Investigation into the circumstances surrounding the death of a man in February 2007 at Town Moor Approved Premises in the South Yorkshire Probation Area

Report by the Prisons and Probation Ombudsman for England and Wales

November 2007

This is the report of an investigation into the circumstances surrounding the death of a man. The man died aged 33 in February 2007 in Town Moor Approved Premises, South Yorkshire. He was found dead in his bed by the hostel manager after his staff told him that the man had not taken his medication the night before. The initial post mortem report could find no apparent cause of death, but the results of a subsequent toxicology examination showed the fatal use of illicit heroin.

I would like to offer my condolences to the man's family. He was a young man with a past troubled by drug and alcohol abuse. He had begun to address these problems before he died, and hostel staff and drug intervention programme workers were pleased with his attitude and progress. In the two weeks he resided at Town Moor, he had also enjoyed seeing his family and working on a church allotment.

The investigation was led by one of my investigators. One of my Family Liaison Officers contacted the man's family to explain the investigation process and to ask whether they had any specific questions about the circumstances of his death.

I am grateful to the manager, staff and residents of Town Moor for their co-operation with this investigation. I am also grateful for the assistance of a seconded probation officer from HMP Doncaster, and to the man's home probation officer and the two drug intervention workers who worked with him on his release from prison.

The Probation Service in South Yorkshire emerges well from this investigation.
I have made a single recommendation and the text of my report draws attention to an example of good practice.

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

Stephen Shaw CBE
Prisons and Probation Ombudsman **November 2007**

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SUMMARY

The man was 33 years old when he died. His life was troubled by addictions to alcohol and drugs and these led him into a pattern of offending. His first conviction was at age 17, and he spent several short periods in prison between 1998 and 2004. The man suffered from drug induced psychosis and needed regular medication to control violent outbursts.

In March 2005, the man was convicted of Assault Occasioning Actual Bodily Harm and sentenced to 27 months in prison. He served his sentence at HMP Doncaster. On 23 June 2006, the man was released on licence to a residential and rehabilitative care unit with 24 hour supervision from qualified mental health professionals.

On 4 October 2006, the man was recalled from his period on licence after he persistently made threatening and racist remarks to members of staff. He was also accused of bullying other residents and refused to take his medication on some occasions. He was returned to Doncaster prison.

On 24 November 2006 a Parole Board review panel concluded that the man's recall to prison had been appropriate and that he should be released at his licence expiry date, 8 February 2007, subject to a satisfactory release address.

The man was released to Town Moor Approved Premises on 8 February 2007. Included in his licence conditions were stipulations that he must address his drug and alcohol problems and take his medication every day.

On his release, the man engaged with drug intervention programme (DIP) workers in Doncaster. He attended his appointment with Doncaster Alcohol Services (DAS) and met as required with his offender manager (probation officer) and his keyworker. He contacted social services and saw a GP to obtain further medication. He took his medication every day until the night before he died. He saw his family and began work on a church allotment project which he enjoyed very much.

The man tested positive for heroin and crack cocaine at a routine drug test on 13 February. He admitted to taking the drugs the day after his release and said that it was a "one off". It was decided not to recall him from licence. He tested negative at a further test on 20 February. Staff at Town Moor, his offender manager and the DIP workers were all impressed with the man's attitude and motivation during his time there. Sadly, the man died from the fatal use of illicit heroin on 22 February.

I conclude that the man was well managed at Town Moor and that his death could not have been foreseen. I make two recommendations.

THE INVESTIGATION PROCESS

1. I was notified of the man's death on 22 February 2007. The investigation was allocated to one of my investigators. On 9 March, notices were issued to staff and residents at Town Moor telling them that an investigation would be taking place and inviting those who wished to see the investigator to make themselves known. The Coroner was contacted and a copy of the post mortem report was requested and received.

2. My investigator visited Town Moor on 20 March. She met the manager, the deputy manager, and an assistant chief officer for South Yorkshire Probation Area. My investigator was provided with the man's hostel record, and spoke to the man's keyworker. She visited the man's room and spoke informally to some residents and staff.

3. My investigator obtained the man's prison record from HMP Doncaster. She spoke to the prison's senior probation officer, and a seconded probation officer who had worked with the man. She also spoke to the man's offender manager, and to two drug intervention workers based in Doncaster. My investigator spoke to a resident at Town Moor who had known the man.

4. One of my family liaison officers, contacted the man's mother. Although she did not feel the need for my colleagues to visit her, she asked to be kept informed of the progress of the investigation. She said that she had had intermittent contact with her son over the past few years because he had been in and out of prison. He always came to see her when he was out of prison, but it was usually "out of the blue". She said her son had come to see her when he was at Town Moor and that he had looked well. The man's mother thought that he was making progress in addressing his drug addiction, and he had enjoyed a family meal in celebration of his son's birthday. She said that staff at Town Moor had been very helpful following her son's death. She had appreciated being able to spend some time in his room and talk to staff about the last two weeks of his life.

TOWN MOOR APPROVED PREMISES

5. Town Moor opened as a bail hostel in May 1991. It was previously a private hotel and occupies two converted houses in a residential street in Doncaster. Until January 2007 it was one of the biggest hostels of its kind in England and Wales, but the closure of its 'cluster houses' reduced the number of beds from 39 to 18. The cluster houses were used as a half way house between residents living in the hostel and returning to live in the community. Staff expressed a concern to my investigator that their closure would make it more difficult for them to prepare residents for a return to the community.

6. Town Moor takes male residents on bail, licence or community order who are judged to present a high or very high risk to the public according to the Probation Service's OASys (Offender Assessment System) risk assessment tool. Most residents are referred as a result of a Multi-Agency Public Protection Panel (MAPPP). The role of the hostel is to seek to reduce the residents' risk to others before their licence ends. To this end Town Moor has contracts with The Garage (a substance misuse organisation which provides Drug Intervention Programme – DIP – workers), Doncaster Alcohol Services (DAS) and ETE (Employment, Training and Education). A community psychiatric nurse (CPN) is available for visits, and two psychiatrists attend the hostel weekly. The expectation is for residents to be in work or actively seeking work.

7. Town Moor is staffed by a manager, a deputy manager, three probation service officers (PSOs), two hostel support workers and an administrative officer. Six other staff and one agency worker are on duty every night. The hostel has a kitchen where three meals a day are prepared for residents, and there is a laundry, games room and communal area with a television. Residents have their own rooms and keys but must sign in and out when coming and going from the hostel. Entry to the hostel is by door buzzer and every communal area is covered by CCTV. All residents must be in the hostel between 11.00pm and 7.00am. The demand for beds is high and there is a long waiting list for places. The length of stay can vary from a few days to 18 months, but most residents will remain for about four to six months.

THE EVENTS LEADING UP TO THE MAN'S DEATH

From 30 March 2005 to 7 February 2007

8. On 30 March 2005, the man was sentenced at a Crown Court to 27 months imprisonment for Actual Bodily Harm (ABH). He served his sentence in HMP Doncaster. The seconded probation officer, arranged for the man to meet with two DIP workers from Doncaster. They visited him in the prison on several occasions.

9. On 23 June 2006, the man was released on licence to a residential and rehabilitative care unit with 24 hour supervision from qualified mental health professionals. The terms of his licence required the man to reside at care unit and only leave the premises under escort. Other licence conditions required him to attend medical and mental health appointments and to address his drug and alcohol addictions.

10. On 4 October 2006, the man was recalled from his period on licence after he persistently made threatening and racist remarks to members of staff at the care unit. He was also accused of bullying other residents and refused to take his medication on some occasions. He was returned to HMP Doncaster.

11. At his first reception health screen on 5 October, the man is recorded as looking "generally well". He said he had not used drugs or consumed alcohol for 18 months. He was referred to the doctor because he needed repeat prescriptions for olanzapine and chlorpromazine (two drugs known as 'anti-psychotics' and used in the treatment of schizophrenia and psychotic depression). On the same day he was seen by a CARATs (counselling, assessment, referral, advice and throughcare) worker and signed a service withdrawal disclaimer form on the grounds of "no drugs used". A note was made on the form by the CARATs worker to review the situation on 2 November, but there is no other CARATs documentation on the man's prison file.

12. On 6 October, the man was seen by the prison doctor and referred to a visiting consultant forensic psychiatrist. The psychiatrist saw the man on 12 October. He noted on the man's continuous clinical record that he had been prescribed olanzapine, chlorpromazine and procycladine (a drug taken to lessen the side effects of the anti-psychotics) but was missing his morning dose because he did not wake up in time to receive it on the wing.

13. The psychiatrist saw the man a second time on 26 October. He said that the man complained of having paranoid thoughts and thoughts of self-harm. The man presented as agitated but not aggressive or threatening. The psychiatrist made a note to increase The man's dose of olanzapine. Following this consultation, the psychiatrist wrote to the prison doctor. He said that in light of the man's thoughts of self-harm he had been moved to the vulnerable prisoner unit and was in a shared cell.

14. On 24 November, a panel of the Parole Board sat to consider the decision to recall the man from licence. The result was sent to the parole clerk at Doncaster prison on 29 November. The panel concluded that the recall was appropriate as he man's behaviour at care unit indicated that he presented too high a risk to be managed in the community. The panel thought careful planning was needed for the man's eventual release, and agreed with a risk management plan prepared by the man's offender manager that suggested a comprehensive psychiatric assessment and suitable release address were essential before the man could be released. The panel agreed to release him on his notional licence expiry date (LED) on 8 February 2007. The man should be subject to similar additional conditions to those on his previous licence, and the nature of his accommodation would be informed by on-going assessment.

15. The psychiatrist saw the man again on 30 November. He reported in the man's continuous clinical record that the man's paranoia was not getting any better and that he had complained that people were staring at him and talking about him. He said the man told him that he dare not go into the showers. The man was still getting up too late to receive his morning dose of chlorpromazine. The psychiatrist said that the man presented as rational and amenable to discussion and was not hostile or distraught. He made a note to see the man in two weeks time but there is no record of this consultation taking place. (My investigator left messages for the psychiatrist asking if he would ring her but he did not return her calls.)

16. Following this meeting the psychiatrist again wrote to the prison doctor. He said, "The core disturbance here is profound disturbance in his personality which at times lends itself to psychotic episodes." The psychiatrist said he had rationalised the man's medication to take account of the fact that the man had told him he was unlikely to ever get up for his morning dose of chlorpromazine while at Doncaster.

17. The seconded probation officer told my investigator that, when the man was first recalled to Doncaster, he told him he had no interest in seeing either of the DIP workers from Doncaster. He said the man was still being supervised by an offender manager. The man was adamant that he did not want to be released into the Nottinghamshire area because "there was nothing for him there". The seconded probation officer said that he saw his role primarily as "oiling the wheels of release" and his main aim in working with the man was to transfer him back to South Yorkshire Probation Service (SYPS) and to find suitable accommodation for him in the Doncaster area.

18. In December 2006, the man's offender manager and the hostel manager exchanged emails about the possibility of the man being released to Town Moor. The hostel manager suggested that the offender manager contact Town Moor's local probation office if she wished a transfer to SYPS to go ahead. On 8 January 2007, Nottinghamshire Probation Area completed an Approved Premises Referral Form. On 10 January, the hostel manager emailed the offender manager and said that he had not heard anything further about the man's transfer. However, he had been contacted by the

probation department at Doncaster prison who were under the impression that the man would be going to Town Moor on 8 February 2007. The offender manager replied that the man's transfer to SYPS was in progress. The hostel manager suggested that Town Moor agree that the man was suitable before the transfer was completed.

19. On 11 January 2007, Town Moor received a copy of the referral form, the man's OASys assessment and a list of his pre-convictions. The deputy hostel manager emailed the offender manager to raise "considerable concerns" about the man's accommodation in Approved Premises. The deputy manager said she was concerned that the man had been recalled from his placement at the care unit because his risk to staff and residents had been "too high". She was concerned that the man was deemed to present a considerable risk to others if he did not take his medication and if he chose to abuse drugs and alcohol. She was also concerned that the man was not suitable to live in a hostel environment as he said that he did not like people and preferred to be isolated. The deputy manager said that, if Town Moor were to be persuaded that the man was suitable, they must attend a Multi Agency Public Protection Panel (MAPPP) before his release.

20. On 24 January, a MAPPP took place in Mansfield. The meeting was attended by the offender manager and two other representatives from Nottinghamshire Probation, and by the seconded probation officer, an offender manager who was designated to become the man's offender manager in South Yorkshire and representatives from South Yorkshire MAPPA unit. The seconded probation officer told the meeting that the man was adamant that he did not wish to live in Nottinghamshire on his release. The man's risk factors were discussed and it was agreed that he would be released to a hostel in South Yorkshire that could provide supervision of the man's medication and mental health support. An action plan was drawn up. This included updating the man's risk management plan, talking to the man about working with a Drug Intervention Programme (DIP) worker, arranging for Doncaster prison to provide the man with anti-psychotic medication for his release, and explaining the licence conditions to the man.

21. Between 25 January and 5 February, the man's licence conditions were finalised and he was formally accepted for a place at Town Moor. The seconded probation officer arranged for the DIP workers from to visit the man in prison. Arrangements were made for him to be met on his release from prison by oner4 of the workers and taken to see the offender manager before being taken to Town Moor. The seconded probation officers arranged for the man to be released with sufficient medication pending an appointment with a GP, and arrangements were made for the man to see the DIP team and Doncaster Alcohol Services (DAS) on 9 February.

From 8 February to 22 February 2007

22. On 8 February, the offender manager emailed the hostel manager to tell him that she had received the man's OASys assessment. She said that the man had previously assaulted a prisoner after he "got on his nerves". She said

that she had spoken to the seconded probation officer who had discussed the man's licence conditions with him. She said that the seconded probation officer had told her that the man thought he would drink alcohol very quickly after release.

23. Later that morning, the man was met at Doncaster prison by one of the DIP workers and taken to see his offender manager. The offender manager went through the man's licence conditions with him and completed an OASys assessment. The man's objectives were recorded as:

> "For the man to comply with his licence conditions.
> To attend appointments with DIP and Community Alcohol Team
> For the man to comply with his medication."

24. After his meeting with his offender manager, the man was taken to Town Moor. He handed in the olanzapine, chlorpromazine and procycladine that he had left Doncaster with. He was shown his room and taken around the hostel, and had a full induction meeting with his key worker. The key worker completed form HRM1 (hostel record of risk assessment). He judged the man to present a high risk to the public and staff, particularly if he failed to take his medication. The key worker listed the proposed action to minimise the man's risk as, "licence conditions, supervision, keywork sessions, drug/alcohol screening, referral to drugs/alcohol services, single room."

25. The man signed the Town Moor drug and alcohol policy to say that he would comply with the drug and alcohol treatment programme. He agreed to provide a urine sample for testing every Wednesday. He signed a medical application for a local GP practice so that he could get a prescription for his medication. The man also signed the hostel rules and agreed to go to Doncaster Department of Social Services (DSS) to register for benefits so that he could pay his hostel rent.

26. On 8 February, a staff member made an entry in the man's electronic hostel log file that the man had returned to the hostel at 2.00pm smelling strongly of alcohol. The offender manager, her senior probation officer, the hostel manager and deputy manager discussed this incident but decided against recalling the man. They took into account the fact that it was the man's first day out of prison, that his licence did not say that he could not drink alcohol and that he presented no problems on his return to the hostel. The offender manager drafted the necessary recall paperwork in case of any further incidents and emailed it to Town Moor.

27. On 9 February, the man attended his appointments with and DIP worker and DAS. He also registered at the medical practice and went to Doncaster DSS. He attended a further appointment with the DIP team on 12 February. On 13 February, the man tested positive for heroin and crack cocaine at his weekly urine test. On 14 February, he had a keywork session with key worker. According to his electronic log file, the man admitted to using heroin and crack cocaine on Friday 9 February. He was adamant that this was a 'one off'.

28. At his keywork session on 14 February, the man said he felt that he had settled in well at Town Moor and liked it more than he thought he would. He had obtained more medication and a sick note from the doctor for three months. He said he was hoping to start taking Antabuse (medication given to recovering alcoholics to help them abstain from alcohol) on 1 March but he needed to have liver function tests first. He confirmed he had made a claim to the DSS and said he had met with his DIP worker and talked about relapse prevention. The man admitted he had been drinking alcohol but said that he limited himself to two or three cans of lager a day. He said he had seen his mother and son 'most days' and had also spent time with his cousin. He said his mother was trying to set up a meeting with his daughter but was having difficulty in contacting his ex-partner. The key worker discussed the man's limited literacy and numeracy skills. The man said he would only consider one to one tuition as he found it difficult to cope in groups.

29. On 16 February, the hostel manager spoke to the man about his alcohol consumption. The man told him that he was drinking two cans of lager a day. The manager warned him about the consequences of mixing alcohol and his medication and the man told him that he had always done this and there would not be a problem. Following this meeting the manager spoke to the offender manager and confirmed that the man had tested positive for heroin and crack cocaine on 13 February. The hostel manager also made an entry on the man's electronic log.

30. The offender manager told my investigator that she considered recalling the man to prison after his drugs test. She discussed it with her senior probation officer and the Town Moor staff and it was decided not to do so. She said the man was adamant that it was a one off incident. It was not unusual for someone with his profile to use on release. He was now engaging with his DIP workers. The offender manager said that a further failed drug test would have put a different complexion on the matter, but the man tested negative on 20 February.

31. On 19 February, the man went to help on a church allotment project run by the chaplain from Doncaster prison. On his return he told staff that he had enjoyed the day and would be going again on 21 and 23 February. That afternoon he attended a three way meeting with his offender manager and a probation service worker from Town Moor. At the meeting it was decided that the offender manager would work with the man on victim and racism awareness at their weekly meetings. The meeting discussed the man's continued need to work with the DIP workers, especially in the light of his recent drug test. The man said he was no longer keen on taking Antabuse, and it was decided that a programme to help him manage his alcohol intake might be more appropriate for him. The man expressed a willingness to do the assessment for the Education Training and Employment (ETE) course and thought was given to how he could do the coursework without attending a group session. The man asked whether he could go back to living on the streets when his licence expired because he found it less stressful. He was

given information about supported accommodation and seemed happy with the idea of it. The man was praised for his behaviour in the hostel and his conduct at the meeting.

32. On 20 February, the man tested negative at his weekly drug test. Later the same day he attended an appointment with a DIP worker. He returned to the hostel smelling strongly of alcohol but staff noted that he did not appear drunk.

33. On 21 February, the electronic log sheet shows the man left the hostel at 2.29pm to go into Doncaster for "a beer". He returned at 3.34pm and staff noticed he smelt of alcohol. The man went out again at 4.35pm and returned in the evening. At 10.59pm, a member of staff noted that the man had not come down to take his evening medication. He went to the man's room to remind him but was unable to wake him.

34. At 8.30am on 22 February, the hostel manager was told at the morning hand over meeting that the man had missed taking his medication the previous evening. The manager then attended a monthly team meeting at 9.00am and went up to the man's room at about 11.39am. The manager told my investigator that he was not worried about the man, but intended to speak to him because not taking his medication was a breach of his licence conditions and he thought he might have to recall the man to prison. When the manager entered the man's room he found him dead in bed. An ambulance was called and paramedics confirmed that he was dead. The toxicology report indicates that the man had died from an overdose of heroin.

The response to the man's death

35. The deputy hotel manager provided the paramedics with personal information about the man and the police were called. The deputy manager informed an assistant chief officer with South Yorkshire Probation, and she came straight to Town Moor. The deputy manager and the assistant chief officer told the residents in the hostel of the man's death. One of the residents told staff that he had seen the man "hanging around with some wrong 'uns" during the day and drinking heavily. The police visited the man's mother and broke the news of his death. The offender manager was told and she informed other people that had worked with the man.

36. Town Moor does not have its own local instructions telling staff what procedures to follow in the event of the death of a resident. The hostel manager told my investigator that he printed off a copy of Probation Circular 02/2004 'Deaths of Approved Premises' Residents'. All subsequent contact with the police and the Coroner was recorded on the man's electronic log file.

37. On 27 February, the man's mother and step-father visited Town Moor to collect the man's belongings. They spoke to the manager and deputy manager and spent some time alone in the man's room.

WHAT STAFF AND RESIDENTS SAID

38. The seconded probation officer at Doncaster prison, said that he had known the man since before he was released on licence to the care unit. He said when he first met the man he was not at all co-operative and did not want anyone to ”interfere” with him. He said the man had a strong sense of his own independence and was very much “his own man”. The seconded probation officer said he thought the man’s attitude had changed and he was making progress. He said the man was “delighted” when he was accepted at Town Moor. He added that the man had always told him the first thing he would do on release was to go to Tescos and get drunk. He was impressed that the man had continued to see his DIP workers and had gone to the allotment project.

39. The man’s offender manager, said that she had spoken to the seconded probation officer when she had first been given the man’s case. She said the man had initially not seemed very co-operative and had always said that he would drink on release. She thought that his attitude changed after the MAPPP in January and the man asked to see the DIP workers again. She said she had been concerned that the man would breach his licence within a week of release, but he settled well at Town Moor and was engaging with DIP and DAS. The offender manager said the man had really enjoyed the allotment project and she had decided to relax his curfew to allow him to attend the project all day. She had not had a chance to begin work with the man on his racism and violence issues, and was in the process of arranging a mental health assessment for him. She had discussed the man’s drinking with him. She said the man knew it was a problem but he had not been drunk or aggressive in the hostel.

40. A DIP worker said he had known the man for between 12-15 months. He said it was a departure for the man to accept a hostel place because he had always been resistant to going to one. The DIP worker said he thought there had been a definite change in the man's behaviour on his release to Town Moor. He thought that the man had realised that he wanted to live his life in a different way and that his behaviour was affecting other people including his children. The DIP worker said he thought the man was doing very well at Town Moor. He had discussed the man’s drinking with him and was satisfied that he had it under control. The DIP worker said he was “devastated” when he heard the man had died. He thought that drugs were no longer part of the man’s life and that he was “walking the walk as well as talking the talk”.

41. Another of the DIP workers said that he had known the man for over a year and had visited him in HMP Doncaster before his release to Town Moor. He said that the man had suffered years of addiction but appeared to be addressing his drug problem before he died. He said that the man had appeared very positive about his future.

42. The man’s key worker described him as “a sound bloke, really motivated”. He said the man had wanted to see his children and came across as self-

aware. He said the man knew that if he did not take his medication he became “not a nice person”. The key worker said the man appeared very positive. He enjoyed his son’s birthday and seemed to be very happy. He was well liked in the hostel and was always polite and courteous. The key worker thought the man had been pleasantly surprised by Town Moor as his previous experience of hostels had not been good. He was shocked by the man’s death.

43. A resident at Town Moor, said he had known the man for two or three years. He described the man in Town Moor as “alert”, “happyish” and “chatty”. He said the man obviously enjoyed working on the allotment project and had talked a lot about his children and the family dogs. The resident said the man had been especially cheerful after his son’s birthday meal when he had eaten a 52oz steak. He said he had talked to some of the man’s friends and they had also thought that he was doing well. The resident said he had been concerned that the man was starting to drink more and he had told him to be careful. He said the night before he died the man was laughing and joking. He was very surprised when he found out the next day that the man was dead.

ISSUES CONSIDERED DURING THE INVESTIGATION

The man's allocation to Town Moor

44. The Parole Board said in November 2006 that the man should be released to accommodation that could provide supervision of the man's medication and mental health support. It also recommended that the man undertake a mental health assessment. I consider that Town Moor was an appropriate allocation for the man. Staff were able to supervise his medication and keep a record of when he took it. The hostel is visited by a Community Psychiatric Nurse and two psychiatrists. The man's electronic log file shows that, at the time he died, the offender manager and staff at Town Moor were in the process of arranging a mental health assessment for The man via his GP.

45. Town Moor staff took appropriate steps to reassure themselves about the man before he was accepted for a place. A MAPPP was convened in January and the exact details of the man's licence were determined before his release. Staff told my investigator that they were pleasantly surprised when they met the man. They were concerned about him because they had heard about his reasons for recall and his attitude to other prisoners. They were also concerned about the number of additional conditions on the man's licence. When they met him they found him to be cheerful and polite. As noted at paragraph 46 above, the man's keyworker, described him as "a sound bloke, really motivated". Although Town Moor staff spoke to the man's offender manager and SYPS staff attended the MAPPP, no one had met the man before he arrived at the hostel. It may have helped them come to their decision if they had visited him in Doncaster prison, in the same way he was visited by the DIP workers.

I recommend that, should a similar situation arise in the future, Town Moor staff should consider visiting prospective residents before they are accepted for a bed.

The man's management in Town Moor

46. The man was released with the following additional licence conditions:

- Notify your supervising officer of any developing relationships with women/men
- To comply with any requirements specified by your supervising officer for the purpose of ensuring that you address your domestic abuse and violent offending behaviour problems
- To comply with any requirements specified by your supervising officer for the purpose of ensuring that you address your alcohol/drug offending behaviour problems by attending appointments made with substance misuse workers
- Not seek to approach or communicate with two named people without the prior approval of your supervising officer or social services

- To comply with any requirements specified by your supervising officer for the purpose of ensuring that you address your racist behaviour problems
- To attend all appointments arranged for you with a medical practitioner and co-operate fully with any care or treatment they recommend, to register with a general practitioner within two days of your release as directed by your supervising officer
- Confine yourself to an address approved by your supervising officer between the hours of 2.00pm and 2.30pm daily unless otherwise authorised by your supervising officer
- To permanently reside at Town Moor bail hostel and must not leave to reside elsewhere without the prior approval of your supervising officer.

47. With the exception of missing his evening medication on 21 February, The man complied with all these conditions. He observed the daily curfew and attended all his appointments with DAS and the DIP workers. He registered with a GP within two days of release. He agreed to address his racist and violent behaviour in weekly sessions with his offender manager. In addition, he complied with the hostel rules requiring him to register for benefits with social services.

48. On 19 February 2007, the man began work on the church allotment project run by the chaplain at Doncaster prison. By all accounts, the man thoroughly enjoyed this work and consideration was being given to relaxing his curfew so that he could spend all day there. The man was unable to work on his release, and engaging him in purposeful activity was an important way of preventing the boredom that could lead him back to taking drugs. I note also that consideration was being given to ways of helping the man undertake an ETE course.

49. The man openly drank alcohol on a daily basis as soon as he was released and he tested positive for heroin and cocaine on 13 February. Both these occurrences were discussed by his offender manager, her supervising officer and Town Moor staff. It was decided that it was not appropriate to revoke the man's licence and return him to prison. I consider that this was sensible. It is not unknown for prisoners to lapse on release and then begin the hard work involved in addressing their alcohol and drug problems. I agree that a further positive drug test would have put the matter in a different light. I note that the substance misuse workers who had known the man for some time were impressed with his motivation during his time at Town Moor.

50. The man was tested for drugs regularly and randomly during his time in Town Moor.

The response to the man's death

51. The man was already dead when he was found by the hostel manger on the morning of 22 February. The ambulance and police were called promptly

and a log of all subsequent contact was kept. My office was contacted on the same day. A copy of Probation Circular 02/2004 was obtained and its instructions followed. The other residents were told promptly what had happened. The man's friend said he was happy with the level of support he had received from staff following his friend's death.

52. I am pleased that the man's mother and step-father were able to visit Town Moor, talk to staff and spend time in his room alone. This was good practice.

CONCLUSION AND RECOMMENDATIONS

53. The man appeared to be doing well at Town Moor. He complied with the extra conditions on his licence and engaged with substance misuse workers and his offender manager as required. He appeared to have discovered a new motivation for changing his life and breaking the pattern of addiction that had been his curse for so long. Sadly, he does not appear to have been able to remain drug free. I believe the man was well managed by probation staff during his time in Town Moor and his death could not have been foreseen or prevented.

54. I make a single recommendation:

> **I recommend that, should a similar situation arise in the future, Town Moor staff should consider visiting prospective residents before they are accepted for a bed.**