Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ian Wadsworth, a resident at Elm Bank Approved Premises, on 21 January 2023

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 HM Prison and Probation Service 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 Ian Wadsworth died of methadone toxicity on 21 January 2023, at Elm Bank Approved Premises. He was 47 years old. I offer my condolences to his family and friends.

On 20 January, after Mr Wadsworth told a residential worker that he had taken illicitly obtained prescription drugs, the approved premises manager acted decisively to try to reduce the risk of him overdosing.

The response of the AP staff when they found Mr Wadsworth unresponsive in his room suggested a lack of confidence which the approved premises manager will need to address.

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

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

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Summary

Events

1. On 22 June 2019, Mr Ian Wadsworth was remanded to HMP Hull. On 23 December, he was sentenced to seven years in prison for burglary, robbery and possessing a bladed article. On 21 December 2022, Mr Wadsworth was released from HMP Humber on licence to Elm Bank Approved Premises (AP).

2. On 19 January 2023, a residential worker tested Mr Wadsworth for illicit substances. Mr Wadsworth told her that he had self-medicated with pregabalin (used to treat epilepsy, anxiety, and nerve pain).

3. On 20 January, approved premises staff searched Mr Wadsworth's room. They found a small white tablet at the back of a drawer which they disposed of (there is no information about what the tablet was or if it belonged to Mr Wadsworth). The AP manager was concerned that Mr Wadsworth was self-medicating with pregabalin as he was also prescribed high risk medication including methadone. She issued Mr Wadsworth a notice of concern (a low-level warning) for misusing prescribed drugs, asked for approved premises staff to obtain a verbal response from him at welfare checks, to keep him under monitoring and asked for an audit of Mr Wadsworth's in-possession medication.

4. That day, Mr Wadsworth told his community offender manager (COM) that he had bought the pregabalin in a pub on Christmas Eve and was taking it as and when he felt he needed to. Mr Wadsworth's COM gave him a verbal warning for disclosing that he had used unprescribed medication.

5. A residential worker removed Mr Wadsworth's medication in-possession status because the audit revealed that he was only sporadically taking his prescribed medication.

6. At about 11.00pm that night, a residential worker and a residential assistant, carried out a welfare check and saw Mr Wadsworth in his room lying on his bed, dressed. He asked to have a meal the next day.

Events of 21 January

7. At about 6.05am on 21 January, the residential assistant carried out the first welfare check of the morning. When Mr Wadsworth did not respond, the assistant opened the door and thought Mr Wadsworth had died. The residential assistant returned to the staff office and told his colleague. They collected the first aid bag and returned to Mr Wadsworth's room. Mr Wadsworth was blue in colour and stiff. Staff called for an ambulance. The emergency services operator tried to give the staff instructions to begin CPR, but they were reluctant. The residential assistant was sure that Mr Wadsworth was dead.

8. At about 7.04am, ambulance paramedics arrived at Elm Bank and at 7.10am, confirmed that he had died.

Findings

Events of 21 January

9. The staff who found Mr Wadsworth were reluctant to properly assess him for signs of life, or death, or to follow the emergency services operator's instructions. They did not consider using naloxone (which can reverse the effects of an opioid overdose) and were not certain of its use.

Good practice

10. On 20 January, after Mr Wadsworth told a residential worker that he had taken an illicitly obtained prescription drug the approved premises manager promptly took action arranging a room search, asking approved premises staff to obtain a verbal response from him at welfare checks and to keep him under monitoring, arranging a medication in-possession audit and issuing Mr Wadsworth with a notice of concern.

Recommendations

- The manager of Elm Bank Approved Premises should ensure that all staff understand their responsibilities during medical emergencies, including that:
    - Staff act promptly in a life-threatening situation.
    - First aid is commenced immediately on discovery of a resident who is unconscious and not breathing, unless there are obvious reasons why this would be inappropriate, for example clear signs of rigor mortis.
- The Manager of Elm Bank Approved Premises should ensure that staff are aware how to use naloxone in a medical emergency.

The Investigation Process

11. On 23 January, the PPO was notified of Mr Wadsworth's death.

12. The investigator issued notices to staff and prisoners at Elm Bank Approved Premises informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

13. The investigator interviewed three members of staff at Elm Bank on 11 May.

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

15. The Ombudsman's family liaison officer wrote to Mr Wadsworth's mother, to explain the investigation and to ask if she had any matters she wanted us to consider. She had no specific questions.

16. We shared the initial report with the National Probation Service. There were no factual inaccuracies.

17. We shared the initial report with Mr Wadsworth's mother. She did not respond.

Background Information

Elm Bank Approved Premises

18. Approved premises (formerly known as probation and bail hostels) mostly accommodate offenders released from prison on licence and those directed there by the courts as a condition of bail. Their purpose is to provide a supportive and structured environment. Residents are responsible for their own healthcare and are expected to register with a GP.

19. Elm Bank Approved Premises is a 22-bed residence for men, providing one disabled room, three double rooms and eighteen single rooms. Elm Bank is an enhanced Approved Premises and accommodates critical public protection cases and national security division cases. It is one of four approved premises operated by the West Yorkshire Probation Area.

Previous deaths at Elm Bank Approved Premises

20. There have been two previous deaths at Elm Bank, the last death being in 2011.

Key Events

21. On 22 June 2019, Mr Ian Wadsworth was remanded to HMP Hull. On 23 December, Mr Wadsworth was sentenced to seven years in prison for burglary, robbery and possessing a bladed article. On 2 January 2020, he was transferred to HMP Humber. On 21 December 2022, Mr Wadsworth was released on licence to Elm Bank Approved Premises.

22. A residential worker carried out Mr Wadsworth's approved premises induction where he agreed to comply with the premises rules and the medication in-possession rules. Mr Wadsworth signed that he understood that he may have a reduced tolerance to drugs and alcohol which could increase the risk of an overdose. Mr Wadsworth signed that he understood the benefits of naloxone (used to counter the effects of opioid overdose) but declined to have it to use.

23. Mr Wadsworth's community offender manager (COM) carried out Mr Wadsworth's probation induction by telephone.

24. An AP residential worker booked Mr Wadsworth's medication (apixaban - an anticoagulant, atorvastatin for cardiovascular disease, lansoprazole and omeprazole for acid reflux, mirtazapine - an antidepressant and quetiapine, an anti-psychotic medication) into the AP medicines cabinet.

25. On 22 December, an AP residential worker carried out Mr Wadsworth's second stage induction. Mr Wadsworth said that he had completed the Greenway Medical Practice registration form and would hand it in at the practice.

26. On 23 December, an AP residential worker booked Mr Wadsworth's methadone into the AP medicines cabinet for it to be dispensed daily by staff. The AP manager said that residents usually receive their methadone at the Kirklees Pharmacy, but for bank holidays a member of staff collects the methadone from the pharmacy to give to the resident over the holiday period.

27. On 23 December, Mr Wadsworth saw a probation service officer, who was also his key worker, for a key worker session. Mr Wadsworth told her that he had enough methadone for the Christmas period. She completed a Support and Safety Plan (SaSP) which included an assessment of Mr Wadsworth's risk of self-harm. Mr Wadsworth told her that he was not likely to self-harm and that his main concern was with finding accommodation before the end of his stay at Elm Bank.

28. On 29 December, a probation service officer saw Mr Wadsworth for a key worker session. Mr Wadsworth told her that he been to Chart (Kirklees drug and alcohol service) and was receiving 60ml of methadone daily at the Kirklees Pharmacy. She noted that Mr Wadsworth completed a claim for universal credit.

29. On 30 December, Mr Wadsworth had a telephone appointment with a probation officer. Mr Wadsworth told her that he was worried that he did not have accommodation arranged for when he left the AP.

30. On 3 January 2023, a residential worker noted that Mr Wadsworth came back from the chemist annoyed that he could not collect his medication. He told her that he had dihydrocodeine (an opioid pain killer) in-possession in prison and could not

understand why he could not collect and have this in his possession at Elm Bank. The AP manager said that when residents arrive at Elm Bank their medication is taken from them until a medication assessment is carried out and that resident's medication is collected from the pharmacy by a member of staff.

31. On 4 January, Mr Wadsworth had a key worker session with his key worker and complained to her about the medication process. She carried out a medication in-possession risk assessment and noted that Mr Wadsworth could have his prescribed drugs in-possession except his dihydrocodeine.

32. On 5 January, the COM completed a duty to refer (DTR) to Wakefield Council. (The Homelessness Reduction Act 2017 requires prisons and probation services to refer anyone who is homeless or at risk of becoming homeless within 56 days to a local housing authority.) Mr Wadsworth told her that his brother lived in Wakefield, and he wanted to live in the same area.

33. On 11 January, the COM met Mr Wadsworth at Elm Bank. She noted that Mr Wadsworth had made positive steps: attending agencies for his medication and for support, registering with a GP, making a claim for benefits, and engaging with the substance misuse service to obtain his methadone prescription. Mr Wadsworth said that a housing officer from Wakefield Council had contacted him to complete a housing assessment.

34. On 12 January, the key worker met Mr Wadsworth for a key work session. Mr Wadsworth told her that his GP had prescribed him new heart medication which was causing him problems and concerned him. Mr Wadsworth said that he didn't think that the doctors were taking him seriously because of his previous drug misuse. She told Mr Wadsworth that she could make a Community Accommodation Service (CAS3- which provides temporary accommodation for up to 84 nights for homeless prison leavers) referral if he was unable to secure accommodation with Wakefield Council.

35. Over the next week, the key worker and the COM worked with Mr Wadsworth to pursue housing options for after he left the AP (he was due to leave on 1 February).

36. On 19 January, an AP residential worker drug tested Mr Wadsworth, who admitted that he had self-medicated with pregabalin. (On 2 February, the test result came back and was positive for opiates.)

37. On 20 January, a senior probation officer discussed Mr Wadsworth with the COM, who said that she would encourage Mr Wadsworth to see his GP and the substance misuse service. The COM said that she would give Mr Wadsworth a verbal warning and make clear to him the consequences of continuing to use illicit substances.

38. That day, two AP residential workers searched Mr Wadsworth's room. They found a small white tablet at the back of a drawer which they disposed of (there is no information as to what this tablet was or if it belonged to Mr Wadsworth). One AP worker noted that Mr Wadsworth admitted self-medicating with pregabalin which was a concern as he was also prescribed high-risk medication including methadone. She noted that Mr Wadsworth's speech was very slurred, but she did not know if this was an effect of the methadone or misuse of prescribed drugs on top of his daily methadone dose. She issued Mr Wadsworth a notice of concern (a

low-level warning) for misusing prescribed drugs. She asked for approved premises staff to obtain a verbal response from him at welfare checks, to keep him under monitoring and asked for an audit of Mr Wadsworth's in-possession medication.

39. That day, the COM held a planned weekly telephone appointment with Mr Wadsworth. Mr Wadsworth told her that he felt that he should have been prescribed pregabalin as his current medication was not allowing him to manage his pain and that he had bought the pregabalin in a pub on Christmas Eve and was taking it as and when he felt he needed to. She explained the AP manager's concerns about Mr Wadsworth's illicit use of prescribed medication on top of his prescribed medication. She gave Mr Wadsworth a verbal warning for disclosing that he had used pregabalin. She told Mr Wadsworth that she had chased Wakefield Council for the result of his housing assessment and told him that he had a planned meeting on 27 January with a member of staff from Shelter, and that she had arranged a three-way meeting with his key worker to prepare for his move from Elm Bank.

40. At 6.22pm on 20 January, after an AP residential worker carried out the medication in-possession audit, he noted that because Mr Wadsworth was only sporadically taking his medication, and he withdrew Mr Wadsworth's medication in-possession status. He noted that he was particularly concerned that Mr Wadsworth was not taking his apixaban and atorvastatin medication as prescribed.

41. At 8.50pm, Mr Wadsworth told an AP residential worker that he was frustrated about the medication process. She told him that there was a medication process for a reason, and it was to keep the residents safe.

42. At about 11.00pm, an AP residential worker and a residential assistant carried out a welfare check and saw Mr Wadsworth in his room. Mr Wadsworth was lying on his bed, dressed. He asked to have a meal the next day.

Events of 21 January 2023

43. At about 6.05am on 21 January, the residential assistant went to Mr Wadsworth's room to carry out a welfare check. He knocked on the door, but Mr Wadsworth did not respond, so he opened the door. From the door, he said that he knew that Mr Wadsworth was dead. He said that Mr Wadsworth's face was withdrawn and there was blood around his nose and liquid around his mouth, his arm was exposed and really pale. He went downstairs to the office and told the AP worker.

44. The AP residential worker collected the first aid bag and went with the residential assistant to Mr Wadsworth's room. She saw Mr Wadsworth lying on the bed in the same position that he was in when she saw him the previous night. She said that he looked really blue and pale and stiff like a statue. She shouted from the door before entering the room. She saw dried blood around his nose and dried liquid around his mouth. The residential assistant shook Mr Wadsworth's arm, which he said felt really cold. They did not otherwise touch Mr Wadsworth or carry out any other checks for signs of life or death.

45. The residential worker went back to the office and telephoned the ambulance service. She told the operator that Mr Wadsworth was not breathing. She did not say that Mr Wadsworth was dead. The operator rang her back on a mobile phone so that the staff could return to Mr Wadsworth's room to provide further information.

She told the operator that she could not be in Mr Wadsworth's room alone (it is not clear why), so the operator told her to collect the defibrillator while the residential assistant went into Mr Wadsworth's room.

46. The operator instructed them to move Mr Wadsworth to the floor and begin chest compressions. The residential assistant told the operator they were not comfortable to do so and, when pressed by the operator, said this was because they thought Mr Wadsworth had been dead for some time. The operator asked if Mr Wadsworth was beyond any help and the residential assistant said that he thought so. At this point, the operator told them to leave everything as they had found it. They closed the door and went to the office to wait for the ambulance.

47. At about 7.04am, ambulance paramedics arrived at Elm Bank and, at 7.10am, confirmed that he had died.

Contact with Mr Wadsworth's family

48. Police officers informed Mr Wadsworth's mother and father that he had died. On 22 January, the AP manager telephoned Mr Wadsworth's mother and offered her condolences. She remained in contact with Mr Wadsworth's mother. Mr Wadsworth's funeral took place on 27 February.

Support for prisoners and staff

49. After Mr Wadsworth's death, the AP manager debriefed the staff who found Mr Wadsworth unresponsive to ensure they had the opportunity to discuss any issues arising, and to offer support. She also directed them to other workplace support services.

50. The AP manager posted notices informing other residents of Mr Wadsworth's death and offering support. She held a meeting with the residents to provide an opportunity to talk.

Post-mortem report

51. A post-mortem examination established that Mr Wadsworth died from methadone toxicity.

52. Toxicology tests showed that Mr Wadsworth had taken methadone. A consultant pathologist said that the concentration of methadone was within the range encountered in fatalities associated with methadone use even in chronic and therefore tolerant users. He said that the risk of death is increased in individuals with reduced tolerance to methadone (following a period of abstinence). Toxicology tests showed that Mr Wadsworth had also taken quetiapine (antipsychotic medication), which was prescribed to him. The pathologist said that the concentration was higher than those usually encountered in therapy but lower than those encountered in fatalities attributed to quetiapine use alone. He said that quetiapine used with methadone may have enhanced the central nervous system depressant effects of the methadone, increasing the risk of death. Toxicology tests showed that Mr Wadsworth had also taken dihydrocodeine, diazepam, mirtazapine and pregabalin within the ranges encountered in therapy.

Findings

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53. We have some concerns about the response of the AP residential worker and residential assistant when they found Mr Wadsworth unresponsive on the morning of 21 January. Both were experienced members of staff who had received first aid training (the AP residential worker in June 2022, and the residential worker prior to that) but their accounts, and the content of their call with the ambulance operator, suggest that they were reluctant to touch or properly assess Mr Wadsworth for signs of life, or to move him and begin CPR.

54. Eventually, the staff described to the operator signs that Mr Wadsworth was already dead, but it seems they had not established whether rigor mortis was present (the stiffening of the limbs after death and an accepted sign that CPR is not appropriate). The content of the call with the operator did not make clear that their reluctance to begin CPR was because they were sure Mr Wadsworth was dead.

55. In interview, the AP residential worker described feeling shocked and scared and said she had never been in such a situation before. We understand that it can be difficult to make effective decisions in high stress situations like this, but that is what staff at Elm Bank must be supported to do. We make the following recommendation:

    The Manager of Elm Bank Approved Premises should ensure that all staff understand their responsibilities during medical emergencies, including that:

    - **Staff act promptly in a life-threatening situation.**
    - **First aid is commenced immediately on discovery of a resident who is unconscious and not breathing, unless there are obvious reasons why this would be inappropriate, for example clear signs of rigor mortis.**

56. Neither the AP residential worker nor the residential assistant considered giving Mr Wadsworth a dose of naloxone. In interview, they appeared unsure about when it was appropriate to use naloxone. The AP manager told us that all staff at Elm Bank are trained in the use of naloxone, which is available in the first aid bags and the medicines cabinet. We make the following recommendation:

    The Manager of Elm Bank Approved Premises should ensure that staff are aware how to use naloxone in a medical emergency.

AP manager to note

57. The AP manager will want to consider how best to share the learning from this investigation with the AP residential worker and residential assistant.

Good practice

58. On 20 January, after Mr Wadsworth told a residential worker that he had taken an illicitly obtained prescription drug, the AP manager promptly took action. She arranged for a room search, noted her concern that Mr Wadsworth was self-

medicating with pregabalin, asked for approved premises staff to obtain a verbal response from him at welfare checks, asked staff to keep him under monitoring, asked for an audit of Mr Wadsworth's in-possession medication and issued Mr Wadsworth with a notice of concern. We consider that she took appropriate, swift action to address the issue.

Inquest

The inquest into Mr Wadsworth's death was held on 16 June 2023 and a verdict of drug related death was recorded. The coroner concluded that Mr Wadsworth's death was due to methadone toxicity.

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