Investigation into the circumstances surrounding the death of a man at an Approved Premises in September 2009

Report by the Prisons and Probation Ombudsman for England and Wales

October 2010

This is the report of an investigation into the circumstances of the death of a man at an Approved Premises in September 2009. He was found collapsed in his room at about 10.30pm, following a breath test earlier that evening which detected a large amount of alcohol in his system. After resuscitation efforts, he was pronounced dead at 10.55pm. The post mortem report gave both heroin and alcohol toxicity as the cause of the man's death.

I would like to offer this public expression of condolences to the man's family and friends for their loss. A key objective of all my investigations is to ensure that the bereaved family has the opportunity to raise concerns and contribute to my investigation. The man's mother raised a number of concerns by telephone with two of my family liaison officers. These were relayed to my colleague who carried out the investigation on my behalf. I trust that my investigation addresses the man's mother's questions. It is with regret this report has been significantly delayed and I offer my sincere apologies for this.

I would like to thank all the staff at the Approved Premises and the man's offender manager and the partnership workers who were interviewed as part of this investigation.

The man had been a resident at the hostel since 12 June and although not without incident, he was perceived to be doing well. He struggled with his alcohol intake but neither his family nor staff at the Approved Premises had known him to inject heroin. However, on a day in September, in the company of a known drug using resident, he took heroin and died shortly afterwards. Initially, the other resident was arrested in connection with his death, but this charge was later dropped.

The task of supervising high risk offenders in the community is a fine balance between continually assessing risk whilst recognising small improvements in behaviour and giving people the opportunity to make changes to their life. Unfortunately, the man could not abstain from alcohol, which was linked to his offending, but was making attempts to try to control his intake.

This report presents a favourable view of the Approved Premises and the care and support that staff offered the man. It also reflects well on the interventions of his offender manager and partnership workers. Throughout his stay at the Approved Premises, the man was enthusiastically supervised and monitored. Regrettably, one of the extra sanctions imposed to monitor his drinking in early August, when his behaviour was deteriorating, was not conveyed to all staff and the daily alcohol testing did not take place. I make three recommendations.

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

Jane Webb
Acting Prisons and Probation Ombudsman **October 2010**

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SUMMARY

The man was sentenced to 16 months for an offence of actual bodily harm (ABH) and burglary on 23 February 2009. He had been on remand for those offences since September 2008 and whilst in custody, had become mentally unwell. A psychiatrist assessed him as suffering from delusions and concluded that he should be hospitalised for an assessment. However, he showed significant improvement in his mental health and so remained in custody.

The man was released unexpectedly on licence on 11 June 2008 from HMP Winchester. It had been mistakenly documented that he was remanded in custody for an outstanding offence and was likely to be released in August. Preparation for his release was being overseen by the Multi Agency Public Protection Arrangements (MAPPA – monitoring procedures for high risk offenders) and a referral to the Approved Premises was already in motion. He was accepted at short notice by the approved premises and arrived there on 12 June.

Due to an administrative error, a number of specific conditions tailored to help the man address his previous offending were not attached to his licence and it took a few days for this to be rectified by the prison. Specifically, these conditions required him to comply with requirements to address his alcohol and drug problems.

In many respects, the man settled into the hostel well. He attended meetings with his key worker, offender manager, alcohol worker, Community Psychiatric Nurse and voluntarily attended a local drug and alcohol programme. By all accounts, his appearance improved. He continued to be monitored by local MAPPA team. He had two outstanding offences, the first of which, a charge of grievous bodily harm (GBH) was due for trial in September and he was expecting a prison sentence if found guilty.

The man found it difficult to control his drinking and abstinence was not a realistic goal for him. He was, however, taking steps to reduce it and had some alcohol free days. There were a number of episodes which caused concern for staff. In one case, he was seen to be associating with a high risk offender who lived nearby and was told to stop. In late July to early August, he returned to the hostel drunk on a number of occasions and received a verbal and written warning. On 31 July, he hit another resident after he had been drinking. Following this, he was placed on an 8pm curfew and it was decided he would be alcohol tested every night. However, the new testing regime was not communicated to all staff and he remained on random twice weekly testing.

The man had been drinking heavily the night of his death and took heroin with another resident in his room. Although he had self-harmed in the past, and was known to be worried about an upcoming court appearance, there is no evidence to suggest that this was a deliberate suicide attempt. It would appear that his inability to control his risk taking behaviour and substance misuse eventually led to his death.

Staff at Approved Premises are increasingly dealing with residents who present a high risk of serious offending and have to balance managing their risk with setting realistic goals to address offending behaviour. I make three recommendations.

THE INVESTIGATION PROCESS

1. My colleague opened the investigation on 23 September and collected the documentation relating to the man. She met the manager of the Approved Premises and Senior Probation Officer and was given a tour of the premises including the man's room. She returned to interview staff on two further occasions. Notices were issued to staff and residents telling them of the investigation and offering the opportunity to speak with my colleague. One resident came forward as a result of these notices.

2. My colleague attended the probation office in Portsmouth and interviewed his offender manager and a member from the alcohol interventions team. She interviewed five staff at the hostel, one resident and a community psychiatric nurse. My colleague asked to speak to a number of other residents but some declined or did not turn up. Two had been recalled to prison.

3. My investigator liaised with detective constables from the local police force in relation to their investigation into the circumstances of the man's death. Given the potential involvement of another resident, that resident's records were also examined by my colleague and discussed with the manager of the hostel. In addition, the resident interviewed by my investigator had raised concerns about the management of the other resident.

4. A family liaison officer from my office made contact with the man's mother offering her the opportunity to meet with both herself and the investigator. She discussed the purpose of the investigation and to raise any questions or concerns she had about the care her son received in the Approved Premises. The man's mother shared the letter she had sent to the coroner expressing her concerns with the family liaison officer.

5. The man's mother felt that her son had changed quite drastically since his release from custody and was determined to better himself. She said that she was aware that he was still drinking but was adamant that he was not a heroin user. He had a needle site on his left arm and was left handed which she believes suggests that he did not inject himself. She thought he was tested for alcohol every night and that he attended all his appointments. She expressed concern that the other resident had not been recalled from what she had been told about his behaviour from other residents.

The Approved Premises

6. Approved premises, formerly known as Probation and Bail Hostels, accommodate high risk offenders under probation supervision. Residents typically come under multi agency public protection arrangements (MAPPA) and have either been released from prison on licence, are on community orders with condition to reside their or are on bail.

7. The Approved Premises can accommodate 22 residents and is part of Hampshire Probation Service. At least 95% or more of its residents are on licence and most are subject to MAPPA level 2. Level 2 residents need enhanced supervision which can include a standard curfew of 11pm to 7am, reporting to staff during the day, drug and alcohol testing and key work sessions. The hostel has closed-circuit television (CCTV) inside the premises but not in the residents' bedrooms. Staff check on residents twice a night. Residents can be searched when they return to the approved premises and no alcohol is allowed in the building. A system of verbal, written and then final warnings is operated and ultimately a resident can be recalled to prison if necessary. The decision to proceed with a recall application will depend on the resident's circumstances, motivation and risk.

8. The hostel manager, who is a Senior Probation Officer, oversees all aspects of hostel activity. Residential Service Officers run the hostel from day to day, and night waking staff provide support and care to residents overnight. Each resident has a named key worker, who is allocated five or six residents at a time. Key workers are expected to have a one to one session per week with each of their allocated residents. At the time of the man's death, a number of staff working at the Approved Premises had been there for a significant length of time and there was little reliance on agency staff. All staff are trained in Cardio Pulmonary Resuscitation (CPR).

9. Each resident has an offender manager (OM) based at their probation office who is responsible for the management of the licence but liaise with approved premises staff. There are partnership agencies based at the probation office who provide additional support and specialised interventions. The man was under the supervision of an offender manager and reported to Portsmouth Probation Office.

10. The alcohol interventions team at Portsmouth are staff employed by Portsmouth City Council and work primarily with probation clients who have a need for support with their drinking. They usually see someone for up to six sessions and an appointment with the alcohol interventions team can count towards the client's licence requirement as a probation appointment or can be in addition to probation appointments. They have access to the computer system (known as CRAMS) which records all offender manager contacts and other information. Staff at the approved premises also access the CRAMS system. Contact and information at the hostel is recorded on the individual contact log and, if necessary and of importance, the information is also recorded on CRAMS by the hostel workers.

11. The drug test uses saliva and tests for cocaine and opiates. Alcohol levels are tested using a breathalyser which registers the equivalent of the drink drive limit as a reading of .35 milligrams (mg) of alcohol in 100 millilitres (ml) of breath. Anything over this reading would be over the drink drive limit. Night staff are usually responsible for carrying out the drug and alcohol tests, often because they will be the only staff working at the standard 11.00pm curfew when most residents are required to return to the hostel. Depending on the conditions of the resident's licence, a high reading would not always lead to a warning. This would depend on the resident's behaviour at the time and whether it is a pattern of behaviour or suggestive of a deterioration. Regardless of the outcome, test results are reported to the offender manager by email and/or directly onto CRAMS. Some workers record the results additionally in the resident's contact log although this was not always the case.

12. When they arrive at the approved premises, new residents become a temporary patient at the Homeless Healthcare Centre in Southampton. Through this practice, residents have access to a visiting nurse and the community mental health team straight away. Any medication prescribed to residents is kept by staff in the approved premises' office and signed for by the resident on collection. A drugs outreach worker for Southampton, who represents a number of drug agencies, will assess residents and link them in with the most appropriate treatment programmes. Some agencies, like the Cranstoun project, a drug and alcohol service, take self-referrals and attendance is voluntary. For voluntary schemes, the project would share with the approved premises staff whether or not a resident had attended for a session although they would not share the content of the session, which remains confidential.

KEY FINDINGS

13. The man was sentenced to 16 months for an offence of ABH and burglary on 23 February 2009, having been on remand at HMP Winchester since the previous September. Preparations for his release, thought to be likely in August, were being considered at the MAPPA meeting. (The purpose of MAPPA meetings are to share relevant information, assess the risks posed by an individual and give careful consideration to how best they can be supported and supervised post-release so as to manage the risks most effectively.) He was rated as a MAPPA level 2, the category for the majority of high risk offenders, because his risk in the community required other agencies, in addition to the probation service, to be involved. (Level 3, the highest, applies to very few people, known as the 'critical few'.) The man's probation officer had applied for a place for him at the Approved Premises and this was under consideration.

14. However, without warning, the man was released early from Winchester on 11 June. It had been wrongly documented that he was remanded into custody in relation to an outstanding arson charge. He had given his mother's address as his home address. In accordance with his licence, he reported to the Portsmouth Probation Office on Friday 12 June to see his probation officer. The Approved Premises agreed to take him as a resident on a short-term basis.

15. The man's licence was generic and did not contain the further conditions as requested by his probation officer with the prison. (The prison eventually prepared the amended licence and it was signed by the man on 18 June.) The other conditions, which had been agreed at a MAPPA meeting on 13 May, included

> "Comply with any requirements specified by your Supervising Officer for the purpose of ensuring that you address your alcohol misuse problems.
>
> "Comply with any requirements specified by your Supervising Officer for the purpose of ensuring that you address your drug misuse problems."

16. On 13 June, the man had a key working session with a residential service officer and it was agreed that he would be tested twice a week to monitor his drinking and be randomly drug tested. The residential service officer was also known as the activities officer as he organises a number of activities with residents – cycle trips, forest days and cooking. In interview for this investigation, he said that the man became involved in all these activities during his time at the Approved Premises. The key working session involved an assessment of the risk of self harm. He was noted to have previously cut his arms and was assessed as at medium risk to himself. The man's probation officer recorded triggers as when the man felt feeling depressed and having an emotionally affected personality disorder. They agreed that he would be referred to Community Psychiatric Nurse (CPN).

17. The following day, the man was assaulted by some other residents in his room and was left with a swollen eye. The senior probation officer and manager of the approved premises said the man would not say what had happened and it was another resident who told staff of the incident. In response, a number of residents, who were on final warnings were recalled to prison.

18. The man met with his probation officer on 16 June and was referred to the alcohol intervention service. Another MAPPA meeting was held and it was agreed that he could remain long-term at the Approved Premises. On 18 June, he had another key working session and said that he had been drunk twice since release but had returned to the hostel and slept it off.

19. On 23 June, the man was tested for alcohol and gave a positive reading. From the records, this appears to have been the first time that he was tested. On 24 June, another MAPPA meeting was held to give an update on the man. On 27 June, he gave another positive alcohol reading.

20. The man saw a member from the alcohol intervention team for the first time on 30 June. She saw him with another colleague as he had been assessed as quite high risk because of the nature of his offences and previous mental health problems. However, at the end of the session it was felt appropriate for her to see the man alone. She described the ethos of the team to my investigator as being service-user led. Rather than abstaining from alcohol completely, the man wanted to manage it and keep his intake stable. He was alcohol tested that evening and gave a positive reading.

21. The man saw his offender manager on 1 July. The next day he received a verbal warning for being very drunk. Again, on 3 July he gave a positive reading and was recorded as "very drunk but no management problem". It was also noted that he had been seen visiting a MAPPA 3 offender who lived nearby. On 4 July, a note in the hostel log said "had been drinking" and again, on 6 July, "had been drinking but ok with drink".

22. On 8 July, the man's offender manager visited him at the hostel and discussed his recent behaviour with him. The offender manager told the man he was close to being evicted and that he could face recall due to his drinking and association with the nearby high risk resident. The man accepted this and, at a three way meeting with his key worker and offender manager on 14 July, it was agreed that his behaviour had improved. He gave two negative alcohol tests on 17 and 19 July.

23. A CPN from the homeless healthcare team saw the man on 20 July. In interview, the nurse thought she had seen him about four or five times, although, from the records, it looks like only twice. Initially there had been some concerns about his mental health because of the psychiatric intervention in the past and his self harming. The man was on Olanzapine (an anti-psychotic drug) which she explained to my investigator was often used with "people that very stressed out or become violent, it has got lots of other uses but I would mainly say with [this man] probably to just calm him down a little bit really".

24. The man was also taking Procyclidine which the CPN described as:

> "something he had had in the past with various other anti psychotics had ease symptoms which basically can be shaking, drawn in tongue, shaky. They weren't acute from what I observed however he was given a prescription for Percyclidine which counteracts those effects".

25. The man saw the member of staff from the alcohol interventions team on 21 July and later gave a positive alcohol test. Again, on 23 July he returned to the Approved Premises very drunk and that there was a suspicion that he was smoking cannabis in his room in his records. On 30 July, he was again very drunk.

26. The next day, the man tested positively for alcohol and it was later recorded that he had punched another resident. He subsequently apologised to the other resident who did not want the incident to be taken any further. The manager of the Approved Premises and senior probation officer said in interview that they did consider recalling the man but decided to try to continue to work with him. At a key working session on 1 August, he was given a formal warning for being very drunk on these two occasions, and, in response on 3 August, he was placed on an 8.00pm curfew and that he was to be tested for alcohol every night. This instruction was recorded in the key working records and the Approved Premises' contact log. However, these tests were not carried out.

27. On 4 August, the man spoke to the manager of the approved premises and senior probation officer about how he was going to limit his drinking. He gave a negative test that evening. On 10 August, he was given a verbal warning as suspected of having been drinking in the approved premises.

28. The man saw a probation officer on 14 August and reflected that the 8.00pm curfew was helping him with his drinking. Nevertheless, he gave a positive alcohol test that evening and was again thought to be associating with another high risk offender who was not a resident at the Approved Premises. On 19 August, the man saw his offender manager and was again warned about the risk of eviction. He also saw his alcohol worker and reported that he was attending the Cranstoun project.

29. There was a scheduled MAPPA meeting on 26 August and the manager of the Approved Premises feed back the recent events at the Approved Premises with the caveat that the man was doing well there. The CPN was also present and related that she had seen him twice and was not overly concerned for his mental health. It is recorded in the MAPPA notes that she found "[the man] to be a very likeable character who is quite insightful and who has progressed well since his release from prison". The next MAPPA meeting was arranged for November.

30. The man saw his offender manager that day who recorded that he was looking much better and seemed to be drinking less. He gave a negative alcohol test that evening. On 27 August, the man smelt of alcohol and gave a positive reading on 29 August.

31. On 1 September, the CPN saw the man for the last time (he was due for an appointment with the CPN on both 10 and 17 September but these were cancelled). In interview, she said that she felt that he had progressed in his time at the approved premises and ”I would say was heading in the right direction just anxious at times in terms of his pending court case”. In his contact log, it is recorded that the nurse advised staff that he had no treatable mental health illness but would continue to see him until his court case was completed. The CPN thought long term he might need counselling but nothing she could provide. It was recorded that although he continued to be at risk of self harm, the risk was only apparent after or during specific incident or stressful period when drunk or under the influence of alcohol. The nurse concluded that his risk of self harm could not be managed with medication.

32. The man saw the member of staff from the alcohol interventions team on 2 September and this was recorded as his twelfth appointment with the probation service. He told the substance misuse support worker he was still attending the Cranstoun project three times a week, attending both group and individual sessions. He gave a negative alcohol test on 3 September, and a positive one the next day and also on 6 and 9 September.

33. On 14 September, the man had a key working session with a residential service officer. It was recorded that the man was feeling the pressure of all his appointments and had missed one of his Cranstoun appointments. In interview, the residential service officer said that the man was attending Cranstoun and probation and was feeling overwhelmed with all the sessions. The man did mention his court date but nothing caused concern for the residential service officer. He also said that he wanted his Olanzapine prescription increased as it “was not holding him”.

34. The residential service officer recorded in the key working sessions notes that “there is a risk as his court date gets close and he gets more uptight/drinks more, incidents may spiral out of control”. Also, he recorded that “he is trying to avoid being emotionally dragged back to square one and feeling like he’s back at scratch with his life/prison beckoning”.

35. On 17 September, the man saw the member of staff from the alcohol interventions team for his sixth appointment with her. In interview, she recalled that she spent about an hour with him on that occasion which was one of their longest sessions. The substance misuse support worker described him as being very interactive and engaging well with her. She felt it was in a productive session and hence told my investigator that she was very shocked about the circumstances of his death. My investigator asked her whether heroin had ever been mentioned and she recalled that he had spoken about his previous use of amphetamines but not heroin. In terms of alcohol intake, the man said that he was drinking one to two cans of cider a day and having one or two alcohol free days a week. The substance misuse support worker was satisfied that the man’s drinking had not increased since he got the warnings in early August.

36. The substance misuse support worker said that they did not arrange another session. She was aware that he was in court fairly soon and was working with a

number of other organisations so she did not want to overload him. She intended to discuss with his offender manager about the best way forward and possibly renew contact after his court appearances.

The evening of the man's death

37. The man is recorded as returning to the Approved Premises at 7.30pm, going out again at 7.40pm, in again at 7.50pm and then out again five minutes later. It is not recorded what time he came back but he was alcohol tested by a residential service officer at about 8.37pm. He gave a reading of 1.78 mgs which is the equivalent of being six times over the limit for driving. In interview, she said

    ”even though he was in drink and I believe it was quite high (the breathalysing reading) for him, for somebody else that intake level could have incapacity them or they couldn't speak. For him, he was sat upright and he was still talking to me absolutely fine so the level of intake for him didn't affect him as it could have affected somebody else so he was quite happy and he was quite honest and just had a really good chat with me.”

38. The residential service officer said that the man did talk about a court case the next week but he did not seem overly anxious or gave any indication that he was considering using heroin. In the observation book, she wrote that the man was “boisterous but manageable”.

39. At 9.00pm, a member of staff started her shift as the Night Waking Supervisor. In interview, she said that she recalled speaking with the man for about ten minutes not long after she came on duty. The conversation was light hearted and they spoke about her recent holiday. She said that the man said he had had a couple of drinks ”but that is his normal self, he normally comes in he has had a couple of drinks and he goes to his room and sleeps and that is like an everyday occurrence”. He asked for some bread but staff were unable to give him any and he accepted this with good humour.

40. At about 9.15pm, the Night Waking Supervisor contacted the area manager regarding another resident who had not returned to the hostel for his curfew. She made contact with the area manager because the resident was subject to a final written warning for previous poor behaviour. The area manager decided to go to the hostel as she was in the vicinity and by the time she got there the resident had returned at about 9.25pm. The residential service officer searched his bag as they thought he was rather jumpy but did not find anything. Staff suspected he had been using drugs and he then tested positively. The area manager decided that any decision about enforcement could be left until Monday when his offender manager could contribute to the decision.

41. The residential service officer went off duty at 10.00pm and the Night Waking Assistant started his shift. The second Night Waking Assistant said she spent some time in the office monitoring the CCTV showing the television room because residents seemed to be quite boisterous.

42. According to CCTV footage, the man went into his room with the other resident at 10.11pm and then another resident went in at 10.26pm. Fifteen minutes later, the second resident left and went to the television room and the first resident left the man's room a minute later. (The CCTV was looked at in detail after the man's death and staff at the time were not aware of the events of the evening in terms of who was where in the Approved Premises.)

43. At approximately 10.45pm, some residents from the television room came to the office and told staff that the man was in difficulty. The second Night Waking Supervisor led the way upstairs followed by the first Night Waking Supervisor and the residents. The area manager remained in the office to deal with any returning residents. They entered the man's room and found him on the bed. The second Night Waking Supervisor described his face as being blue. She checked for a pulse and asked the first Night Waking Supervisor to call for an ambulance. Staff normally carry radios but in their haste to respond they did not pick them up from the office.

44. With the help of the other residents, the second Night Waking Supervisor moved the man onto the floor and she started CPR. In interview, she said that she was trained and that she knew that if doing CPR alone it is most efficient to do compressions rather than stopping to give breath. She said she felt like she was doing it for 15 minutes until the first Night Waking Supervisor returned upstairs. In interview, CCTV shows the first Night Waking Supervisor returning to the man's room at 10.50pm. Ambulance staff reached the room at 10.55pm.

45. The first Night Waking Supervisor also had to leave the man's side to switch off the alarm, just prior to the paramedics arriving. The alarm had been set off by a resident leaving the hostel. Early the next morning, at about 6.30am, the same resident returned to the Approved Premises wanting to collect his stuff. He was taken to his room by the first Night Waking Supervisor whilst the second Night Waking Supervisor phoned the police. However, he ran off before the police arrived. He was eventually arrested but the charge of supplying drugs was later dropped.

46. The man's mother was informed by the police of his death. The family later visited the Approved Premises and spoke with staff and residents. Once the man's room was released by the police, the family spent some time there and collected his belongings. Three members of staff and a resident attended the man's funeral.

47. Staff interviewed for this investigation felt they had been supported after the man's death. It was clear that the Approved Premises provided a supportive environment in which staff felt able to discuss issues with one another and with the management team.

ISSUES

48. The man faced a number of problems and had engaged with a number of agencies to try to overcome these. From his mother's account, he was motivated and progressing well. The manager of the Approved Premises knew him from when he had been a resident a few years previously at another hostel and compared his behaviour at that time to when he was at this Approved Premises. Then he had drunk very heavily and had been recalled very soon after release from prison. She felt this time he was thinking more about the future and attempting to control his drinking, although she acknowledged this was very difficult for him.

49. However, the man decided to use heroin on the evening of his death. He was very drunk, giving a reading of 1.78, which affected his decision making. He was due in court the next week which he had spoken about that night and he was expecting a prison sentence which may have made him feel more inclined to partake in risk-taking behaviour. He had been randomly tested for drugs on a number of occasions whilst at the Approved Premises and all had been negative. (Twice they had been unable to test him as his saliva was too thick.)

50. In early August, the man's behaviour caused staff concern and in response a curfew of 8.00pm and daily alcohol tests were agreed. Although this decision was recorded in at least two places, and the curfew was correctly imposed, the daily alcohol tests did not take place. It is unclear why this did not happen.

51. There are a number of different communication channels at the Approved Premises. There are individual resident records, a handover book, CRAMS, testing sheets, daily events and emails. My investigator had to cross reference different records to get a complete picture of the testing results. The decision to test the man was recorded in his records, on email and on CRAMS. However, not all staff were aware of the new requirement and consequently the tests did not take place. At least six weeks passed between the imposition of these new conditions and the man's death.

52. It is a fine balance, and very difficult task, for staff in an approved premises to try to help someone reintegrate into the community whilst protecting the public. It is not clear whether testing the man daily would have made a difference. Staff were all aware that he was drinking on a regular basis anyway. If tests had been carried out, they may have acted as an indication to the man that his drinking was being seriously monitored and that it may have reached the stage where further sanctions would have needed to be taken. On the day he died, the man was very drunk and gave a high reading, yet staff were not particularly concerned because he usually just went to bed and slept without causing disruption.

    I recommend that Hampshire Probation Service undertake a review of their record keeping to ensure that their methods are the most efficient and robust.

53. The resident who was present when the man died and was initially charged in relation to the supply of drugs was on a final warning at the Approved Premises.

Another resident, and the man's mother, have questioned whether he should have still have been allowed to reside there following the discovery of drug paraphernalia in his room. He was issued with a warning for this. On the evening of his death, he returned to the hostel after his curfew which had prompted staff to telephone the area manager for advice. Once he returned, she took the view that any decision could wait until the Monday morning. He also gave a positive reading for drugs and again, staff had been trying to work with him since his arrival at the hostel a few weeks earlier.

I recommend that Hampshire Probation Service conduct a review into whether this resident should have been allowed to remain at the hostel.

54. Once the man had been found, one of the staff had to leave his room to raise the alarm and summon help, leaving the other person alone. A method by which staff could summon help quicker, allowing the first Night Waking Supervisor to stay with the second Night Waking Supervisor, would have been preferable. Staff are issued with radios but they did not take them with them in their haste to response to the emergency.

I recommend that staff carry their radios with them at all times and that consideration be given to staff being issued with mobile phones when they are on duty.

CONCLUSION

The man was at the Approved Premises for 14 weeks and during this time he had regular contact with his key worker, offender manager, alcohol worker, saw his CPN and attended voluntarily to a drug and alcohol project. He appeared to be making efforts to change his behaviour and engage with all the services available to him. However, his alcohol consumption remained high although he was able to go some days without drinking.

Having identified that he was struggling in early September, his key worker imposed an 8pm curfew and placed him on daily alcohol testing in response. He seemed to respond well to the earlier curfew and always returned in time. Due to a breakdown in communication, staff were not, however, aware that he should be tested daily. He remained on random testing which showed he was continuing to drink regularly and sometimes heavily. With the exception of early August, when he hit another resident, his behaviour when under the influence did not cause staff concern.

On the day he died, he returned to the hostel six times over the limit for driving. He presented as boisterous but staff were not concerned. Later, he took a fatal dose of heroin. In conclusion, staff could not have known that the man was going to partake in the high risk behaviour that led to his death.

RECOMMENDATIONS

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