

**Investigation into the circumstances surrounding the death
of a man at an Approved Premises in the
Northumbria Probation Trust area
in September 2010**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

November 2011

This is the report of an investigation into the death of a man. He was found dead in his room at an approved premises in September 2010. He was 43 years old.

I extend my condolences to the man's family and friends and all those affected by his death. I apologise for the delay in issuing this report and for any additional distress this might have caused.

This investigation was undertaken by one of my senior investigators. I would like to take this opportunity to thank all of the staff at the approved premises, and in particular the manager, for their co-operation during the investigation. .

The man arrived at the approved premises less than a month before his death. At that time he was on bail, having been charged with burglary. He had previously been a resident at the approved premises and seemed happy to be there.

During the man's time at the approved premises, nothing happened to cause staff any concern about his welfare. However, at the final room check in the late evening on a day in September, he was found lying on the floor of his room. Staff attempted to resuscitate him but when ambulance paramedics arrived soon after they confirmed that he was dead.

When the man's room was searched, various empty packets of medicines were found, as well as an empty bottle of another medicine and empty bottles of alcohol. The prescription labels had been removed from all of the medicine containers so it is unclear to whom they had been prescribed (although they had not been prescribed to him). A post mortem indicated that his death was due to respiratory suppression caused through the combined effects of methadone, tramadol, diazepam and codeine.

This report makes two recommendations. One concerns assessing residents' suitability for holding medication in their own possession. The other concerns the need for staff to take any prescribed medication from new residents if they have any on arrival.

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.

Thea Walton
Acting Deputy Ombudsman

November 2011

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SUMMARY

1. In June 2010, the man was arrested and charged with burglary. After spending several weeks on remand in prison he was bailed, subject to a number of licence conditions. (For those awaiting trial, the courts may allow the person to remain in the community but might also make their bail subject to certain licence conditions. If the person fails to abide to their licences conditions the court has the discretion to place the person in custody.) One of the man's licence conditions was for him to reside at a particular address. When he was later asked to leave that address, a place was found for him at the approved premises.
2. The man arrived at the premises on 16 August 2010 and received a full induction. He had resided at the premises some years previously and the staff remembered him from that time.
3. Much of the man's offending history was linked to his misuse of alcohol and drugs. He told staff that as he now realised the damage that alcohol had caused, he had ceased drinking. He also reported receiving several prescribed medicines, including methadone.
4. The man quickly settled into the approved premises. It would seem that he was something of a loner so while at the premises tended to spend most of his time in his own room. During his days he spent a lot of time with his teenage son as well as visiting his mother. On more than one evening when he returned to the premises, it was apparent to staff that he had had consumed alcohol. However, residents at approved premises are permitted to drink alcohol when away from the premises, although they are not permitted to bring alcohol into the premises.
5. On 6 September, the man was told that the charges against him were being dropped. He became concerned that he would have to leave the premises, thereby becoming homeless. However, arrangements were being made for an outstanding supervision order, which still had 11 months left to run, to be made the basis instead for his continued residence.
6. The man remained inside the premises for most of the day on the day of his death. The only time he went out was in the morning when he went to the local pharmacy to receive his daily dose of methadone. The last time that he was seen alive was at 6.00pm during a routine room check by staff. Staff noted that he was well at that time. When the next check was made at 11.00pm, he was found lying on the floor and apparently lifeless. Staff attempted to resuscitate him, but without success.
7. When the man's room was searched, empty bottles of alcohol were found as well as empty packets of medication and an empty bottle of medication. None of these medications had been prescribed to him.
8. At post mortem, the man's death was attributed to respiratory suppression caused by the combined effects of methadone, tramadol, diazepam and codeine.

9. This report makes two recommendations. One is about assessing residents' suitability for retaining medication in possession. The other is about the need for staff to take any prescribed medication from new residents if they have any on arrival.

THE INVESTIGATION PROCESS

10. The Ombudsman's investigator in this case made a preliminary visit to the approved premises on 17 September 2010, when he met several of the staff including the manager of the premises. He also met a number of the residents. One resident had spoken with the man and he agreed to speak further with the investigator.
11. Notices about the investigation and its terms of reference were displayed around the premises and invited staff and residents to contact the investigator should they wish to do so. No further residents came forward to speak with the investigator.
12. The investigator subsequently returned to the premises when he interviewed eight members of staff and the man's Offender Manager (Probation Officer). He also spoke in more detail with the resident who he met on his initial visit. The investigator provided feedback to the premises manager on his initial findings.
13. HM Coroner for Tyne and Wear Newcastle District was informed of the nature and scope of the investigation. A copy of the post mortem was obtained from the Coroner's office. A copy of this report will be sent to the Coroner to assist with his enquiries into the man's death.
14. One of my family liaison officers contacted the man's mother. She and the investigator subsequently visited his mother at her home. The man's ex sister-in-law was also present. The family asked a number of questions surrounding his time in the approved premises that the investigator was able to answer at the meeting. The family also raised a number of other concerns that they wished to have included as part of the investigation. They asked when he last had a medical consultation and how he had been able to acquire the various medicines that he had apparently taken on the day of his death. His mother questioned what staff had observed at the time of the 6.00pm room check on the day of her son's death. She said that her son had decided to stop drinking alcohol on that day and there would have been obvious physical signs of alcohol withdrawal. His mother said that her son had misused prescribed medications for a long time, but she was certain that he would not have wished to take his life.
15. The man's mother clarified matters concerning her own prescribed medication. At one stage, the investigator had understood that she was being prescribed methadone and that her son had taken a bottle of this medication from her home. She confirmed that at no time had she ever taken or been in possession of methadone. She had been prescribed Oramorph (a strong opioid painkiller) and her son had taken a bottle of this medication. He did this without her knowledge.

THE APPROVED PREMISES

16. The approved premises is run by a registered charity. Approved premises were formerly known as probation and bail hostels. They provide an enhanced level of residential supervision in the community in a supportive and structured living environment for high risk offenders. (The Society is contracted to provide services on behalf of Northumbria Probation Trust.)
17. The approved premises has 20 rooms. Staffing comprises a manager and deputy manager with a frontline team made up of two project workers (previously known as key workers), eight project support workers and two night care workers. The premises also employs administrative and domestic staff.
18. The majority of residents at the approved premises are required to stay as a condition of a court order or prison licence. Residents include those who have committed serious, violent and dangerous offences and who have completed the custodial part of their sentence. Others, such as this man, are prolific lower risk offenders who are resident as a condition of a bail or licence order.
19. Each resident is allocated a project support worker who acts as their primary point of contact during their stay. Regular support worker sessions also give residents the opportunity to discuss their difficulties in depth. Approved premises do not provide healthcare facilities; instead, residents register at a local doctors' surgery. Most prescribed medication is held by the premises and issued to residents by staff on a daily basis. Controlled medication, such as methadone, is generally given to residents at the local pharmacy.
20. Whilst at a premises, residents pay rent and must abide by certain rules and regulations, such as observing an overnight curfew. During the day, residents are free to go out unaccompanied, although they are required to tell staff where they are going and who they are meeting. Some residents will have restrictions barring them from visiting certain areas. Breakfast and dinner is provided to all residents.
21. The approved premises has an established process for inducting new residents. The process includes informing the resident about the premises rules and the standard of behaviour expected of them. Premises have a strict policy forbidding possession on site of alcohol and drugs. Residents are not forbidden from visiting a public house and consuming alcohol away from the premises.
22. Room checks at the approved premises are made four times a day: at 7.45am, midday, 6.00pm and 11.00pm. This is to check on the welfare of the resident. Staff work in pairs while making these checks. In addition, a minimum of one random room search is made each week. (In the case of a resident deemed at high risk, the morning check is made at 7.00am. The man was not believed to be at risk.)
23. The man's death was the second at the approved premises since the Ombudsman took on the responsibility for the investigation of deaths in custody in April 2004. The first death was in late April 2004. The resident died

while away from the premises and in circumstances entirely different to the circumstances surrounding this man's death.

KEY EVENTS

24. The man was born in Exeter in February 1967 and lived there until the age of five when his parents separated. He then moved with his mother to County Durham. He reported spending time in his childhood in local authority care and having been educated at a variety of establishments catering for disruptive children. He also reported that it was at the last of these establishments that he began offending with some of his peers. From that time he compiled an extensive history of comparatively minor offences, mainly burglary, theft and motor offences. He had once been married and had a son who, by 2010, was in his early teens.
25. The man served several prison sentences. During one sentence he obtained a qualification in plastering and he later obtained work in that trade. However, he reported that his employment history had been affected by his misuse of alcohol. He also had a history of misusing prescribed medicines. He acknowledged that his misuse of alcohol was linked to his offending history.
26. In June 2010, the man was arrested and charged with burglary. He was remanded into custody at HMP Durham in early July and he remained in custody until 10 August, when he was granted bail. One of his bail conditions was that he should reside at a particular named address. The address was that of a friend and the importance for him in having somewhere to live, was that his offending history was often linked to homelessness (as well as to alcohol misuse).
27. In the middle of August, the man's friend asked him to leave the house. This would have put him in breach of his bail conditions and liable for recall to prison. However, a place at the approved premises was found for him and he moved in on 16 August. (He had previously resided for a time at the approved premises some years before.) His licence conditions were re-defined. His conditions then were that he should live and sleep each night at the approved premises, he should remain indoors at the premises between 8.00pm and 7.00am daily, he should not contact prosecution witnesses and he should not enter a specified area of Northumberland.
28. My investigator spoke with a project support worker at the approved premises who carried out an induction interview with the man on his arrival. The project support worker remembered him from his previous time at the premises and they chatted about changes since that time. The man said that he was pleased to be back. The project support worker completed various induction papers and explained the rules and regulations for the premises; one of which was that residents were not allowed to bring alcohol into the premises. He said that he had stopped drinking alcohol as he now realised that it was not good for his health. He also reported being in receipt of some prescribed medications. These included methadone, which he collected on a daily basis. He said that he had left the other medication at his mother's house and he would ask her to bring it to the premises the following day. (His records contain no further reference to any such medication. There is no record of them being brought to the premises and no record of him being challenged about their whereabouts.)

29. My investigator asked the project support worker about the checks made on residents to ensure they are not bringing alcohol onto the premises. She said that if residents return to the premises with a carrier bag, staff will try to see if the bag contains alcohol. However, if the resident has a back pack or shoulder bag staff can do little about that unless they have significant concerns about what the resident might be carrying.
30. As with all approved premises, residents register at a nearby doctors' surgery. When medication is prescribed to a resident, the medication is delivered by the local pharmacy to the premises. Most medicines are held by the premises and issued to residents on a daily basis. The man registered at the doctors' surgery that day and was prescribed three medicines. Two, omeprazole (an antacid) and propranolol (a beta blocker most often prescribed for high blood pressure and angina), were dispensed to the approved premises. The other medicine prescribed was 50 millilitres (ml) of methadone (an opioid used mainly for people addicted to stronger opioids such as heroin). Residents receiving methadone visit the pharmacy on a daily basis where they are given this medicine (they swallow the medicine in front of the pharmacist to prevent them from taking it away to sell it or to stockpile it). At weekends, a supply of methadone is dispensed to the premises and staff there give the medicine (again, residents must swallow the medicine in front of the staff).
31. On 17 August, the man attended a meeting with an offender manager. He told her that he was happy to be back at the approved premises and that the premises had not changed since he was last there apart from a "lick of paint".
32. On the same day, the man attended an appointment with the Project Answer drug treatment service for drug and alcohol testing. He tested positive for methadone and benzodiazepines but said he had been prescribed these while in police custody (he presumably meant while in prison custody). He denied any illicit drug use. He also denied any use of alcohol and this was confirmed through a negative breathalyser test.
33. The man had a project worker at the approved premises. She told my investigator that she remembered him from his previous time at the premises. She confirmed that he was something of a loner who mainly spent his time in his own room when back at the premises. She was aware that his offending history was linked to his misuse of alcohol and drugs. She understood that he was able to abstain from alcohol for a period of time but when problems arose in his life he would resort to using alcohol and drugs again to help him cope. He reported taking an overdose of painkillers in June 2007 due to anxieties at that time. She noted though that his records showed no current concerns regarding possible self-harm.
34. At meetings with his project worker on 21 and 27 August, the man spoke about the fact that alcohol continued to be his mechanism for dealing with stress. He mentioned that he was spending a lot of time building a relationship with his son. He said that his son now wanted to live with him and he was feeling stressed about that because he could not do anything at that time about setting up a home together. He was also spending time decorating his mother's home. He confirmed that he had "been for a few pints" one evening that week and

there was another evening when she could smell alcohol on his breath. He denied having had a drink that time however. She told him that in order for her to help him, he needed to be honest with her. They agreed that he would keep a “drinks diary” to record how much alcohol he was consuming each day. They also agreed that she would make a referral to one of the organisations supporting people with addictions. Addaction was the organisation selected.

35. On 27 August, the man had another meeting with probation. He said that “things were going okay” at the approved premises and he spoke about the contact he was having with his son. He admitted to having had “a couple of drinks”, but otherwise felt he was doing well in controlling his use of alcohol. He also said that his methadone prescription had been increased to 60 ml per day, although he was unsure whether that would be enough.
36. The man tested positive for methadone and benzodiazepines again on 28 August. He again denied any illicit drug use saying that benzodiazepines stay in the system for 28 days. He again denied any alcohol consumption and a breathalyser test again proved negative.
37. At a formal, documented, meeting with his project worker on 31 August, the man spoke again about how well things were going with his son. He said that he was filling in his drinks diary and would bring it to the next meeting. He also said that an appointment had been made for him to attend Addaction on Friday 3 September, and asked if this appointment could be changed. He said that Friday was the last day of the school holiday and therefore his last day with his son. She was able to change this appointment to the following Tuesday, 7 September.
38. Entries in the man’s records for the next three days were very similar. It seems he spent most of his days out of the premises and, on returning in the evening, spent most of his time in his room.
39. On 4 September, a member of staff at the approved premises noted smelling alcohol on the man’s breath on his return to the premises at 7.30pm that evening. However, he did not appear to be drunk and he had his evening meal before going to bed.
40. The man’s medication charts show that this was the last day that he took his prescribed omeprazole and propranolol. However, he continued to take his methadone.
41. At interview with my investigator, the manager of the approved premises said that there had been no procedure in place at the premises to highlight instances where a resident had failed to collect their medication. Following the man’s death a procedure was introduced where a night-time audit is carried out to identify instances where residents were failing to collect medication. Another omission identified in this man’s case was that no consideration was made with regard to his suitability to hold medication in-possession (this would be where a resident retains their medication in their own possession as happens in the wider community). The manager added, though, that had an assessment been made the man would not have been allowed to hold medication in-possession.

42. Talking about the man in general terms, the manager said that nothing occurred to suggest that he had not settled into the premises. He was happy to be at the premises and was progressing well, including in his engagement with his son. The manager also spoke about the requirement for random room searches. He confirmed that the premises will conduct one room search per week, although the search will often be risk related: this can be in terms of risk to the self or risk to the public. He gave an example of targeting for one room search a resident who might have been accessing the internet (this is not permitted). He said that there was no reason with this man to target him for a room search.
43. On 5 September, another of the project workers at the approved premises noted that the man had told him that his mother was suspected as having a serious illness. He was upset at having received this news.
44. On 6 September, the man told staff that the burglary charges against him were being dropped. This meant that he was no longer subject to any bail conditions, one of which was the requirement that he was to reside at the approved premises. He became anxious on hearing this news as he feared he would have to leave the premises, thereby becoming homeless.
45. When the man's project worker carried out room checks on the morning of 7 September, she noted that the man appeared to have tears in his eyes. However, when she asked if he was okay, he answered that he was. Soon after this, he approached another project worker to tell him about his concerns at the possibility of losing his place at the approved premises. The project worker said that it might be possible for him to remain at the premises on the basis that he was subject to a supervision order (which then had a further 11 months to run). The project worker told him that he would speak with the manager and with his offender manager (probation officer) about this.
46. That evening, the man went to the lounge to watch football on television before retiring to his room.
47. The man next went to Project Answer on 8 September. This time, he only tested positive for methadone. No alcohol was detected in the breathalyser test and he denied any alcohol use. That evening, staff from Group 4 Security (a private security contractor) came to the premises to remove his security tag (he had been required to wear such a tag while he remained on bail).
48. Another project support worker at the approved premises told my investigator that her role entails different shift patterns, including night shifts. At the time the man was at the premises she had worked a series of night shifts and met him a number of times when he came downstairs in the early morning to use the ironing board. She said that her son and the man's son shared the same forename and that led to them chatting. She said that he always seemed quite "chirpy", never suggesting that he was low in mood. She confirmed that he did not mix much with other residents and while inside the premises tended to spend most of his time in his own room.

49. The investigator spoke with one of the residents at the approved premises. The resident said that the man was a loner who spent a lot of his time in his room. Most of the man's conversations had been about his days out with his son. They did not see so much of each other in the last few days, but at no time did the resident notice anything to suggest that he might deliberately harm himself.
50. On a day in September, the man left the approved premises at 9.00am to receive his methadone at the pharmacy. He returned shortly afterwards. Later that day a project worker told him that he would be able to remain at the approved premises as a condition of a supervision order.
51. There is no other information in the man's records to show what he did during the remainder of that day. He did not sign himself back out at any point and did not come to the dining room for his evening meal (which is served at around 4.00pm to 4.30pm).
52. At 6.00pm, the man's project worker at the approved premises and a fellow project support worker carried out a routine room check together. The man's project worker told my investigator that when they reached his room she spoke with him about the good news that the burglary charges against him had been dropped. He confirmed this and added that he had also been told that he could remain at the approved premises. The fellow project support officer made an entry in the man's records to say that he had been seen at the time of the 6.00pm room check and that he appeared to be "fine".
53. The man's project support worker and fellow project support worker did the last room check together at 11.00pm. When they checked his room they found him lying on the floor with his head and shoulders underneath the bed. They moved him away from the bed and checked him for signs of life. They were unable to detect a pulse and his body was cold. The staff attempted to resuscitate the man. The fellow project support worker gave a series of chest compressions, but when the man's project support worker tried to give emergency breaths (mouth to mouth breathing) she was unable to open his mouth. At that point, the fellow project support worker went downstairs to the main office to telephone for an emergency ambulance while the man's project support worker continued giving chest compressions until the ambulance arrived around ten minutes later. In her account of the events, the man's project support worker noted that when the ambulance paramedics examined him they suggested that he had been dead for approximately two to three hours.
54. The manager of the approved premises was at home when he was told about the man's death. He went to the approved premises at which point ambulance paramedics and police officers were in attendance. He had a briefing meeting with the man's project support worker and fellow project support worker and after they had given statements to the police he drove them to their homes (the night staff had arrived for duty by then). He told them that they could telephone him at any time during the night if they felt they needed to speak with someone. The manager returned to the approved premises until the police had completed their work and the man's body had been taken to outside hospital. Staff were offered further support over the following days.

55. Police officers visited the man's mother to inform her of the news. The manager later telephoned her to offer his own condolences and to offer her the opportunity to visit the approved premises. He subsequently visited her at her home to return her son's property. The manager and the Committee Chair of the Society of St Vincent de Paul attended the man's funeral.
56. When the man's room was searched a number of empty medicine packets were discovered. The medicines involved were: co-dydromol, omeprazole, Augmentin, codeine phosphate, paracetamol with codeine and Propranolol. An empty bottle of Oramorph oral solution was also found as well as three empty bottles of a cream, wine and whisky liqueur (14.5% alcohol by volume – this is weaker than sherry). The packets and bottles were found hidden in various parts of the room. Most of the medication labels had been removed so it is not known for whom the prescriptions had been written.
57. A letter to the man from Addaction was found in the room. The letter showed that he had failed to attend an appointment on 7 September and had been offered another appointment for 14 September.

The man's cause of death

58. A post mortem examination was carried out by a consultant histopathologist. (A histopathologist specialises in the diagnosis and study of disease through the interpretation of cells and tissue samples.) Blood and urine samples were taken for toxicological analysis. The consultant histopathologist reported that she found no evidence of significant natural disease in the man's organs, other than a fatty liver (probably related to the effects of alcohol), and moderate coronary artery atheroma (narrowing of the arteries in the heart caused from fatty deposits). She also found some changes in his lungs consistent with asthma, although she noted that there was no evidence of this disease in the man's life-time.
59. The consultant histopathologist went on to consider the toxicological analysis. No alcohol was detected. Low levels of paracetamol, omeprazole (antacid), tramadol (opioid analgesic), diazepam (a sedative) and codeine (opioid analgesic) were detected. The levels detected for all these medicines were consistent within a therapeutic dosage (meaning a dosage that would be prescribed by a doctor). Omeprazole was the only one of these medicines that had been prescribed for the man. He had also been prescribed methadone and, although the blood concentration of this medicine was relatively high, she noted that the concentration could be consistent with chronic therapeutic dosage.
60. Having listed these toxicological findings, the consultant histopathologist went on to explain that:

“... The potential for methadone to suppress respiration would be enhanced in the presence of these other drugs (tramadol, diazepam and codeine) which also have the potential for respiratory suppression ... It therefore seems most likely that [the man] died as a result of a combination of the

effects of methadone, tramadol, diazepam and codeine, acting together to suppress respiration and cause his death.”

ISSUES

The man's cause of death

61. The man's cause of death would seem to have been respiratory suppression as a result of various substances that he had taken. Of the substances found in the man's system and which appear to have contributed to his death, the only medication he was being prescribed was methadone. He was not being prescribed tramadol, diazepam or codeine. The consultant histopathologist has explained that the tramadol, diazepam and codeine were all at therapeutic levels (a level consistent with what would be found where the medicines had been prescribed for the patient by a doctor). She said that the level of methadone was high, but was possibly at a therapeutic level. He was being prescribed 60 ml of methadone, which is a reasonably high level. Various empty packets of other medicines were found concealed in the man's room after his death but the prescription labels had been removed so it is not possible to determine to whom the medication belonged and how and when he was able to acquire it.
62. Also found in the man's room was an empty bottle of Oramorph (a strong opioid painkiller). This medicine had been prescribed to his mother but he had taken it from her home. The man's mother was certain that her son would not have wished to take his life. Her views accord with the evidence obtained from the staff and by one of the other residents. No one had any reason to suspect that he intended to harm himself and it is clear that he was gaining great happiness from re-building a close relationship with his son. The man's intention and motivation in taking these substances is therefore unclear.

The bottles of alcohol found in the man's room

63. In addition to the medicine packets found in the man's room, three empty bottles of alcohol were also found (these were found underneath clothing). The bottles were of a cream, whisky and wine mixture. No alcohol was detected during toxicological examination so he had clearly not had anything to drink close to the time of his death. Although residents are allowed to drink alcohol when away from the premises, they are not permitted to bring alcohol back to the premises. However, staff have limited powers in preventing residents from disobeying rules on this matter. If staff have good reason to suspect that residents are carrying alcohol, the resident can be challenged. But if any alcohol is hidden in a back-pack or shoulder bag, staff will usually trust the resident not to be concealing anything untoward.
64. Residents' rooms are subject to searches on a random basis. However only one room need be checked each week and the man's room was not selected for checking during his time at the premises. Had the man been deemed to be at risk either to himself or to the public, he might have been targeted for a room search. However, there would seem to be no particular reason to target him for a search. Alcohol was an identified problem for him and on more than one occasion staff smelt alcohol on his breath on his return to the premises in the evening. But residents are permitted to consume alcohol when away from the premises and on no occasions did he return in an inebriated state. Therefore,

outside of the possibility that he could have been caught out during a random room search, there is nothing that staff could realistically have done to prevent any smuggling of alcohol.

Omissions in dealing with the man's prescribed medications

65. There were a number of omissions in the way the premises dealt with issues relating to the man's prescribed medications. On his arrival at the approved premises, he should have been assessed for his suitability to hold some of his medication in his own possession. Such an assessment was not carried out in his case. However, there was no direct impact on his care as a result of this omission, as he was not allowed to keep any of his prescribed medicines in his own possession.

I recommend that the premises manager ensure that new residents are always assessed for their suitability to hold medication in possession

66. Another omission is that the man said on arrival at the approved premises that he had left his prescribed medications at his mother's house and that he would ask her to bring them to the premises the following day. Had that occurred the premises would have taken the medication from him and issued doses on a daily basis. This matter was never pursued by the premises so it is unclear what happened to any medication that he might have left elsewhere.

I recommend that the premises manager remind staff about the need to ensure that new residents hand in previously prescribed medications

67. The final omission was the failure to notice at the time that the man ceased collecting two of his prescribed medicines, omeprazole and propranolol, from 5 September onwards. This was recognised only after his death. We do not know whether it was a conscious decision on his part to cease taking this medication or whether he simply forgot. As with any resident, he was perfectly entitled to decline any or all of his medication if that was what he wished. However, by their very nature, many residents at approved premises are those who require support and assistance with various aspects of daily living. It might only have required a reminder for him to start collecting his medication again. When the manager recognised this omission, he introduced a system whereby an audit is carried out three times per week to check that residents have been collecting their medication. This was subsequently reduced to a single check per week following discussions at the area approved premises managers meeting. As this action has already been taken, I make no recommendation of my own.

CONCLUSION

68. Nothing occurred during the man's brief stay at the approved premises to cause staff to have any concern for his welfare. His history of drug and alcohol abuse was well documented but he seemed to be controlling his use of these substances. On at least two occasions he returned to the premises having apparently consumed alcohol, but consumption off the premises is not forbidden.
69. The man's death would seem to have been caused through respiratory suppression through use of a number of substances, only one of which was a medication prescribed to him. His intention and motivation remains unclear.

RECOMMENDATIONS

The following recommendations were made in the draft report. The Probation Trust's responses to the recommendations appear in italics below each recommendation:

1. I recommend that the premises manager ensure that new residents are always assessed for their suitability to hold medication in possession

Probation Trust response: Although medication in possession assessments are normally carried out as required, the manager has reinforced this by including it as an agenda item in weekly staff meetings. He has also spoken to the individual responsible for the omission in this man's case.

2. I recommend that the premises manager remind staff about the need to ensure that new residents hand in previously prescribed medications.

Probation Trust response: The manager has briefed staff in line with this recommendation and has highlighted that the handover checklist needs to be used in order to ensure that tasks such as this are followed up.