Investigation into the circumstances surrounding the death of a man on 4 May 2005 at an approved premises in the West Yorkshire Probation Area

Prisons and Probation Ombudsman for England and Wales

September 2005

The man was aged 32 when he died on 4 May 2005 in his room at approved premises, soon after he was released from HMP Leeds. A syringe was in his hand. The loss of any family member is distressing, especially when the person to die is still young, and I offer my sincere condolences to his family and friends.

This is a report into the circumstances surrounding his death. A member of my office carried out the investigation. I would like to thank the approved premises Manager for making the necessary facilities available to my investigator.

I am satisfied that the care and treatment of the man during his time in custody at Leeds Prison, and while a resident at the approved premises, were appropriate. Nevertheless, a number of issues have arisen and my report includes recommendations for both the National Probation Service and the Prison Service.

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Prisons and Probation Ombudsman **September 2005**

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Summary

1. The man was released on licence from HMP Leeds on 29 April 2005. (He had been recalled to prison following a custodial sentence of 16 months imposed by Batley and Dewsbury Magistrates' Court.) His licence conditions required him to reside at an approved premises, situated in a suburb of Leeds.

2. He had been described as a prolific drug user and was prescribed naltrexone by the prison doctor following his recall to prison. He had been referred to the Counselling Assessment Referral Advice and Throughcare (CARATS) team at the prison. However, they were unaware that naltrexone had been prescribed by the prison doctor, which meant that they in turn were unable to pass on the information to the approved premises management.

3. On 29 April, he arrived at the approved premises. He fell asleep during the induction, apparently under the influence of a substance. He subsequently told a Community Psychiatric Nurse (CPN) and his Probation Officer that he had used heroin, which he said he had taken in prison.

4. At 6:19pm on 4 May, the man, who had been out during the day, returned to his room and was not seen to leave his room again after that time.

5. At 11:00pm the Assistant Residential Officer (ARO) checked the rooms of those men who were on curfew, to ensure that they were in the approved premises and complying with their licence conditions. He entered the man's room (104) and found him sitting upright on the bed, holding a syringe in his right hand and a loose tourniquet applied to his upper left arm. No signs of life were apparent.

6. The ARO informed his colleague and they again checked for signs of life. They then telephoned the emergency services who arrived at 11:20pm. Soon afterwards, the paramedic staff declared that the man was dead. The police informed the family of his death during the night.

The man

7. One of my Family Liaison Officers has made contact with the man's family, who have not raised any issues for the investigation to consider. The details regarding him have been obtained from the available recorded information contained within the Offender Assessment System (OASys).

8. He was aged 15 when he was first convicted of a criminal offence and had received one custodial sentence prior to the age of 21, and six subsequently. He was considered as "High Risk" of violent offending, with one previous conviction for an offence of violence. The OASys record shows that his offences were carried out whilst under the influence of drugs and/or alcohol.

9. He is recorded as living with his parents in West Yorkshire. He left school before the minimum leaving age, with no qualifications. His employment record shows him as working in the textile industry as a machinist, however he was unemployed at the time of his conviction.

10. In 1997, he and his wife split up, and she left taking their three children with her. He had had no further contact with his ex wife or children since then. He told the officer entering the OASys information that, following the break up of the marriage, he had made an attempt to harm himself.

The Approved Premises

11. The approved premises are a voluntary managed facility run by The Knights of St Columbia.

12. The approved premises are located in Leeds and is spread over three buildings. It offers a good standard of accommodation for 28 residents. All residents are either on licence, bail or a Community Rehabilitation Order with a Condition of Residence. The residents are in the main considered to be at medium to very high risk of harm to the public.

13. The approved premises operate a curfew for the majority of residents from 11:00pm to 6:00am. Residents undergo a full assessment with their Case Manager and are required to tackle the causes of their offending.

Conduct of the Investigation

14. Following notification of the death of the man, my investigator contacted the Manager who briefed him about the circumstances. The investigator agreed with the Manager to commence the investigation on 18 May. The Manager agreed to collate the files and records relating to the man and made arrangements to display my investigation notices to residents, informing them of the Ombudsman's investigation.

15. On 18 May, my investigator opened the investigation and received an in-depth briefing from the Manager. The investigator also met the Deputy Manager, an Assistant Chief Probation Officer, Residential Services West Yorkshire Probation Board and the Secretary of the Management Committee.

16. The Manager escorted the investigator to the room where the man was found and also gave him a full tour of the facility.

17. The records and files relating to the man's death were examined, and staff identified whom the investigator would need to interview. The Manager made the necessary arrangements for the interviews to take place.

18. As the man had been released from HMP Leeds on the Friday prior to his death, my investigator visited the prison to discuss the available drug services. He also met with the prison doctor in order to understand how clinicians communicate with the prison drugs services (CARATS).

Key Findings

19. On 23 February 2005, the man had been returned to prison following the revocation of an earlier licence. He had been informed in writing by the Parole Board that he had been recalled to prison for breaching two licence conditions:

    5(i) failed to keep in contact with his supervising officer and failed to attend an appointment on 7 February
    5(vi) On 16 January he was arrested for Driving Whilst Disqualified and No Insurance.

    On 17 January, he had been arrested for a Breach of the Peace, with a further arrest on 22 January for another Breach of the Peace offence. The Parole Board recorded that it had been reported that he had been reluctant to make any progress on his offending behaviour and had returned to drug use.

20. HMP Leeds has a dedicated drug treatment team, which offers a support and advice service for prisoners. The CARATS team met the man on 23 February to assess his drug use and related issues.

21. On 24 February, he was placed on a 14-day detoxification programme, and prescribed DF118 tablets and nitrazepam. He had experience of the detoxification programme in Leeds, as he had accessed the service during a previous custodial period in 2001, and had been prescribed DF118 tablets.

22. Following his appointment on 24 February, he met with the Throughcare Worker in the CARATS team, and was given an appointment for aftercare and naltrexone. He told the Throughcare Worker that he had a £50.00 per day heroin habit and would either inject or smoke the drug.

23. The Throughcare Worker discussed a release plan with him, which he then sent to the “Way Ahead” organisation, which is a Drug Intervention Programme, based in Dewsbury. He told the Throughcare Worker that a member of the Way Ahead team had agreed to meet him at the prison, on his release from custody. My investigator has not been able to confirm this with the Way Ahead team.

24. The CARATS team issue all prisoners who have been prescribed naltrexone an advice leaflet explaining the dangers of taking naltrexone and using any drug. The prisoner is required to sign the CARATS record to confirm that the leaflet has been issued to him and that he understands the risks. The record shows that he signed the record to acknowledge that he had been given this information.

25. The CARATS team routinely inform external support agencies of any medication that has been supplied to the prisoner for his discharge. However, they were unaware that, on 6 April, the prison doctor prescribed

a 28 day course of naltrexone to the man. This meant that they were unable to inform the approved premises that he had been prescribed the naltrexone.

26. An examination of the CARATS referral procedures and his medical record show clear evidence that wholly appropriate steps were taken to refer him to community drug services and General Practitioners.

27. My investigator met the doctor who prescribed the naltrexone, to enquire why the CARATS team would not have been informed that the man had a 28-day supply of the drug. It was clear to the investigator that it was not a deliberate act on anyone's part that they were not informed, but rather a communications issue.

    The Governor and Primary Care Trust should ensure that effective communication systems are in place between the Healthcare Department and the CARATS team, to ensure seamless throughcare.

28. The doctor was asked to explain the procedure for ensuring that prisoners prescribed naltrexone were actually taking the medication as prescribed. A member of the nursing staff, interviewed with the doctor, said that when the prisoner demonstrated on at least three occasions that he was taking the medication, he would be left alone to continue without further intervention from Healthcare staff. My investigator understands that the prisoner is required to attend the Healthcare Centre on at least three occasions and take the medication in the presence of a member of the nursing staff.

29. Following the man's death, a total of 25 naltrexone tablets were found in his room. They were in a box marked as being issued at HMP Leeds. The hostel staff were unaware that the naltrexone had been supplied to him, or that he had them in his possession.

30. As no further prescription for naltrexone was made, I can only conclude that the 25 tablets found in his room were the remainder of the prescription issued on 6 April, and that the present system based on trust can be open to abuse. I am concerned that the control of prescribed medication is not robust enough to ensure that the prisoner is taking the drug as intended.

    The Governor, in partnership with the PCT, should review the issue and control of prescribed medication to ensure prisoners comply with their treatment regimes.

31. He was released again from custody on 29 April 2005, on a conditional licence and reported to the approved premises.

32. It is a requirement for all residents of the approved premises to hand to the staff any prescribed drugs and medication that they have in their possession. This includes any medication that can be purchased off the shelf at any chemist. Staff keep strict control of medication and only issue

items at the appropriate time. The control mechanisms in place require all medication to be kept in a locked cabinet and any item issued is recorded in a ledger. The member of staff issuing the medication and the resident receiving the medication sign the ledger to acknowledge the issue and receipt.

33. On Tuesday 3 May the CPN and Addiction Therapist of the Leeds Addiction Unit visited the approved premises. The CPN provides assistance for those people living in approved premises who have problems with drugs or alcohol. She attends for one and a half days per week and screens all new residents who have a history of abusing drugs or alcohol.

34. The policy is to drug test all residents with a history of substance abuse, at least once per week. Additionally, staff can use their discretion to carry out random drug testing if they suspect that a resident has taken an illicit substance. The man had been tested that morning and had produced a clean sample of urine.

35. When the CPN met him, he informed her that he had last used heroin on the previous Friday (29 April). She described him as being alert and knowing what he wanted to do in relation to drug treatment, and that he appeared motivated.

36. He said that he had been given naltrexone tablets by "Life Line", which is a needle exchange service based in Dewsbury. The CPN subsequently checked with the "Life Line" centre and they confirmed that they had not issued him with naltrexone. The assessment indicated that no further clinical follow-up was required, unless the clinical picture changed. Any change would be as a result of further drug use, and would be detected in the routine urine tests.

37. During the night, staffing levels at the Approved Premises are at a minimum, with one Residential Officer (RO) and one ARO on duty. The RO is required to sleep on the premises and to respond and support the ARO as required. The RO acts as the first contact point for the ARO and is contactable by internal telephone and radio.

38. At 6:15pm, on Wednesday 4 May, the man returned to the approved premises – having been out all day – and collected his room key from the RO. He said that the man then returned to his room. Minutes later, at 6:17pm, he returned to the office and the RO said it was noticeable that he had removed some clothing. He said that the man told him that he had two appointments for the following day, but the RO could not recall what the appointments were for. He added that, although he had noticed the man sweating, he was not concerned and thought that it was possibly due to the heat. He said that at approximately 6:19pm, the man returned to his room and he did not see him again.

39. The RO was sure that the times quoted were correct, as the approved premises are monitored by video camera and the video recording gave the times.

40. Under normal circumstances, the RO and ARO both check that residents are in the building by carrying out a curfew check and then locking the entrance doors. However, on this occasion the RO was dealing with a resident who had returned after having consumed alcohol and so he asked the ARO to carry out the curfew check on his own.

41. At 11:00pm, the ARO commenced the curfew check and began on the ground floor. At 11:10pm, he arrived at the man's room and, as there was no response to his knocks on the door, he used his master key to enter the room. When he went in he saw that the man was sitting on his bed, slumped against the wall. He saw that there was a belt around his right arm and a trace of blood on the back of his right hand, close to his knuckles. He called out the man's name three times, but did not receive a response. He tapped him on the knee, but again did not receive a response. He checked for signs of life and said that his body was cold to the touch and he could not detect any signs of breathing. He locked the room door and left to inform the RO.

42. The RO and the ARO returned to the man's room and again checked for signs of life, but found none. The ARO left the room to telephone the emergency services, plus the on call manager and the area Probation Service's Assistant Chief Officer.

43. The RO moved the man's body to check again for signs of life and said that his body was cold to the touch and that he could not detect any pulse or breathing. At that stage he decided that the man was dead. He checked again for signs of life and thought that he had detected a small pulse and so laid him on his back, on the bed, and attempted to perform Cardio Pulmonary Resuscitation (CPR). As he moved him, he noticed a syringe in his right hand, which he removed and placed on the bedside cabinet. He said that the syringe contained a brown liquid. He said that, following the second chest compression, he believed that the man was dead and so stopped any further attempt at resuscitation. He considered that it was inappropriate to continue with CPR, as the man was cold to the touch.

44. The RO said that he has received training in first aid – which includes CPR – and that his certificate is up to date. The approved premises manager confirmed that all his staff hold current First Aid Certificates. Although I do not believe it made any difference on this occasion, I note that the RO attempted to carry out CPR on the bed. Good practice would have been to have laid the man on the floor or other hard surface.

    All staff should be reminded that CPR should be carried out on a hard surface. Furthermore, if staff commence CPR then it must be continued until the arrival of the emergency services.

45. At approximately 11.20pm, the paramedic team arrived and checked the man for signs of life. They connected an Electro Cardio Graph (ECG) machine to him, but this gave no indication of life. The paramedics pronounced that he was dead and left the building soon afterwards. At the same time as the paramedics, the police arrived and took over responsibility for the incident.

46. The police informed the man's family of his death. During the night, two of his brothers arrived at the hostel wanting to view his body. The police refused the request as the area was still under investigation as a potential crime scene. His brothers were upset at the refusal, but the Police Officer was able to defuse the situation peacefully and they left the building. The RO recalled that one of the brothers asked if the man had been murdered, which might explain their reaction at the time.

47. My investigator met with the man's Probation Officer. She said she had agreed that, on his release from prison, he could return to Dewsbury between 12:00pm and 12:30pm to collect some of his belongings. She had also instructed him to be at the approved premises before 4:00pm on the day of release. The Case Record Administration and Management System (CRAMS), which is a database used by the Probation Service, notes that on 29 April at 3:54pm he arrived at the approved premises under the influence of a substance and had fallen asleep during the induction.

48. On 3 May, the PO met with him to discuss plans during his stay and for the future. During the interview, he admitted that he had taken drugs in Leeds Prison on the previous Friday. She confirmed that he had been tested for drugs on the morning of 3 May, and that the test had shown that he was clean of drugs. She described him as a prolific drug user, with no motivation to address his drug use. She also said that she was unaware that he had been issued with naltrexone. She said it would be helpful in the future if the Probation Officer was informed, as it would aid the support mechanisms.

    The Governor, PCT and Probation Area should seek to develop an information sharing protocol to ensure that Case Workers are informed of relevant medical information on a prisoner's release from custody, including medication and health and social care needs.

Recommendations for HMP Leeds

1. The Governor should ensure that effective communication systems are in place between the Healthcare Department and the CARATS team to ensure seamless throughcare.

2. The Governor, in partnership with the PCT, should review the issue and control of prescribed medication to ensure prisoners comply with their treatment regimes.

Recommendations for the Probation Area

1. All staff should be reminded that CPR should be carried out on a hard surface. Furthermore, if staff commence CPR then it must be continued until the arrival of the emergency services.

Joint Recommendation

1. The Governor, PCT and Probation Area should seek to develop an information sharing protocol to ensure that Case Workers are informed of relevant medical information on a prisoner's release from custody, including medication and health and social care needs.