison, as well as other health issues, but was careful about the type of pain medication he used because of his problems with substance misuse. He took his antidepressants and went to his room.

24. The following day, staff conducted their routine weekly search of all residents' rooms and found nothing of concern in Mr Pinkney's. Mr Pinkney and another resident went out, and on return he asked for two paracetamol and his medication before retiring to his room. On 15 November, apart from going to the pharmacy for his methadone, he remained in the AP and no concerns were raised.

25. On 16 November, Mr Pinkney met a member of the regional AP drug strategy team to provide some input into the drug strategy and intervention pack that they were creating. He talked of his long-term plans for his recovery and said he would be speaking to his doctor about reducing his methadone prescription. It was his hope to become a drugs worker through a peer mentor programme when he had reached

the appropriate stage of his recovery. He said that he was considering moving to an AP near Liverpool that had a good recovery and rehabilitation structure. She said she would obtain further information on the AP for Mr Pinkney. He later went to the pharmacy for his medication and attended an appointment at the Job Centre. He complied with his curfew and collected and took his medication.

26. Mr Pinkney was due to see his probation practitioner on 17 November but did not attend. Given that he had engaged with staff up to this point, she accepted that this was an error. She rescheduled the appointment for 24 November.

27. On 18 November, Mr Pinkney had a meeting with his probation key worker (a named member of staff to engage with each resident and provide a responsive service, reflecting individual needs). Mr Pinkney said that he found some days emotionally difficult and that his mental health had been "up and down". He speculated that this might also have been affected by some ongoing health concerns and a knee operation he was due to have. Mr Pinkney had no fixed plans for when he left the AP, though he said he would like to go to a residential rehabilitation facility. He was unsure of how to go about this. In the short-term he planned to find somewhere close to his family.

28. At midday, Mr Pinkney telephoned the AP. He said that he knew he was supposed to report to staff but was in a queue in the medical centre. Staff spoke to the centre's receptionist who confirmed that he was waiting in long a queue. When Mr Pinkney returned, he asked for two paracetamol and then talked with other residents before closing his door.

29. On 19 November, Mr Pinkney handed in his medication and prescriptions for the next two weeks to one of the AP's residential workers. Mr Pinkney took his daily medication and asked for paracetamol.

30. On 21 November, the probation practitioner discussed Mr Pinkney with her manager. AP staff had given positive feedback about Mr Pinkney's attitude to addressing his substance misuse issues. The routine weekly room search found nothing of concern.

31. On 24 November, Mr Pinkney had a meeting with his probation practitioner. He told her that he had a number of medical problems stemming from injuries sustained in a traffic accident in 2016. He still wanted to move to a rehabilitation centre near Liverpool but would need funding. He would also need to reduce his current methadone prescription. Mr Pinkney also had a key work session with his probation key worker. He talked about his medical issues and said that he had a doctor's appointment to discuss these. He confirmed his long-term plan to enter a rehabilitation centre. His probation keyworker completed a routine drug test, the results of which were negative.

32. On 25 November, Mr Pinkney complied with his curfew, but was otherwise out during the day. He attended the Job Centre with a fellow resident, and later went for a walk with another resident. He returned to the AP at 9.10pm. An AP residential worker gave him his medication and noted that he appeared grey and clammy and had trouble getting the medication out of the packet. He told her that he had been walking and that he had lost fitness in prison. Just before 9.50pm, he went out again. Another resident seemed keen for Mr Pinkney to return, watching out of the

window for him. In interview, the residential worker said that unlike Mr Pinkney, this resident did not know the local area, and she thought that he was waiting to ask Mr Pinkney about his local knowledge. Mr Pinkney returned to the AP at 10.30pm. Staff had no concerns about him.

33. Staff made a welfare check on residents at 11.00pm. At 12.50am the AP residential worker was monitoring the AP's CCTV system and saw the resident from the neighbouring room go to Mr Pinkney's room and speak to him at the door. She was about to go and tell them to settle down when the other resident went back to his room and they each closed their doors. Over the course of the night, Mr Pinkney did not leave his room and staff did not record any concerns overnight. (Mr Pinkney was not subject to any night checks.)

34. At 6.00am on 26 November, staff carried out their usual welfare checks on residents. A residential worker arrived at Mr Pinkney's room and found him lying on the floor. He used his radio to call for a colleague, who arrived moments later and tried to get a response from Mr Pinkney but could not do so. They could see what appeared to be a needle in his leg. Mr Pinkney was not breathing, had no pulse, and showed no signs of life. The colleague called 999 and described the situation to the operator, who said that any attempt to revive Mr Pinkney would be futile, and they would notify the police. A paramedic later attended and at 10.15am officially pronounced that Mr Pinkney had died.

Contact with Mr Pinkney's family

35. The police contacted Mr Pinkney's family and informed them of his death. AP staff followed up and made their own contact with Mr Pinkney's family.

36. The Probation Service contributed to the cost of Mr Pinkney's funeral, in line with national policy.

Support for residents and staff

37. After Mr Pinkney's death, the AP manager debriefed staff to ensure they had the opportunity to discuss any issues arising, and to offer support.

38. AP staff spoke to residents in case they had been adversely affected by Mr Pinkney's death.

Post-mortem report

39. The post-mortem report showed that Mr Pinkney died of methadone toxicity. There was evidence of alcohol and cocaine in Mr Pinkney's system.

Findings

40. Mr Pinkney engaged well with staff and AP rules throughout his time at The Crescent. Staff provided a good standard of support overall.

Assessment and management of risk

41. Post-mortem tests showed that Mr Pinkney died of methadone toxicity. There were also traces of alcohol and cocaine in his system. Mr Pinkney had longstanding substance misuse issues for which he was prescribed methadone (a synthetic opioid used to treat heroin dependence) in prison. Mr Pinkney was provided with continuity of his methadone prescription on release and had plans to reduce his prescription. He was open about his issues with staff and talked about his plans for recovery in detail, including a rehabilitation centre he was interested in joining. There were no obvious issues surrounding his compliance with his methadone prescription, which he was required to collect and administer with oversight from a pharmacist.

42. In October 2022, mandatory drugs tests were rolled out nationally for AP residents. Two tests are now required during a resident's stay. The Crescent was part way through the implementation of a new process for drugs testing on arrival when Mr Pinkney arrived. They did not test him, due to an oversight, but did check for signs of illicit substance misuse and found no concerns. In response to the learning from Mr Pinkney's death, the AP manager quickly issued a notice to staff, reminding them to test residents on arrival.

43. AP residents may also be tested on suspicion of illicit substance misuse. Routine engagement and room checks did not find any signs of substance misuse so no drugs tests were completed on the basis of suspicion for Mr Pinkney. He was given a random drug test on one occasion, on 24 November, for which the result was negative.

44. The next day, Mr Pinkney returned from a walk with another resident and appeared grey and clammy. A residential worker asked him if he was okay, and he said that he had been walking on a cold night, had become unfit in prison, and had a number of health issues. She said in interview that this appeared consistent with his appearance, and he showed no common signs of drug use such as slurring his words, being unsteady on his feet, or having changes to the appearance of his eyes in a way associated with drug use. She had no suspicion that he was under the influence of drugs.

45. Mr Pinkney's licence conditions included compliance with drug testing required by his probation practitioner. When Mr Pinkney died, these were yet to be scheduled.

46. We found no evidence that staff missed signs that Mr Pinkney's risk of substance misuse had increased. The failure to test Mr Pinkney on arrival was an isolated oversight that was quickly identified and addressed and we found no suggestion that this was a systemic issue, or that it had any bearing on his death. We do not make any recommendations.

Inquest

47. The inquest, held on 17 April 2024, concluded that Mr Pinkney died after taking an unintentional overdose of both prescribed and non-prescribed medication.

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