Circumstances surrounding the death of a man at an Approved Premises in July 2004

Report by the Prisons and Probation Ombudsman for England and Wales

January 2005

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This is a report of an investigation into the death of a man in an Approved Probation Premises, in July 2004.

The purposes of my investigation were to discover whether the level of care provided for the man by the Approved Premises was sufficient, and whether there are any lessons that can be learned to help prevent a similar death in the future.

The death of a loved one is a devastating experience, and I would like to offer my sincere condolences to the man's family and friends. Since this investigation, the man's father has also sadly died.

An investigator from the Prisons and Probation Ombudsman's Office carried out the investigation with the assistance of the Assistant Chief Officer of the local Probation Area. I am grateful to him for facilitating the investigation, for providing policy advice and for helping interview members of staff and residents. I am also grateful for the co-operation that the Investigators received from the local Probation Area, the local police, HMP Featherstone and, in particular, from the manager and staff of the Approved Premises.

The Investigators conducted formal interviews with the hostel manager, deputy manager, hostel staff and hostel residents. The Investigators also examined other documents provided by the local Probation Area, the Parole Board and Featherstone prison.

This report presents a generally favourable view of the Approved Premises and the care and support that staff offer to residents. The local Probation Service decided a final warning was warranted and Lifer Management Unit accepted this. However, like the Investigator, I am surprised that the man's clear and repeated breaches of his licence conditions did not result in him being referred back to the Parole Board for possible recall to prison.

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PRISONS AND PROBATION OMBUDSMAN JANUARY 2005

Summary

The man was released on life licence from Featherstone prison for the second time in March 2004. He went to live at the Approved Premises in accordance with his licence conditions.

The deceased was a man with complex needs. Licence conditions were tailored to help him address his previous offending behaviour and help reduce the considerable risk he could pose.

Although he made some effort to complete the Domestic Violence Intervention Program (DVIP), he found it difficult to control his drinking habits. At times, he seemed to show a lack of regard to his licence conditions, and his behaviour began to give cause for concern.

The man died in July at the Approved Premises. He had been drinking heavily and then took heroin with another resident who raised the alarm and staff attempted resuscitation until the paramedics arrived. The paramedics took the man to hospital but, by the time they arrived at the hospital, he had died.

The deceased was an intelligent man, with a great deal to offer. It would appear that his inability to control his risk taking behaviour eventually led to his own death.

The death of this man has raised several issues for Approved Premises and the wider Probation Service. There is a question mark over whether the man should have been referred to the Parole Board for recall. It is surprising to the investigation team that referral for recall had not been given further consideration. It is also of concern that the man felt able to take drugs on hostel premises.

Staff involved in attempting to resuscitate the man acted appropriately and with care. It was clear that many staff and residents had been very affected by the death.

As in other Approved Premises, staff at the hostel are increasingly dealing with residents who present a high risk of serious reoffending. A great deal is expected of these staff, a fact that is insufficiently appreciated by the rest of the criminal justice system and by the public at large.

The report makes eight recommendations. However, it is important to stress that this hostel appeared to be a supportive environment for both staff and residents.

The Approved Premises

5. Approved Premises, formerly known as Probation and Bail Hostels, are approved by the Secretary of State within Section 9 of the Criminal Justice and Court Services Act 2000. Their purpose is to provide accommodation for persons granted bail in criminal proceedings, and in connection with the supervision and rehabilitation of persons convicted of offences. Approved Premises can provide a supportive, structured environment in the community for high risk and difficult to manage offenders. The management of offenders accommodated in Approved Premises is governed by the National Standards for the Supervision of Offenders and the guidance contained in the National Approved Premises Handbook.

6. This hostel can hold 18 residents, 15 men and three women. Residents share kitchen and bathroom facilities.

7. The hostel accepts offenders on bail and subject to community penalties or prison licences. Residents must be over the age of 18 but the hostel will consider any type of offender depending upon the level of assessed risk and the dynamics of the resident group at any particular point in time.

8. Over the last ten years or so, the profile of the Approved Premises population has gradually shifted toward a preponderance of offenders assessed as posing a high risk of harm to the public. Premises no longer simply offer accommodation for those who have nowhere else to go, and the purpose of this hostel is to provide an enhanced level of supervision for some of the most difficult and high-risk offenders in the community. Accordingly, there is a curfew from 11pm to 7am (for those not working) but earlier curfew hours can be enforced.

9. The staffing complement is:
Manager (Part time)
Deputy Manager
Six Assistant wardens (four full time, two part time)
Two night staff (there is one sleeping and one waking staff member each night)
Administrative Services Officer.

10. There is a frequent need for relief cover, but there tends to be a pool of relief staff who are called upon. They carry out all duties except key work. Assistant wardens perform key working duties where they meet with residents weekly.

Pre release planning

11. In the period leading up to the man's release from prison a number of meetings were held under the auspices of the Multi Agency Public Protection Arrangements. The purpose of the meetings was to share relevant information, assess the risks posed and give careful consideration to how he could best be supported and supervised post-release so as to manage the risks most effectively. The last of these meetings before his release from prison and was held on 22 January 2004. It was attended by nine members of staff from the police, probation, probation victims unit, the approved premises and Featherstone prison.

12. A member of staff from the lifer unit in Featherstone prison presented concerns he had regarding the man's contact with his former girlfriend. The man had continued to deny any contact, but evidence from the prison pin phone system demonstrated that he had in fact been in regular contact with her.

13. Referrals had already been made to appropriate services such as the Advisory Service on Alcohol and the Domestic Violence Intervention Programme.

14. The man was an intelligent man studying for a master's degree and had made good progress in prison. By far the two key concerns with him were a) his drinking and b) his potential for violence in relationships. Alcohol preceded the violence in his index offence, previous offences and his previous licence recall. The level of concern is reflected in the fact that three of the 11 licence conditions directly relate to these issues.

> He shall abide by the rules and curfew requirements of any hostel in which he is currently residing and any contact with his probation officer as he might reasonably require. He shall also work with and comply with any reasonable direction of his Probation Hostel Manager, particularly relating to matters of supervision, on-going education, alcohol and his other risk factors.
>
> He shall comply with any requirements reasonably imposed on him by his probation officer for the purpose of ensuring that he addresses his risk areas including alcohol, anger, relationship and domestic violence issues.
>
> He shall attend upon such counsellors or other professionals including any domestic violence programme, the Advisory Service on Alcohol and any appropriate psychological assessment.

15. Furthermore, due to the above risk factors there was concern that the man may get involved in a complex relationship as he was with the victim of his index offence, and when he was recalled. There were two further licence conditions instructing the man to inform his probation officer of the developing

nature of any personal relationship, and to have no contact with his former girlfriend.

The man's time at the Approved Premises

16. The man arrived at the hostel in March 2004. He was inducted and apprised of the rules and regulations. It was noted by staff that he was very upfront and quite intimidating. He had a huge physical presence. As time went on, he proved himself to be popular with a good sense of humour.

17. The man was allocated a key worker in the hostel. It was agreed with the man's probation officer, that he would remain the supervising officer, with the key worker holding responsibility for the day to day contact with the man.

18. In many respects, the man settled well into the hostel. He attended all meetings with his key worker, made slow but steady progress on the Domestic Violence Intervention Programme, and after some reluctance attended meetings with the Advisory Service on Alcohol. However, there was cause for concern in other aspects of his behaviour, in particular his excessive drinking. This was reported in a supervision report by his probation officer on 20 April and the man subsequently received his first formal warning. It was agreed this would be the last report written by his probation officer and that his key worker would carry out all future reports. Between the man's release and the date of the first supervision report, the man had returned to the hostel drunk on at least four occasions. There had also been a police intelligence report alleging that he had contact with his former girlfriend.

19. Each key worker holds an individual file on each of the residents they supervise, however, there are some more general records for the hostel as a whole. The hostel records events in a variety of different ways. There is a hostel log book, a handover book and an individual record which has two parts; the week by week notes, and the more in depth extended record sheet. The hostel log book consists of anything significant that happens in the day. It is not a detailed record of an individual. Some staff will comment if a resident is drunk or under the influence of drugs, but others feel it is not necessary unless the resident is causing problems as a result of their intoxication. The handover book contains basic information on routines, notices or warnings about residents, record sheets that have been raised, outstanding jobs that need to be completed, and alert staff to things they need to know or need to do. Anyone can make entries into the log book and handover book. There is also a staff meeting every Monday afternoon where every case is briefly reviewed. There is no formal recording of these meetings. Part time staff and agency staff will not normally attend these meetings, and therefore rely on the log book and handover book for information on residents.

20. As time went on, some of the man's behaviour still gave cause for concern. There was another intelligence report from the police that he had been seen with a woman matching his former girlfriend’s description, but generally he seemed to be adjusting to life outside of prison. It should be noted however, that during this time of relative stability, interviews with staff

show that he was drinking regularly. Although this was not always noted in the log book, some staff said they thought that he drank most days.

21. Unfortunately, the man continued to show an apparent lack of regard to his licence conditions. He continued drinking, and his key worker received reports from another resident that he had started injecting heroin. He denied this. His key worker decided to complete a drug test with him. The results were negative. There was other information from other residents about him carrying a knife, that he had been drinking on hostel premises at 7am and had been bragging about seeing his former girlfriend. He was late back to the hostel on three occasions and, although he phoned, he missed his curfew time. Then on 17 July, he stayed out all night.

22. The key worker was concerned that the man was escalating out of control, and continued to inform his probation officer and risk manager of the issues. The key worker also tried to work closely with the man and warn him of the impact of his actions. The risk manager discussed the situation with the area manager and decided that the man should be issued a final warning for his continued drinking and overnight stay - generally stretching the boundaries. The key worker wrote a report to the lifer management unit on 21 July and they issued him with the final warning on 29 July.

The week leading up to the man's death

23. On 23 July, the man arrived back at the hostel in time for his curfew having been drinking. On 26 July, he was unwell, suffering from sickness and diarrhoea. He then developed chest pains so a doctor was called. The doctor attended and gave him some tablets to stop the sickness and some painkillers.

24. On 28 July, the man was suffering with back pain. Staff were concerned about him and called the doctor again. However the man had left to sign on when the doctor arrived. The man did attend the Domestic Violence Intervention Programme that evening and took part. The following day a staff member from the DVIP emailed the key worker, probation officer and risk manager to update them on the man's progress at the group. His progress was acceptable. She also noted that when the man had rolled up his trouser leg it had revealed "lacerations of his lower left leg…which looked quite nasty". In interview, the key worker said he had not asked the man about this, as he had not seen it as an issue. When the man returned to the hostel that evening, staff noted that he seemed "really under the influence" and did not want to take his medication. The key worker said that the man might have been thinking he would be recalled to prison after his recent behaviour and staying out all night.

25. On 30 July, the man spent the day with a close friend. They went walking in the hills. His friend said that the man was still in some pain with his back but generally in good spirits. Amongst other things, they discussed the man's future and the possibility of him moving closer to the coast where he felt he could get more support.

26. When the man returned to the hostel he had a meeting with his key worker. He mentioned the future possibilities of moving closer to the coast, and they also completed a drinking diary. The man reported not having had a drink all week except on the Thursday. The key worker and the man completed a worksheet about situations where he found it easy and difficult to avoid drinking. It is worth noting that he reported finding it difficult to avoid alcohol when "I'm on a really big high and I want to celebrate…When I've got money in my pocket…When I'm with the wrong people". On his list of "wrong people" the man included his former girlfriend. The key worker used this meeting to inform him that he was being given a final warning for his continued drinking and overnight absence, rather than being breached and referred back to the Parole Board for possible licence recall. In the extended record sheet, the key worker reported that he still did not feel the man fully accepted the implications of his drinking habits.

27. On 31 July, the man again complained of backache and went to the doctor’s surgery. He returned at 10am having been prescribed co-dydramol tablets. The man's close friend, whom he had seen the day before said that he had phoned both her, and his father and again seemed in good spirits.

28. Having spent the afternoon drinking, the man returned to the hostel at about 8.30pm. He spoke to a relief warden in the front office, asking why his flatmate had been moved to another flat. The relief warden reported in the log book that the man felt he was being singled out and felt “someone is trying to push him all the time". In interview, the key worker explained that the reason for the move was purely to accommodate a new resident with differing needs, and was nothing to do with the man or his conduct. The key worker also said there was no reason why the reasons for any such move could not be explained. However, relief staff might not know the reasons as they are normally discussed at meetings.

29. In interview, the relief warden said that the man went out again that night, but was back before curfew. Another resident living at the hostel, was interviewed. He reported that they had gone together to buy some heroin, and taken it back to the hostel, but reported that they had not done this together before. However, a female resident, who was friends with the man who subsequently died, said he did take heroin by injection. The man who died, and the other resident had gone to his room where they had both taken it. The second resident reported *“We arranged to get some and we came back to the hostel and took the drugs, was talking for about half hour and then I ended up douching which is like being under the influence of the drug.”* He went on to say that he awoke again at about ten to eleven. The man was sitting in the chair and he tried to wake him but could not. The second resident left the room and ran down the stairs to see if the man's flat mate was there, but he was not. As he came out of the man's flat, he saw two members of staff coming up the stairs: the relief warden and a night warden. He told staff that the man was not moving and they all ran back up the stairs.

30. There is no evidence to suggest that the man intended to take his own life.

The Crisis Management

31. The night warden stated that when they all arrived at the scene, they knew from the man's appearance that something was seriously wrong. The relief warden left the room, ran back down the stairs to the ground floor and asked another relief warden based in the front office, to call an ambulance. In the meantime, the night warden had checked to see if the man was breathing. She could not feel a breath and could not detect a pulse. The night warden asked the second resident to help her, and together they moved the man onto the floor and placed him on his back. The night warden then commenced CPR. Soon after, the relief warden returned to the room and helped with the CPR, taking it in turns to perform chest compressions and breathe for the man. Mouth guards had been issued to staff should mouth to mouth resuscitation become necessary, but at the time neither member of staff was carrying a guard. The ambulance arrived after about five minutes. The relief warden based in the office showed the paramedics to the scene, and they took over the CPR. Staff were aware at this time that the man appeared to have taken a drugs overdose.

32. The second resident waited in the doorway, but once the ambulance arrived he moved into the kitchen. The ambulance crew requested another ambulance, which was better equipped to help carry the man down the stairs. From the time that the man was found by staff, until he left in the ambulance, the night warden did not leave him. The two relief wardens organised the paramedics and helped carry the paramedics' equipment.

33. Once the paramedics had left with the man, the staff made sure all the appropriate people were contacted. Staff attempted to make sure no-one went into the room and the second resident was given another room for the night. However, there was an opportunity for the second resident, and others, to go into the room before staff had a chance to double lock the door.

34. A little later, the hospital phoned to say that the man had been pronounced dead before they reached the hospital.

35. The following morning all residents in the Approved Premises were told individually about the death. However, the female resident that had been friends with the deceased, had been on weekend leave. She returned to the hostel on the Monday, and the news was broken to her then. She had been close to him, and she was angry and upset. One of the assistant wardens, noted in the log book that the female resident blamed the second resident because "he should not have injected him", and because two of her friends had been arrested. (This refers to the people who the local Police subsequently arrested and charged for allegedly supplying the heroin).

36. The Assistant Chief Officer, attended the hostel on 2 August to see how staff were and to outline the support that was available to them should they need it.

Consideration and Conclusions

37. There are several issues that warrant further exploration. The issues my investigation looked at are: whether the man should have been referred for recall to prison; communication issues within the hostel; the issue of mouth guards and mobile telephones; allegations surrounding the actual consumption of heroin; psychiatric services provision in the hostel, funeral expenses assistance, and support for staff and residents after the man's death.

Potential recall

38. The Parole Board were primarily concerned with a) The man's drinking habits and how alcohol had been an element in his offending, and b) Domestic violence. This concern is evident from the fact that three of the eleven licence conditions relate to the man addressing his alcohol and domestic violence problems. From the time that he was released until he died, it was reported in the log book by staff that he had returned to the hostel drunk on six occasions. However, on interview, all staff that knew him reported him being a regular drinker - some staff thought daily. On one occasion, cans of lager were found in the man's room and another resident reported seeing him drinking alcohol early in the morning in the hostel. It is important to note that hostel rules expressly ban the drinking of alcohol and taking of drugs on the hostel grounds.

39. Another licence condition was to abide by the rules and curfew requirements of the hostel. The curfew at the hostel was 11pm. In the man's time at the hostel he returned late on three occasions, and stayed out overnight on one occasion.

40. Yet another licence condition was that the man should not seek to approach or communicate with his former girlfriend. It should be noted that the former girlfriend herself did communicate with various members of the Probation Service in an attempt to have this condition lifted. However, the decision was taken that this condition could not be lifted until the man had completed the Domestic Violence Intervention Programme, and, at the very least, had showed that he could comply with his licence conditions. There were three police intelligence reports concerning the man and his former girlfriend. One referred to the man being seen with a female matching his former girlfriend’s description. One was a report from the man's close friend, who became concerned after having a telephone conversation with the man in which he admitted seeing his former girlfriend, and was concerned about the former girlfriend’s safety and the man's future. The third report was from a witness who had seen the man and his former girlfriend in a public house, under the influence of alcohol. They had been asked to leave the pub. This witness gave an oral account initially, but later provided a written statement shortly before the man's death. The man also cited his former girlfriend as a bad influence on his drinking behaviour.

41. The key worker demonstrated that he was very aware and concerned about the man's behaviour. In the main, there is evidence of the key worker reporting the man's behaviour to the man's probation officer, and risk manager. The key worker was largely responsible for the day to day running of the hostel, management of staff, and overseeing the casework within the hostel. The key worker felt supported by the hostel manager. However, it was not clear to the investigation team, who held ultimate responsibility for the man's case and the roles of key worker, probation officer and risk manager seemed blurred.

42. Had the man been recalled to prison, it is likely he would have been facing a considerable period of time in custody. I understand how this may have contributed to the staff's reluctance to take action. On a day to day basis, staff must consider the fine balance of trying to help someone reintegrate into the community whilst protecting the public. The man did receive a formal and a final warning, and a MAPPP meeting had been arranged for the week following the man's death. However, questions remain as to why enforcement procedures were not enacted at an earlier stage.

43. I recommend that the National Probation Service conduct a review into whether the man should have been referred to the Parole Board for breaching his licence conditions.

The report was shown to the National Probation Directorate and the local Probation Service at draft stage. A review was conducted by the manager of the hostel and concluded that the measures taken were appropriate.

44. I recommend that where management and supervision roles are shared, it is made clear in writing in the case record, who is responsible for different areas of the case management.

Communication

45. In general, conversations and incidents with residents at the hostel were thoroughly recorded by staff. It became clear during the investigation, that staff were very aware that the man was a heavy drinker, although reports of him drinking were only logged six times. Some staff said they made a note if they knew a resident was under the influence of alcohol or drugs; others said they only made a note if residents were disruptive due to their intoxication. It would have made sense in a case such as this, where the licence conditions were strongly linked to his alcohol usage, for staff to have been asked to record any incident relating to alcohol.

46. Staff felt confident they knew who to speak to if they came across a problem with a resident, and said they found the weekly team meetings useful. At these meetings they have an opportunity to discuss their cases and any concerns with the rest of the team and the core team were well aware of risk factors relating to the residents. However, the two part time staff only attend half of these meetings due to their shift pattern, relief staff do not attend these meetings, neither do the regular night staff. These people form a substantial number of staff, and relate to all three members of staff on duty on the evening that the man died. Although this did not contribute to the man's death, the staff on duty had a limited knowledge of the man compared to other staff.

No note is taken of the meetings. Whilst I understand these meetings are informal, minutes would be of great value to the agency and night staff on whom the hostel rely quite heavily.

47. I recommend that a note is taken of the full content of weekly meetings and this recorded in the Meeting minutes book as a reference for all staff.

Mouth guards and emergency response

48. Staff carry pouches that hold items that may be of use in their work around the hostel such as keys. Staff had also been issued with mouth guards to protect themselves and others should mouth to mouth resuscitation be necessary. However, on the evening of the man's death, neither the night warden nor the relief wardens were carrying these mouth guards. This was brought to the management's attention by the night warden.

49. I recommend that staff be reminded to carry the mouth guards on their person at all times.

50. I understand from the manager of the hostel that he verbally reminded the staff to carry mouth guards during a team meeting following the man's death.

51. The man was found in a room on the third floor. When staff arrived, one immediately had to leave the crisis situation to raise the alarm and summon help, leaving the other person alone. A mechanism to raise the alarm quicker, allowing the two staff members to stay together would have been preferable.

52. I recommend that all staff working within the hostel are given mobile telephones or alarms for use when they are on duty.

53. This issue was raised with the manager during the investigation and he reported that he had decided to order mobile telephones.

Injecting heroin

54. Two days after the man died, the female resident who had been friends with the deceased, returned to the hostel from weekend leave. She had felt close to the man, and was upset and angry when she heard of his death. She was heard to say *"he shouldn't have injected him".* This was discussed with the female resident in interview. She reported that the man did use heroin recreationally and she had previously taken it with him. She stated that he never injected himself, sometimes because he was drunk and sometimes he simply could not do it even when he tried. She said he only used very small amounts and she believed the second resident, with whom he had taken drugs with had injected him.

55. During an interview with the second resident, he was clearly upset, and felt in part, responsible for the man's death. This was because he was not sure whether the man would have known where to buy the heroin without his help. The second resident denied injecting the heroin, and said that the man injected himself.

56. Transcripts of both interviews were passed to the police for their consideration. It is also worth noting that the police have arrested and charged two people on suspicion of supplying the heroin to the residents.

Psychiatric services provision

57. It was clear from talking with staff at the hostel that they are eager to support residents. The manager and key worker have evidently worked hard to build and maintain links with drug and alcohol agencies, and with employment and training services. However, concern has been raised about the provision of psychiatric services. The investigation was told it was very difficult to find a Community Psychiatric Nurse (CPN) willing to be involved with residents. After the man's death, there was a raised level of tension at the hostel. There were particular worries about the safety of one resident who had expressed suicidal thoughts to staff. The Psychiatric Emergency Service team had advised them the resident should be taken to A&E if necessary and were felt not to be very helpful. The resident subsequently seriously harmed himself. Although, this issue does not directly concern the death, it is worthy of comment for the benefit of all residents.

58. The hostel management team said they had tried to improve this situation but to no avail. Strategic intervention is needed at both an Area level, and a National level.

59. I recommend that the National Probation Directorate consider with the Department of Health how best to ensure that appropriate and effective psychiatric support is provided to residents of Approved Premises.

60. I recommend that the local Probation Service consider with the local Primary Care Trust how best to ensure that appropriate and effective psychiatric support is provided to residents of Approved Premises.

Support for staff and residents

61. Every member of staff who was interviewed felt they had been supported. Staff, including agency staff, seemed clear on the different avenues of help they had available to them.

62. It is also worth mentioning that two of the residents who were interviewed were very distressed. This caused the investigation team concern and they identified the key workers for those residents and shared their worries with them. The key workers then spent a considerable length of time talking with the residents.

63. It was clear that the hostel provided an extremely supportive environment in which staff felt able to discuss issues with one another and with the management team.

Funeral Expenses

64. The deceased man's father had some difficulty paying for the funeral. When a person dies in Prison Service custody, the Prison Service (under Prison Service Order 2700) will pay reasonable funeral expenses. The National Probation Service has no such provision and expects families to rely on the complex means testing process of the Department of Work and Pensions. Whilst the payment of funeral expenses might not be appropriate in all cases when a resident dies in Approved Premises, this is a matter that merits further consideration.

65. I recommend that the National Probation Directorate considers the introduction of a scheme whereby the reasonable funeral expenses of those who die whilst residing in Approved Premises are met by the relevant Probation Area.

Recommendations

National Probation Directorate

66. I recommend that at the National Probation Service conduct a review into whether the man should have been referred to the parole board for breaching his licence conditions. (Implemented)

67. I recommend that staff be reminded to carry the mouth guards on their person at all times.

68. I recommend that the National Probation Directorate work with the Department of Health to ensure that appropriate and effective psychiatric support is provided to residents of Approved Premises.

69. I recommend that the National Probation Directorate considers the introduction of a scheme whereby the reasonable funeral expenses of those who die whilst residing in Approved Premises are met by the relevant Probation Area.

Local

70. I recommend that where supervision roles are shared, it is made clear in writing, who is responsible for different areas of the case management.

71. I recommend that a note is taken of the full content of weekly meetings and this is recorded in the Meeting minutes book as a reference for all staff.

72. I recommend that all staff working within the hostel are given mobile telephones for use when they are on duty.

73. I recommend that the local Probation Service consider with the local Primary Care Trust how best to ensure that appropriate and effective psychiatric support is provided to residents of Approved Premises.