

**Investigation into the circumstances surrounding the
death of a man in December 2009
at Tulse Hill Approved Premises
in the London Probation Trust**

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

June 2011

This is the report of an investigation into the circumstances surrounding the death of a man. He died in Tulse Hill Approved Premises in December 2009, having arrived there from HMP Highpoint two days earlier. He was 40 years old.

None of the man's family were named on his files and the police have been unable to trace his next of kin. Nevertheless, he will undoubtedly have had some family and friends and I offer them my condolences.

The investigation was undertaken by one of my senior investigators. The investigator and I would like to thank the manager of Tulse Hill Approved Premises and her staff for their co-operation in the investigation. I apologise for the length of time taken to complete the report.

The post-mortem and an additional toxicology report identified that the man had taken a number of drugs prior to his death and the cause of his death was a result of "opiate and codeine intoxication".

It is impossible for me to say whether his death could have reasonably been prevented. I have found gaps in the communications between shift workers, particularly at weekends, which resulted in two drug tests being missed. There was a serious omission in the routine, but very important, standard checks and regular contact with residents. My investigation confirmed the early findings of the hostel manager that a relief member of staff failed to carry out at least one check and to pass key information on to his colleagues. This person is no longer employed by the London Probation Trust and so I do not make a recommendation. I also remind managers to consider the support needs of all the staff affected by the death of a resident.

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 prisoners involved in my investigation.

Jane Webb
Acting Prisons and Probation Ombudsman

June 2011

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SUMMARY

1. The man arrived at Tulse Hill Approved Premises on the afternoon of Friday 4 December having been released from prison on licence. A long term drug user, he had been assessed as high risk of harm to himself if he started to use drugs again soon after his release.
2. The vulnerability to overdose after being in custody is well known and advertised widely in prisons. Aware of this possibility, the hostel deputy manager had given instructions that the man should be drug tested during his induction. Although he was reminded of the risk of accidental overdose by the duty residential assistant, there is no record that the drug test actually took place. The residential assistant who received the instruction from the deputy manager was not the person who eventually carried out the induction and this important opportunity to assess his situation was missed.
3. His first night passed without incident. The man then spent most of the next day, 5 December, out of the hostel, returning in time for his curfew at about 9.00pm.
4. Staff on duty when he returned to the hostel suspected that he was under the influence of drugs or alcohol. He was argumentative and refused to sign his curfew sheet. He then set off a fire alarm on his way up to his room. This information was shared with the standby hostel manager. By this time he had apparently settled down in his room, so a drug test was ordered for the next morning.
5. The man did not leave his room again after 9.11pm. A relief worker says that when he went into his room during the 11.00pm curfew check, he pulled his toe and heard him groan. He took this to mean that the man was well.
6. Staff were expected to make wellbeing checks of each resident at 8.45am the next morning. However, the relief worker apparently did not carry out the check. Apart from a colleague who had been on duty the previous evening, colleagues coming on duty that day were not aware that there were any problems, and were not told about the incident with the alarm or that a drugs test had been ordered by the hostel manager for that morning. Furthermore, this information was not written down in any of the hostel documents. The relief worker subsequently misled the hostel manager about his actions on the shift in question.
7. It was only when one of the duty residential assistants decided to go to the man's room at about 3.00pm to check on his whereabouts that she discovered his body lying on the bed. It appeared to her that he was dead. She told her colleague and rang the emergency services. Attempts at cardio pulmonary resuscitation by both workers failed and he was pronounced dead by paramedics at 4.17pm.
8. It is impossible to say whether his death could have been prevented if either of the drug tests had taken place as planned or if he had been discovered at the standard morning wellbeing check. Drug tests could have established whether he had already started to take drugs and at the very least would have been another opportunity to reinforce the risk of low tolerance after coming out of prison. From

the duty residential assistant's description of his body when she found him, it is probable that he had been dead for some time. No check was made on him after he failed to come down to sign his 7.00am curfew. The best chance for successful intervention after that was the morning wellbeing check about ten hours after he was last seen alive. For reasons unknown, the check was not carried out, and the staff coming on shift in the morning were not told that the relief worker had neglected his duties.

9. I make recommendations about passing of information between staff at the hostel and support for staff after a death.

THE INVESTIGATION PROCESS

10. My investigator had access to all the man's probation records, which were provided by the hostel. He visited the hostel, saw where the man lived, and interviewed three members of staff. The interviews were recorded, and the transcripts are appended to this report. CCTV recordings of the hostel were also made available to the investigation. My investigator remained in touch with the hostel manager throughout the investigation.
11. My investigator also wrote to two former members of hostel staff asking if he could speak to them. He did not receive a reply.
12. Notices were displayed at the hostel to inform both staff and residents of the investigation, and inviting their contributions. None was received.
13. My investigator also spoke to the Metropolitan Police officers who were responsible for investigating the man's death.
14. The man did not have any next of kin noted on his files. My investigator spoke to the Lambeth Missing Persons Unit of the Metropolitan Police, who were making efforts to trace next of kin for the man. At the time of issuing my draft report, they had not located any next of kin.
15. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation. The Coroner's inquest was held on 27 July 2010, before my report was published, with a finding of non-dependent abuse of drugs. I will forward a copy of my report to the Coroner.

TULSE HILL APPROVED PREMISES

16. Approved premises were formerly known as probation and bail hostels. They are approved by the Secretary of State, within Section 9 of the Criminal Justice Act 2000. Approved premises provide a supportive, structured environment in the community for offenders who present a high risk to the public and are difficult to manage. The management of offenders accommodated in approved premises is governed by the National Standards for Supervision of Offenders and the guidance contained in the National Approved Premises Handbook.
17. Offenders can be released from prison on a licence, which contains specific conditions they must abide by. For example, they may be required to report to their home probation officer at a certain address and/or at a certain time. In addition, they may not be allowed to enter a particular area where victims of their crime live, or a specific type of premises such as public houses. If they breach the conditions of their licence they may be recalled to prison.
18. Tulse Hill Approved Premises has 23 single and three double rooms, with a capacity to accommodate 29 residents. Residents pay a weekly service charge for their meals, rooms, and other hostel facilities. The hostel has closed circuit television (CCTV), with monitors in the front office which is staffed 24 hours a day.
19. Approved premises are staffed continually 24 hours a day by different grades of staff working to a shift rota. Between 10.00pm and 9.30am there are two members of staff on duty, one of whom may be a security guard. During the day, there are up to six members of staff on duty, with a minimum requirement for two members of staff to be on duty at all times. There is a pool of relief staff who can be called upon to cover when staff numbers are low. All permanent staff are first aid trained, and casual staff receive basic first aid training.
20. All residents are subject to a curfew, whereby they are required to be in the hostel between the hours of 11.00pm and 7.00am. Some residents may have further individual curfew arrangements. Outside those hours, residents are free to leave the premises without disclosing where they are going. Wellbeing checks are made at regular intervals.

Documents used in approved premises

21. There are a number of documents used by staff to record information about individual residents and key events on a daily basis. Documents used include: the day book, a curfew checklist, a signing out sheet, and the London Probation Trust's computerised case management system, Delius (Delivering Information to Users System).
22. The day book is used to note any interaction between staff and residents and to record any incidents. Delius contains information specific to the individual resident. Staff in hostels sometimes make a brief note in the day book about an event and point to a more full entry in Delius. The Delius entry may be made some time after the event happened, so the record may not run chronologically.

All staff working in the hostel, including relief staff, have access to Delius. It seems that the day book is used as the main method of communication between staff.

23. The curfew checklist is a separate sheet kept which is used to collect the signatures of residents at the 11.00pm hostel curfew time every day. Residents subject to individual curfew times are additionally required to sign a personal curfew sheet separately.

Previous deaths at Tulse Hill

24. The Prisons and Probation Ombudsman has investigated one previous death at Tulse Hill. There were no similarities to the circumstances surrounding the man's death.

KEY EVENTS

25. The man served a sentence of two years imprisonment for communicating false information alleging the presence of bombs. He was released on licence to Ellison House Approved Premises in Camberwell, London. However, on 23 August 2008 he breached his curfew and was recalled to prison. In December 2008, he transferred to HMP Highpoint, and in late 2009 preparations were underway for him to be released on licence to Tulse Hill Approved Premises (referred to hereafter as the hostel).
26. As part of the preparations for release on licence, an Offender Assessment System (OASys – a system to gauge the likelihood of offenders reoffending, and the risks they may pose) report was completed on 16 November. This report contains contingency plans to immediately recall the man to prison should he fail to keep to the conditions of his release licence. The report notes that his probation officer would be responsible for any recall. In his absence, responsibility would fall to an offender manager also based in the Public Protection Unit at Harpenden House, one of Inner London Probation Trust's offices.
27. Further elements of the preparation for release included the completion of a Risk Assessment and Public Protection Plan on 27 November. The plan shows that the man was considered a high risk of accidental death due to reduced tolerance to drugs in the weeks following release from custody. It is not clear what action was taken in relation to this at this stage. He was also noted to be high risk to hostel staff, high risk of self-harm, and high risk of suicide. It is recorded on the form that staff should monitor, among other things, his mental health, his compliance with any medication he might be prescribed, his use of drugs and alcohol, and his overall compliance with the terms of his licence and the hostel's rules and regulations. The terms of his licence included specific conditions that he was to be tested twice weekly for drugs, and must comply with the curfew hours of the hostel.
28. The man was released from Highpoint on 4 December. He reported to the probation office at Harpenden House and was seen by an offender manager. They discussed the conditions of his licence, what was expected of him while he was in the hostel, and dangers of using drugs after a period in prison. He said that he was intending to remain drug-free.
29. After this meeting, the man travelled to Tulse Hill. He arrived at the hostel at 2.40pm and was met by the duty residential assistant (RA). He signed in. The shifts changed, and the night RA took over from the day RA. She then carried out his induction process. She reminded him of the potential danger of taking drugs after his tolerance had decreased while he had not been using them. He paid his deposit for his rent and board and was allocated to room 15, a room at the end of the corridor on the first floor. He was told that his personal curfew hours were between 9.00pm and 7.00am and he had to sign the curfew sheet. It was pointed out that, even if he was in the hostel, it was still his responsibility to go to the office and sign the curfew sheet.

30. An entry on the man's Delius record on 4 December shows that the deputy manager agreed with another member of staff, the day RA, who is one of the hostel's relief workers, that he should be drug tested as part of his induction process. However, the RA did not carry out the induction, and the test was not carried out.
31. Another entry on the Delius system, timed at 3.46pm, was made by the offender manager, reminding staff that an application for recall should be completed should the man fail to comply with his licence, the hostel's core rules, or his curfew. (As well being an offender manager, she also works occasional shifts when required in approved premises. However, this entry appears to have been made in her capacity as his offender manager.)
32. The man signed out of the hostel at 4.15pm, and returned and signed back in at 5.00pm. He signed back out at 5.15pm, and returned and signed in again at 8.15pm. The hostel's curfew sheet bears what appears to be his signature, timed at 9.00pm. The day book contains an entry at 9.20pm saying that he had signed his curfew sheet. However, the hostel's CCTV footage shows one of the hostel's security guards going upstairs at 10.19pm. The guard later explained to the hostel manager that he was on his way to remind the man to sign the curfew sheet at this stage. The man subsequently did so. The duty officer in the hostel that evening later confirmed to the hostel manager that the man was present at 11.00pm, in line with his curfew.
33. The following morning, 5 December, the man signed the curfew sheet at 7.00am. The duty officer was responsible for the wellbeing check on residents. At 8.55am, she made a note in the day book that she had completed the checks and that all residents appeared to be fine. At the same time, he left the hostel.
34. The duty officer sent an e-mail to the deputy manager at 10.15am to inform her that, although she was scheduled to work overnight from 9.30pm that day to 10.00am the following day, the relief worker (who was an experienced relief worker) had agreed to cover her shift.
35. The man was out of the hostel all day. The relief worker and offender manager were on duty when he returned at 9.02pm. He was unsteady on his feet, and was verbally loud and aggressive, appearing to be under the influence of something intoxicating. He refused to sign the curfew sheet, and the signing in and out log does not have a return time entered. He told the offender manager that he did not want to stay at the hostel, and asked her to return the money he had paid the previous day. He told her that she might as well recall him to prison, suggesting that she call the police as he had no intention of staying in the hostel that night. He told her that he had been smoking cannabis, though she suspected that he might be under the influence of stronger drugs.
36. However, he eventually took his room key and entered the hostel. He went up to the first floor and, as he passed the fire alarm, he broke the glass, which set off the alarm. The relief worker went to check the alarm, and confirmed that there was no fire. CCTV footage shows him going into his room at 9.11pm. At this stage staff made no further attempt to discuss what had happened with him.

37. At 9.58pm the offender manager made a telephone call to the duty officer providing managerial cover to all the approved premises in Lambeth and Southwark. By coincidence the manager providing standby cover for the area that night was the manager of the Tulse Hill hostel. The offender manager left a message to say that the man had returned to the hostel apparently under the influence of something, set off the fire alarm, and asked to go back to prison. He had, though, then settled down and was in his room. The offender manager finished her shift at 10.00pm and she left the hostel shortly afterwards. The relief worker remained on duty together with the security guard.
38. The manager telephoned the duty RA at 10.02pm. She said that, as the man had just been released from prison another RA due on duty the next morning should be asked to give him a drug and alcohol test. She said that if there were any further problems, staff at the hostel should inform her as well as the police. This instruction was not recorded in any of the hostel documents.
39. The relief worker said later to the day RA that he saw the man at 11.00pm as part of the general hostel curfew check. CCTV shows that he arrived at the man's door at 11.09pm. He did not fully enter the room, but opened the door and leant forward into the room for less than a minute. He said that the man was in bed and asleep, and so he did not wake him but pulled his toe. This made him let out a groan, and the RA judged that this was an indication that he was okay.
40. After the RA had opened and closed the door, the CCTV shows that no-one else went into or came out of the man's room. The day book indicates that the security guard patrolled the building at 1.00am, 3.00am and 5.00am and the CCTV recordings corroborate this. No problems were encountered on any of these occasions.
41. The man did not sign the curfew sheet at 7.00am on Sunday 6 December. The relief worker later told the hostel manager that he did not go and check the building because he was watching the door and, if he had left the building, he would have seen him do so. Nevertheless, the column of the curfew sheet where residents sign has a "T" written there, as if someone had begun to sign for 6 December. It has not been possible to find out who did this, although consideration has been given to it being an entry in error by the man from the day before.
42. There is a note in the day book that a wellbeing check was completed on residents at 8.45am. The curfew check list also has a tick to indicate that the man (along with other residents) was present at 8.45am. However, the section of the daily task document where staff should confirm that the 8.45am wellbeing check took place has been left blank. The relief worker subsequently told the hostel manager that, although he did not enter the room when he made the check, he could hear him snoring. As the man had been disruptive the previous evening, he did not feel that he should disturb his sleep. His account is not corroborated by the CCTV footage, which indicates that he did not leave the

general office between 7.00am and 9.34am and no-one went to the man's room during this time.

43. The security guard went off duty and left the building at 9.05am. The RA shift was due to change, with the duty residential assistant and the day RA scheduled to begin their shifts at 9.30am. The duty residential assistant arrived at 9.05am. CCTV shows the relief worker leaving the building to speak to his wife in the car park at 9.34am, the only time he left the building during his shift. He could not leave until the next two shift workers had taken over. The day RA arrived at 9.55am.
44. Before going off shift after the day RA arrived, the relief worker gave a verbal handover to the duty residential assistant. She said that he told her that he had seen everybody and they were all fine. She took this to mean that there were no concerns. She said that he did not tell her that the standby duty officer had been contacted the previous night about the man's behaviour or that a drug and alcohol test had been requested for that morning. He later told the hostel manager that, as he thought that the day RA had been present when the man returned to the hostel the previous evening, he assumed that she was aware of this.
45. According to the CCTV footage, the only person who approached the man's door during the early part of Sunday was his neighbour from the next room, who knocked once on the doors to both the man's room and the room opposite at 12.52pm. It appears that there was no response to either knock because the resident walked off down the corridor almost immediately afterwards.
46. The duty residential assistant said in interview that she was concerned that the man might have kept his key after going out on the day of his arrival and she wanted to check this with him during her shift. She had previously asked two other residents to knock on his door but both returned to say that there was no reply when they knocked at 2.33pm and 2.37pm respectively. The day book notes that at 3.05pm she went herself to his room to ensure that he was on the premises.
47. When the duty residential assistant, who is a trained first aider, knocked on the door, she also received no reply. She tried the door and it was unlocked, so she opened it. She saw him lying on the bed, his foot on the pillow and his head on the mattress. She called him, and he did not respond. She saw brown fluid coming from his nose and his mouth, and she checked for a pulse. She could not find one and noticed that his hand was stiff.
48. She came back down the stairs and told the day RA that she thought that he had died. She called for an emergency ambulance and explained the situation. The day book indicates that the ambulance was called at 3.10pm. She then handed the telephone to the RA and returned to his room. The telephone operator took a mobile telephone number from the RA, and then rang her back as she made her way up to the room. The operator gave advice on administering cardio pulmonary resuscitation. (CPR incorporates chest compressions and mouth-to-

mouth resuscitation, to force air in and out of the lungs, to try to make the heart restart.)

49. The duty residential assistant attempted to resuscitate the man. Unable to gain a response, she became upset, and so the RA took her place. The ambulance arrived at approximately 3.30pm, and the paramedics then took charge. They confirmed that he had died, and the official time of death was given as 4.17pm. Checks of his room did not reveal any drug paraphernalia or other signs of drug-taking.
50. The duty residential assistant telephoned the hostel manager but only managed to reach an answering service. She telephoned the manager but, being unable to get through to her, left voicemail messages asking her to call the hostel. She also telephoned the London area duty manager. Shortly afterwards, at 4.10pm, the manager called the hostel and was told what had happened. She spoke to senior officers then made her way into the hostel. At 4.15pm, the London area duty manager telephoned the hostel and helped staff with the contingency plans required for a death in the hostel.
51. The London area duty manager rang the hostel again at 4.55pm to check how things were and that the staff were okay. At 5.15pm, the manager arrived at the hostel and took charge.
52. As part of his induction process, the man had provided details for next of kin. He had named a friend from prison. The manager contacted him and informed him of his death. She did not, however, have any details for any of his family. She provided what information she could to the police, and the Lambeth Missing Persons Unit undertook to try and trace his family. Unfortunately, they were unsuccessful in their attempts.
53. Other residents in the hostel were informed of his death at a residents' meeting called for that purpose. They were told that if they needed any support they should talk to their keyworker or one of the premises managers.

Post mortem

54. A post mortem examination was carried out on 8 December. The report gave the official time of death as 4.17pm on 6 December 2009. The cause of death could not be established at that time. Toxicology tests were therefore undertaken, and they showed the presence of:
 - morphine
 - codeine
 - 6-monoacetylmorphine (which indicates use of heroin)
 - papaverine metabolite (which indicates the use of street heroin)
 - cocaine (consistent with recreational use).
55. The cause of death was subsequently given as opiate and cocaine intoxicification. The pathologist further commented that there was evidence of recent heroin and

cocaine use. Although there were low levels of these drugs at post mortem, the man's death was compatible with their use.

Inquest

56. The Deputy Coroner at Southwark Coroner's Court, presided over an inquest into the man's death on 27 July. The inquest recorded a finding of "non-dependent abuse of drugs".

ISSUES

Communication in the hostel

57. One of the main points to stand out in this investigation is the difficulty for staff communicating information in the hostel. The various documents which are kept, including the day book, Delius electronic notes, a curfew sheet, personal curfew sheets, daily task lists, are all administrative pressures on staff. Information can be missed across staff shifts, and happened twice when the man should have been given drug tests. Also, although it is unlikely to have impacted on the outcome in this instance, the evidence from the hostel's records and CCTV footage for when he signed his curfew sheet on the Friday evening also implies that it was done at three different times. I suggest that the hostel manager should review the way important incidents and requests for actions are communicated between staff.
58. My recommendation may have implications for other London hostels and the London Probation Trust should consider whether any changes should be implemented beyond Tulse Hill.

The hostel manager should ensure that information regarding important incidents and actions pending is being communicated between staff as effectively as possible to avoid duplication and reduce the risk of information being overlooked.

Missed drug tests

59. The man should have been given a drug test when he arrived in the hostel. Even though this was agreed between staff at the hostel, it was overlooked. Additionally, it is clear that the hostel manager had identified the need to test for drugs and alcohol when he awoke on Sunday 6 December. She had given this instruction to the relief worker the previous night after being told about his disruptive behaviour. Unfortunately, this instruction was not passed to the oncoming shift workers at the handover after 9.00am.
60. This important instruction from the hostel manager should have been noted in day book or Delius so that staff coming on duty were reliably informed of the situation. The relief worker said when discussing events with the manager after the man's death that he had made Delius entries on residents as part of his normal RA duties. However, no electronic records were found.
61. He also told the manager that he thought there was no need to tell the day RA that she had to drug test the man that morning because he thought she was on duty when the manager spoke to him the previous evening. Nevertheless, confusion could have been avoided and the drug test would have been more certain if he had either written the instruction in the day book or handed over verbally to the duty residential assistant. Good practice in hostels relies on the full and accurate exchange of information to equip the next shift with the resources to carry out their role satisfactorily. This may entail mentioning each resident in turn and commenting verbally on each one and recording key

information in writing. I understand that this is what should have happened. Key information should be recorded and a routine verbal update allows an opportunity to discuss the implications.

62. It is not possible to say whether the man's death could have been avoided if he had been seen earlier. The time of his death has not been established and there is no information about whether he died suddenly or was ill beforehand. The drugs test would have been an important opportunity to make contact several hours earlier and the failure to hand on information meant this opportunity was missed.

Wellbeing checks

63. Another opportunity to check the man's wellbeing was when the relief worker should have made the standard check that is part of each shift. The hostel requires the duty RA to carry out various checks at fixed times of the day and he should have undertaken a wellbeing check at 8.45am. A clear expectation of staff is that the resident is seen, if in the building, and a brief assessment made about their state of mind and general demeanour. He believed that the man was still in the building as he had not seen him leave and he had been in the office since his morning curfew of 7.00am.
64. As an experienced hostel worker, he was clearly aware of the morning wellbeing check because according to the hostel manager he told her afterwards that he had completed the check on the morning of 6 December. He told the manager that he could hear the man snoring from outside his door but did not go in as he did not want to disturb him. However, one CCTV camera revealed that he did not leave the hostel office between 7.00am and 9.34am and another camera showed that he did not stand outside the man's room as he described to his manager.
65. As with the missed drugs tests, it is impossible to say whether the missed 8.45am wellbeing check would have altered the outcome. It is, however, a serious omission and a missed opportunity to intervene. At the very least, it might have meant that the man could have been found earlier.
66. The preliminary consideration of events by the hostel manager uncovered concerns about the relief worker's behaviour during his shift on 5 and 6 December and the serious implication that he attempted to cover this up. I understand that, as a result, he is no longer employed as a relief worker by London Probation Trust.

It appears that in this case there was no fundamental problem with the system for wellbeing checks, only with the performance of an individual. My investigator was told that since the man's death an additional wellbeing check has been introduced at 10.30am every day. I welcome this development.

Cardio pulmonary resuscitation

67. In interview, the duty residential assistant shared her distress at administering cardio pulmonary resuscitation (CPR) to someone she clearly believed had already died. She described the man's body as being "cold" and "stiff" and she was reluctant to embark on CPR. Indeed, the emergency service telephone operator advised that the day RA take over as she became emotional.
68. The London Probation Trust manual of guidance and instruction for the management and care of residents in approved premises contains guidance to staff in the event of finding a resident who has died. The manual says:
- "It must never be assumed in all cases that because the person appears dead that they are in fact dead. In some cases it may be obvious. If safe to enter the area where the person is then you must check for any signs of life where death is not obvious. Having satisfied yourself that the person is dead then leave the location and seal it off to prevent unauthorised access to the location."
69. The duty residential assistant was first aid trained but she did not find it easy to be clear about her duty of care when faced with someone she did not think could be successfully resuscitated. In the circumstances, I can understand why she followed the advice of the emergency services. This was distressing for her. With hindsight, it is unfortunate that she was not confident about deciding that the man was dead and that she could quite properly make no attempt to resuscitate him.
70. Deaths in approved premises are thankfully rare and, although the duty residential assistant had a first aid qualification, she may well not have dealt with a death before. The Probation Trust may wish to consider whether their manual and the first aid training should include advice on recognising rigor mortis. More deaths occur in prison than in approved premises, and the National Offender Management Service unfortunately has more experience of prisoners being found some time after they have died. My investigations into prison deaths have commented when CPR has begun after rigor mortis has set in. It is undignified as well as stressful for staff. I make no criticism here as the staff followed the advice of the emergency services. However, I encourage the Trust to consider my remarks and decide whether the manual and training covers eventualities such as this.

Support for staff

71. It is clear that the three staff interviewed by my investigator were all aware of the type of support that could be made available for them, from informal support from managers, to counselling. The duty residential assistant raised concerns, however, about the response she received after the man's death. She felt that managers did not demonstrate immediate empathy with her as someone who had just discovered a deceased resident and attempted to resuscitate them. The hostel manager pointed out that policies were followed. As well as being offered counselling, she was also given special leave. Nevertheless, she has

clearly been affected by what happened that day, including how she felt that managers responded to her. She has been troubled by this and said that, in her upset state after the man died, she did not take up the offer of counselling.

72. She did, however, express strong appreciation for the response of the London area duty manager. He was the duty manager she spoke to after discovering the man and she found him very supportive on the telephone. He went through what had happened with her and was clear about what should happen next. Even though she did not meet him in person, she said that his ability to communicate professional support was appreciated.
73. One other member of staff who might have been more than usually affected by the man's death was the offender manager. She not only knew him before he came to the hostel but was also on duty the day before he died. Indeed, she had witnessed his disruptive behaviour and had initiated contact with the standby manager about this. She even took the unusual step of ringing the hostel on the Sunday afternoon to check on his wellbeing, only to be told that he had been found dead. She did not recall subsequently being offered the support which was offered to hostel staff.
74. This did not have any negative repercussions for the offender manager who clearly felt fully supported by her own line manager and was aware of the bereavement counselling service provided by the London Probation Trust. However, in future, the needs of all staff including relief workers should be actively considered when dealing with the aftermath of a death and its possible impact. One way to do this could be to conduct a staff debrief after the event of a death.

The hostel manager should review arrangements for supporting staff involved in a death at the premises and ensure that support is available as required.

CONCLUSION

75. The man was a young man with a troubled past which included mental health problems, drug abuse and periods in prison. He had spent time in approved premises before he arrived at Tulse Hill in December 2009, and so he was familiar with the process.
76. He was aware of the dangers of taking drugs after a period in prison, during which his levels of tolerance to drugs would have decreased. He was reminded of this by his offender manager when he reported to her on the day he was released from prison. He had been assessed as presenting a high risk of harm if he began taking drugs, and his release licence contained a condition that he should be tested for drugs twice a week. His offender manager had sent a reminder to staff at the hostel that, if he were to break the conditions of his licence or not abide by his curfew, procedures should be put in place to recall him to prison.
77. The hostel manager asked for him to be drug tested as part of his induction, but a breakdown in communication meant that this did not happen. He spent the first night in the hostel without incident but, when he returned on the second evening, he appeared to be under the influence of drugs and was in a belligerent mood. After initially refusing to sign his curfew sheet, he eventually went up to his room, setting off a fire alarm as he went.
78. The hostel manager was informed of his behaviour, and she requested for him to be drug tested in the morning. She also said that if he exhibited any further problematic behaviour then both she and the police should be informed.
79. Residents should be given wellbeing checks at 11.00pm and 8.45am. The CCTV footage shows that he was seen at the 11.00pm check, but that the 8.45am check was not done. Nor was the drug test performed. He was not seen until shortly after 3.00pm, when a member of staff went into his room and found him already dead. After alerting a colleague and telephoning 999, the emergency services told her to attempt to resuscitate him. Both staff members followed this advice and performed CPR until the ambulance staff arrived. The paramedics confirmed that he had died.
80. I have found that there were three distinct opportunities to check on him during the two days he was at Tulse Hill. They were the drug tests which should have taken place during induction and on 6 December as well as the wellbeing check which was missed later that morning. We will never know whether any of these interventions could have saved his life, but they were serious omissions which should never be repeated. I am pleased to hear that the relief member of staff involved in this case is no longer employed by the London Probation Trust.

RECOMMENDATIONS

1. The hostel manager should ensure that information regarding important incidents and actions pending is being communicated between staff as effectively as possible to avoid duplication and reduce the risk of information being overlooked.

The Probation Trust has accepted this recommendation. They commented that if approved premises are followed there should be no difficulties in communicating information.

2. The hostel manager should review arrangements for supporting staff involved in a death at the premises and ensure that support is available as required.

The Probation Trust has accepted this recommendation. Having assessed, they are confident that existing arrangements provide for sufficient support to be made available.