REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

This report is made under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

Recipients

This report is being set to.

- The Trustees of Victory Outreach Manchester.
  [redacted]
- [redacted]
- Senior Pastor and Head of Safeguarding [redacted]

Coroner

I am Nigel Meadows, HM Senior Coroner for the area of Manchester City.

Coroner's legal powers

I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

Investigation and Inquest

On 27 November 2017 I commenced an investigation into the death of Janie McFadyen, aged 38 The investigation concluded at the end of the inquest on 26 February 2019.

The cause of death was found to be.

1a Hypothermia
1b Use of Diazepam, Zopiclone, Cocaine and Heroin

The conclusion of the inquest was Drug Related

Circumstances of death

The deceased was born on 6 December 1978 in Irvine, Scotland. (Her mother was for many years employed as an Accident and Emergency nurse, primarily in Ayr) She was the eldest of four siblings Shortly after her 16th birthday, she left home and immediately began taking illicit drugs and quickly followed a pattern of homelessness and staying in hostels or hotels, and would normally tell the authorities that her mother would not allow her to go home although this was untrue. She gravitated back to staying at hostels or rough sleeping. She injected Heroin and consumed such other drugs as she could acquire. For a long period of time she was also being prescribed and taking Methadone

She never married but had a partner who was also a drug user and they had two children, but she was unable to look after them appropriately and they were brought up their grandmother from being a few months old They are both now adults

The deceased claimed to have psychiatric problems, and at one time indicated she suffered from bipolar disorder, but it was not clear what, if any involvement, she had actually had with local mental health services in Scotland. Her mother was aware that she had been admitted to hospital on a number of occasions having suffered overdoses or the toxic effects of illicit drugs. She had also been sentenced to periods of imprisonment.

Over the years, her contact with her mother became increasingly infrequent. She had attended a number of detoxification and drug rehabilitation programs but without success.

In early 2017, she contacted her mother asking for help. She wanted to go into rehabilitation again and try to 'get off drugs', despite her previous history of failing to do so. Through her family, she managed to secure a place at what was understood to be a drug rehabilitation program in Manchester called Victory Outreach. This was essentially a religious retreat. Some of the staff may have been previous drug or alcohol abusers.

The deceased travelled from Scotland to Manchester in July 2017 and her mother, together with some of her siblings, visited her a number of times during her overall stay at the premises. Her mother was told that initially it was what was described as a 'cold turkey' program and she struggled to cope with it in the first few weeks.

It would appear that Victory Outreach run similar facilities elsewhere in Britain as well as in other countries. The service users are asked to sign what is described as a 'withdrawal from substance abuse addiction agreement' This declares that the premises are a drug and alcohol free residential sober living facility and does not

qualify as a detoxification facility. Its approach to recovery is holistic with a strong spiritual emphasis The court understood that an individual with drug and/or alcohol problems would be expected to in effect begin the program in what was described as a 'cold turkey' abstinence state.

The court was not told that the staff at the program had any understanding that sudden abstinence from alcohol can lead to severe withdrawal symptoms and complications which, if untreated, can actually lead to death. However, it did not appear that there were any written protocols, policies or processes used by Victory Outreach in dealing with this.

The agreement also provides that if the service users experiences negative symptoms from substance abuse or addictions they will be referred to a medical facility for treatment However, that may depend upon the service user honestly reporting such symptoms or those at the home being in a position to recognise them. It did not appear that there were any written protocols, policies or processes used by Victory Outreach in dealing with this Nor exactly what 'medical facility' they may be referred to.

The service user is provided with accommodation as well as food and either pays for this privately or through state benefits There is an accommodation charge and separate charges for other aspects of their board and lodging. It is understood that the deceased was receiving Disability Living Allowance and that the relevant local authority would pay the accommodation costs and that she would contribute £40 per week from her other sources of income

The service users also agrees to give permission for those staff at the home to inspect their clothing and possessions, and that this may be conducted at any time when it is deemed necessary. However, it did not appear that there were any written protocols, policies or processes used by Victory Outreach in dealing with this

The normal expected period of stay was between 9 and 12 months.

The service user also agrees to comply with a drug screen and/or alcohol test at random periodic times The service user is also asked to agree that if they decide to leave they will indicate why they wish to do so but they may be able to return following a 28 day waiting period, although there is no guarantee that a vacancy will be available.

The 'departure agreement' in addition describes additional criteria which are recorded as 'walked away, negative departure, asked to leave and other' However, it did not appear that there were any written protocols, policies or processes used by Victory Outreach in defining what these terms actually mean or exactly how this would be operated and what would happen if the service user had relapsed or was about to or there was an imminent risk of this occurring. There can be a number of conditions for return, including daily contact with the director of the home with required church attendance It appears that there is an expectation generally that service users will attend church services, prayer meeting and participate in reading the Bible.

There is a template Drug Test Record Sheet for each service user, which simply indicates a positive or negative result. For drug testing, the court was told this was undertaken by means of a 'urine dip test'. However, it was not clear exactly what drugs were tested for, by what equipment or processes, the accuracy of such testing, the types or nature of any drugs detected or any recognition of the potential acute health implications of positive tests without knowing the quantities involved or the effect of a combination of illicit drugs with or without the consumption of alcohol. However, it did not appear that there were any written protocols, policies or processes used by Victory Outreach in dealing with this

The manager of the female unit acknowledged that they had no power or provision to ask or seek the consent of a service user for an intimate body search in case any illicit drugs had been secreted within the body. This would include within the mouth and other body orifices

It is not clear exactly what relationship Victory Outreach have with local primary and secondary NHS drug and mental health services.

The court was told that there was one local home for female residents, which could cater for up to six occupants, but any individual has to share with a room-mate. There was also another local facility for male residents, but the court was not told exactly how many service users would be able to stay there.

The manager of the female unit is described as being a 'Recovery Program Manager' She personally has no medical qualifications but may have undertaken some training, but it was not clear exactly where, when or what this actually involved. Service users are expected to attend group counselling sessions but can leave the program at any time.

The organisation does not accept service users with mental health problems or who require medication administering. It was understood that applicants are asked to indicate if they have any mental health problems and consent to the organisation contacting previous services who may have diagnosed or treated the individual. This depends upon the person being truthful about their history and providing the right contact details However, it did not appear that there were any written protocols, policies or processes used by Victory Outreach in dealing with this. At the inquest hearing, the manager was unable to indicate what, if any, information the deceased had provided about this aspect or any details of her past and most recent drug abuse history and treatment.

The manager accepted that the deceased struggled in the first few weeks of the program because of the 'cold turkey' aspect It was not clear whether or not there was any understanding of the potential short or longer term health implications of ceasing from prescribed medication or illicit drugs. However, it did not appear that there were any written protocols, policies or processes used by Victory Outreach in dealing with this.

The deceased had indicated that she felt this was her last chance to try to overcome her drug problem.

Service users were not allowed mobile phones and had to be accompanied by a member of staff whenever they left the premises. The court understood that there was a full time manager but with a number of other volunteer staff. However, it was unclear what experience or training each of them may have had and any chain of governance, and what they might do in the event of circumstances arising, and whether or not they could or should seek advice or guidance from someone else However, it did not appear that there were any written protocols, policies or processes used by Victory Outreach in dealing with this

By November 2017 it appeared that the deceased was progressing well and had apparently not provided any positive drug tests, although it was unclear when and exactly how many were undertaken or when Nor had anything been found, either in her shared room or within her clothing or possessions. But again, it was not clear when these searches had been made.

The manager accepted when giving evidence that service users on arrival may not have a genuine or sincerely held Christian faith belief and may feign or pretend to do so. In addition, whilst they may outwardly appear to either continue with such beliefs or develop them, then once again there were a possibility that these may not be genuinely held

The deceased's family visited her from Scotland over the weekend of 18 and 19 November 2017. When they went out, it seems that the deceased behaved unusually because she was singing aloud on public transport and appeared to be restless and her conversation included a degree of religious content, and was unable to maintain eye contact with her family. The family were able actually to stay at the retreat premises but the deceased made no attempt to speak to her family in private Her mother, who was of course a very experienced A&E nurse, described her presentation as being psychotic

Before the family left, they did not raise any concerns about the deceased's behaviour with the manager or any other staff member, but the manager was made aware that on 23 November 2017 it would be the anniversary of the deceased's father's death and that she might have difficulty coping on that day.

The manager also indicated when giving evidence that the deceased had been in the process of developing a relationship with a male service user who was resident in the male unit and they had apparently been exchanging letters It was not, however, clear how the deceased ever first met or had contact with this individual or how long this putative relationship had been ongoing. It was not clear that there were any written protocols, policies or processes used by Victory Outreach in dealing with this.

The manager told the court that the deceased was actively encouraged to consider that the relationship was not appropriate and this was an unhealthy situation. There had been some recognition by the manager that the deceased's behaviour at this time might be described as 'overactive' and that the deceased was supposedly feeling guilty about the situation.

At any rate, this male individual had apparently himself been in the process of leaving the male unit at about the same time as the family's last visit and was understood to be returning to his home address.

The court was told that at the very least, the female service users were locked in the premises at night, although their individual rooms may be open for entrance and exit, and that there would be a member of staff within the premises overnight who had the keys. It was not clear what would happen if a service user wished to leave the premises overnight but was physically or practically unable to do so; or that any consideration had been given to the potential risk of a service user being falsely imprisoned A member of staff would be in possession of keys but it was not clear what would happen if they themselves became incapacitated.

The court was told by the manager that Greater Manchester Fire and Rescue Service were aware of these arrangements and had not raised any concerns This came as a surprise to the court.

The evidence suggested that the deceased had retired to bed on the evening of 22 November 2017 in the company of her roommate but it was not clear at what time. It seems that at some time between then and about 0600 on 23 November 2017, the deceased left her room wearing what was described as a tracksuit and a pair of shoes, but leaving her coat and other belongings behind. An open kitchen window was found and when the staff were alerted to this, a search of the premises was made but the deceased could not be found and it was felt that she had exited the building through this window.

The manager told the court that it was unknown what contact, if any, the deceased had had with the male service user who had left a few days before The manager told the court that previous experience indicated that those who leave the program suddenly return to their home addresses. Sometimes they may simply leave for a short period of time to 'clear their head' but then return. The deceased did not do so for a number of hours and contact was made with her mother to explain the situation. No contemporaneous record was made by the manager of exactly what was said to the deceased's mother, but it seems that the family were left to decide whether or not to contact the Police to report the deceased as a missing person. The manager also learned that the deceased had managed to be able to withdraw about £300 in cash from a bank account

Neither the manager nor any other member of staff thought it appropriate to report the deceased missing to the Police at any time thereafter, even when the deceased had not returned for at least two days and they had no contact with her, and there was no indication that the family had had any contact either.

The deceased was clearly a very vulnerable person who was at constant risk of relapsing into the consumption of drugs with all the attendance risks to her health and life Leaving suddenly in all the circumstances, bearing in mind her recent behaviour and the concerns about her presentation, she was at significant risk of trying to access illicit drugs as quickly as possible. However, it did not appear that there were any written protocols, policies or processes used by Victory Outreach in dealing with this

Overall, it was not clear to the court whether or not the male unit was run on the same basis or indeed any other premises within England and Wales.

It was established that after the deceased left Victory Outreach, she travelled to Manchester, which is a short distance away, and managed to make contact with a known drug user who was a homeless man He indicated that he knew the deceased and that she had purchased from him quantities of illicit drugs. This man claimed that the last time he saw her, she was clearly acting under the influence of drugs

At about 1045 on 25 November 2017, an off duty firefighter happened to be passing close to some derelict land adjacent to Pollard Street East in the centre of Manchester and saw what appeared to the body of a person lying on the ground He immediately went to investigate the situation and discovered the deceased to be a female who was unconscious and unrousable Due to his immediate concerns about her breathing and pulse, he commenced CPR and called the emergency services. An ambulance arrived and paramedics took over the care and management of the deceased. She was conveyed urgently to Manchester Royal Infirmary but had apparently already suffered one cardiac arrest prior to admission and sadly suffered another shortly after arrival. She had an unrecordable low body temperature, from which it was deduced that she must have been outside in the open for some considerable time before she was found. She was pronounced dead very shortly after arrival at hospital because attempts to resuscitate her proved unsuccessful

A subsequent post mortem examination and toxicology tests revealed that she had consumed quantities of Heroin, Diazepam, Zopiclone and Cocaine. The combination of these drugs can result in profound sedation and a loss of consciousness

Coroner's concerns

During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you

The matters of concern are as follows.

1 The clear lack of the apparent existence of appropriate protocols, policies, processes or other guidance to deal with the large number of issues identified above
2. The lack of an apparent clear and cohesive set of arrangements for seeking help and guidance from primary or secondary NHS drug/alcohol and mental health services or seeking advice from the Police about a Missing Persons Policy
3 A complete lack of clarity about when and in what circumstances who leaves the program should be reported to the Police as being a missing person. It is suggested that the deceased would have fallen into the category of a High Risk Missing Person in all the circumstances and that there should be established procedures for dealing with such situations.

4. The inappropriateness of attempting to place the responsibility on members of a family to decide whether or not they wish to report an individual as a missing person to the Police
5 It is suggested that every person who works at either the male or female unit has appropriate and recognised training for their roles and this is regularly reviewed and updated
6. If other similar units run by Victory Outreach are operated in the same way elsewhere in England and Wales, a similar program of review identified in paragraphs 1-5 immediately above should be undertaken.

Action should be taken

In my opinion action should be taken to prevent future deaths and I believe your organisation has the power to take such action.

Your response

You are under a duty to respond to this report within 56 days of the date of this report, namely by 26 April 2019. I, the coroner, may extend the period.

Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.

Copies and publication

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons·

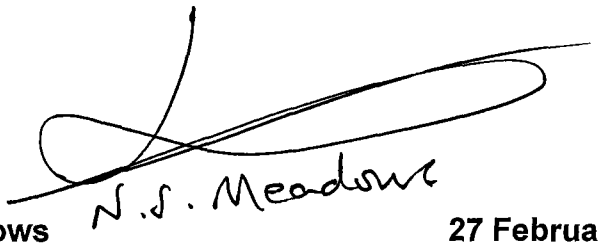
- The family of the deceased

I am also under a duty to send the Chief Coroner a copy of your response

I am also sending a copy for information to:

- Salford City Council Adult Social Services
- Greater Manchester Mental Health NHS Trust
- Greater Manchester Police
- Greater Manchester Fire and Rescue Servicep
- Care Quality Commission

The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.



N Meadows **27 February 2019**
H.M. Senior Coroner – Manchester City area