

**Circumstances surrounding the death a resident in May 2004, at a
Probation Service Approved Premises.**

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

September 2004

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FOREWORD

My office undertook this investigation into the death of a young man apparently from an overdose of non-prescription drugs. The young man was a resident of Approved premises while he was on bail, awaiting an assessment for a Drug Treatment and Testing Order.

The purpose of my investigation was to discover if risk of self-harm had been properly assessed and managed, and to consider whether a sufficient level of care had been provided to the young man by the hostel.

The investigation was carried out by a senior member of staff from my office, with the assistance of an Assistant Chief Officer (ACO) from the Probation Area. My thanks go to the ACO for facilitating the investigation, for providing policy advice and for interviewing staff. I am grateful for the co-operation that

the Investigators received from the Probation Area and, in particular, from the Manager and members of staff at the Approved Premises.

The death of one of your children - whatever their age - is a devastating experience for the parents. I am especially grateful to the young man's parents for agreeing to meet with the Investigators at what was a very emotional time for them. They provided information about their son that was helpful to the investigation. The parents wanted the answers to specific questions about the hostel regime and I have attempted to answer those questions in this report. Their deep distress at the loss of their son was evident and I offer the family my sincere condolences.

The Investigators conducted formal interviews with the Manager and Operational Manager of the premises, with four members of the hostel staff, with two Probation Officers who were involved in the young man's assessment and with a Probation Service Officer who worked with him. The interviews were not recorded but the Investigating Officers' notes have been agreed, and signed by interviewees.

The Investigators obtained information, by telephone, from the young man's aunt, Specialist Drug Services, the Assistant Chief Officer (ACO) with responsibility for hostels, and a Manager from the Drug Management Team. They also examined a variety of documents readily provided by the Probation Area.

SUMMARY

This young man of 25 years had a history of drug use from his early teens, despite all the best efforts of his family to help him. He was due to be sentenced for offences of dishonesty related to his drug abuse and, in April 2004, he was remanded on bail to reside at the Approved Probation Premises where he was to be assessed as to his suitability for a Drug Treatment and Testing Order.

The young man had become drug free during the time he had spent remanded in custody but he tested positive for opiates upon his arrival at the hostel and admitted that he had used drugs on his last night in prison. He admitted to further lapses during the 12 days he spent in the hostel but otherwise continued to demonstrate a mature attitude and was allowed to stay. He was considered suitable for the Order.

By early May 2004, the young man had given two negative drug tests and was happy that the Court could be given a positive report about his progress. Later that night there was an altercation in the hostel that prevented the Night Supervisor giving as much attention as he might otherwise have done when the young man sought assistance around midnight.

On the morning his death was discovered, unusually, the young man missed the house group meeting. When a member of staff went to check on him, he was found unconscious on his bed and it became clear that he had died.

Although I have reached the conclusion that this young man's death would have been difficult to predict or prevent, I have identified areas where management systems, communication procedures and staff induction could be improved. I have made five recommendations.

PART ONE

Background Information

Section one – The young man

The young man was born in 1978 and was 25 years of age when he died. He was the youngest of his mother's six children and was part of a large, close-knit family brought up in the area. His is a sad, but all too familiar, story of a young man for whom the use of drugs overtook everything else in his life despite the best efforts of his family.

The young man began to experiment with drugs during adolescence and, although his parents took him to Scotland, away from his drug using friends, his drug use escalated during the following years. By his early twenties he was a regular intravenous drug user. He told probation officers that he used heroin to mask the effects of 'coming down' after smoking crack cocaine.

He sometimes committed petty offences of dishonesty to fund his drug use and, at Edinburgh Sheriff's Court in March 2003, after the commission of drug and alcohol related offences, the young man was sentenced to a Community Rehabilitation Order. He lost his place in the family home when the extent of his drug use became known to his father and he was then, effectively, homeless.

The young man moved back from Edinburgh in July 2003. He was largely estranged from his family who had become exhausted by their efforts to cope with his mood swings and character changes when he was under the influence of drugs. Nevertheless, he maintained regular contact with an aunt, with whose family he stayed occasionally, and, albeit to a lesser extent, with his mother who arranged to meet him from time to time.

On several occasions the young man made up his mind to address his drug use that was costing him around £120 a day at its height. When he was using drugs he could not recognise the effects of his behaviour upon others but, when he was 'clean', he acknowledged the futility of his lifestyle and the distress it caused.

After a short period of custodial remand in January 2004, the young man appeared at Magistrates' Court for offences of shoplifting and sentence was deferred. During the deferment he signed on for benefit, referred himself to a drug treatment agency and kept in regular contact with a probation officer.

Sadly, he was unable to maintain his good intentions and committed further shoplifting offences for which he was remanded in custody.

The Detoxification the prison confirmed that, at the young man's request, he was blood tested once and urine tested twice during April 2004. All of those tests were negative. When visited by a probation officer for the preparation of a pre-sentence report, the young man suggested that a short prison sentence might enable him to stay drug free and could, therefore, be the best thing for him. However, he also acknowledged that he would face the same difficulties on release.

He was assessed as being reasonably motivated to address his drug use but, to further test his motivation and his suitability for a Drug Treatment and Testing Order, it was decided to request that he be remanded on bail for assessment during a period of residence at the Approved Premises.

With this in mind, later in April, at the prison the young man was inducted into the use of naltrexone, a drug prescribed to counteract the craving for and effects of heroin. He was given an explanatory booklet and staff stressed to him the dangers of taking illegal drugs with naltrexone. He was also given a 'naltrexone users card' to carry in case of accident.

The young man was released from the Magistrates Court with conditions to reside at the Approved Premises, to abide by the financial and disciplinary rules of the hostel, and to keep all appointments with the drug team as directed. Upon release, he was given 7 days' supply of naltrexone.

During his short stay at the hostel the young man presented no management problems and was perceived to be a quiet, benign presence, slightly apart from the main group of residents although liked and respected by them. Staff members had not been able to get to know him well but found him to be motivated with a positive attitude.

From his input into a group work session a few days before his death, it is evident that the young man felt positive about the future, hoping to make amends to his family and be reconciled with them. His key worker described him to the Investigator as one of the nicest lads he had worked with and he was deeply saddened by the young man's death.

Background information

Section two – The Approved Premises

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

accommodated in Approved Premises is governed by the National Standards for the Supervision of Offenders.

The Approved Premises is one of four hostels in the Probation Area. and is very much a part of the Drug Management Strategy for offenders in that area. There is a partnership between the Probation Area's Drug Management Team (DMT), a Specialist Drug Service and the two hostels for drug users. A Day Care Centre is also included in the partnership to provide therapeutic input by means of group work sessions.

Under the terms of the protocol drawn up by the partnership agencies, the Approved Premises is maintained as close to abstinence as possible, whilst it is recognised that residents in the other house are often somewhat less settled and may still use drugs from time to time. Hostel staff are not empowered to search individuals but residents are drug tested twice weekly and rooms can be searched. There is a protocol that residents should be required to leave the hostel if they twice test positive. Any resident of the Approved Premises who is not a management problem could be transferred to the other house if such a move was thought to be in the offender's best interest.

It was the hostel's policy to search one or two rooms, randomly, each day. Since the young man's death, it has been decided that further preventative measures are necessary and any resident, whose test indicates drug use, has his room searched daily. I commend the hostel for taking such positive action promptly.

The hostel is a conversion of three terraced houses. There are eight single rooms, two shared rooms and two others for use in emergency. The hostel can take 12 residents and has been full for most of the time during the past year. Residents can be bailed for Drug Treatment & Testing Order (DTTO) assessment, subject to a DTTO or subject to licence, but all would be managed through the Drug Management Team (DMT).

Night cover is provided by a Night Supervisor, on duty throughout the night, and an Assistant Manager, who sleeps on the premises.

In addition to the accommodation provided, each resident has a Key Worker and there are additional services available as follows:

A Probation Service Officer from DMT runs a life skills group each Wednesday.

Alcoholics Anonymous and Narcotics Anonymous attend on alternate Fridays.

A hepatitis nurse attends twice monthly.

Various volunteers attend - a personal trainer weekly, a counsellor once or twice a week, a provider of basic literacy and numeracy skills, a debt manager and floating support workers (FSWs) from the Cyrenians. FSWs are funded through a government scheme to provide support for up to 2 years for those

who are rehoused from being homeless. The FSWs cannot find accommodation but they can help residents through the processes of applying for benefits, setting up utility accounts, etc.

There are also two cluster houses (soon to be replaced by one larger house) for move-on accommodation.

PART TWO

Events leading up to the young man's death

Section one – The young man's time at the Approved Premises

The young man was admitted to the Approved Premises on the day he arrived and went through an induction procedure. A urine test carried out that day proved positive for both cocaine and opiates and he subsequently admitted that he had used drugs on his last night in prison.

He tested positive a second time two days later but the reading was lower and as heroin can take up to five days to pass through the system, this was not considered to be serious. It was noted that the results of the test were likely to have been connected to the earlier use. However it was subsequently discovered that the young man took heroin on a night in April and disclosed the lapse the following day during a group work session for residents facilitated by the DMT Probation Service Officer. Details of the group discussions are not recorded on residents' personal files and the young man's disclosure was neither noted nor brought to his Key Worker's attention.

I appreciate that the knowledge that group discussions are not recorded may encourage greater openness and honesty from hostel residents but if matters of concern are entirely confined to the group, it is not possible to provide the necessary advice and support.

I recommend that the hostel should take steps to establish a procedure requiring information pertaining to risk, however it is acquired, to be recorded and made available to relevant members of staff.

The young man attended each of the daily group work sessions and met with his Key Worker as required. Records of those meetings indicate that he was positive about the possibility of being sentenced to a DTTO and talked of his plans to try for a college course or training programme if he could become drug free.

Although the young man received support from hostel staff and from the DMT, he was not given an appointment with the Specialist Drug Service. His first appointment with that service was arranged for six days after his next court appearance, provided the court made a Drug Treatment and Testing Order on that day.

Early in May, the young man told his Key Worker that he had used heroin the previous weekend, and the following day he again tested positive for opiates and cocaine. He also admitted that he had quickly stopped taking the naltrexone provided by the prison, which would have reacted badly with heroin and make him ill. When discussing the second lapse, the young man said that a planned reconciliation with a family member had not worked out and he had used drugs as a means of coping with his emotions. His case manager recorded that, with hindsight, the young man could recognise that there were alternatives available to him.

The hostel protocol is that residents will be asked to leave after two positive drug tests but this is not rigidly enforced for a number of reasons. Certainly it appears that the need to meet occupancy targets plays a part in the decision making process but, more important, is the aim of encouraging residents to help themselves to change their lifestyles.

There was considerable discussion between the case manager and the hostel about whether the young man should be allowed to remain. It was decided that, despite two (known) lapses, he presented as mature, realistic and highly motivated. He was therefore allowed to stay and assessed as suitable for a DTTO. A report was prepared for the forthcoming court hearing, proposing such an order. The young man was warned that any further lapses once the order was made could result in his place at the hostel being withdrawn and breach proceedings being implemented.

It can only be a matter of speculation as to whether the same decision would have been reached if it had been known that there had been a third lapse but, by the evening before his death, the young man had provided two negative urine tests. He was described as being very happy with the second one as he knew the test results would stand him in good stead at court. He, jokingly, told the Assistant Manager on duty to be sure to write down the result correctly. His key worker spoke with him on that day and noted that he seemed in a good mood, chatting about football and pleased with his test results. The young man went out during the evening and returned around 2230, in good time for curfew. The Key Worker gave him a breath test that was negative and the young man went upstairs, apparently to his room.

Events leading up to the young man's death

The night of the death

The Key Worker, who was the sleeping member of staff on the night was subsequently told that the young man had watched the television in another resident's room for some time before retiring. The other resident was asked to contact the investigation team before he left the hostel as part of a planned move but he did not do so. A further attempt at contact was made via a letter to his new address but there was no response. Accordingly, it has not been possible to verify what time the young man retired to his own room.

The Night Supervisor described the night as one of the hardest nights he had experienced during the (almost) five years that he had worked at the Approved Premises. He told the Investigator that there had been a situation with two residents, one of whom was drunk, being threatening and abusive and his attention was wholly focussed on diffusing the situation. He recalled that the young man came downstairs around 00:30 to complain that someone had stolen tobacco from his room and to ask what would be done about it. Although the young man was quite composed, the Night Supervisor observed that he appeared drowsy and thought he might have taken drugs. The Night Supervisor told the young man that he would make a note of the loss but did not do so as he was still trying to deal with a difficult situation that, in his words, 'consumed' him.

At 09:00 the following morning, the Assistant Manager – the young man's Key Worker - resumed duty and spent some time discussing the previous night's events with the Night Supervisor, deciding that one of the difficult residents from the previous evening should be evicted. The young man did not appear for breakfast but this did not surprise the Assistant Manager who said that, at weekends, some residents prefer an extra lie-in to a bowl of cereal. He told the Investigator that a member of staff will knock on each resident's door to wake them but nothing is done if a resident misses breakfast unless staff members are aware of particular concerns from the previous evening. No such concerns had been expressed about the young man.

The young man was also missing from the morning house meeting as were two other residents. It would usually be the Assistant Warden's responsibility to return to the main office after the meeting, prepare warnings for those who had missed the meeting and distribute them either by taking them to residents' rooms or by waiting until the resident appeared.

However, on this occasion, the resident to be evicted was told that he would have to leave. He did not take this well and refused to go quietly so that it was necessary for the police to be called. He persisted in hanging around outside the house, ringing the bell and creating a nuisance. Thus, it was some time before the Key Worker had the opportunity to express surprise that the young man had missed the group meeting for the first time. The other member of staff went to the young man's room, to check on him, around 11:15. When there was no reply to his knock, he opened the door and saw the young man lying on the bed. He also noted evidence of drug paraphernalia on the bedside cabinet. The worker had recently completed a first aid course and, knowing that time was of the essence, he made no attempt to resuscitate the young man but hurried downstairs to arrange for an ambulance to be called.

He then returned to the young man's room as speedily as he could to try mouth to mouth resuscitation but all the signs were that he had died. His death was pronounced by the paramedics upon their arrival.

PART THREE

Consideration and conclusions

It was my role to consider if the risk of self harm had been properly assessed and managed, and whether the level of care provided for the young man at the Approved Premises was adequate. In doing so, I also considered whether the hostel procedures were clear to staff and commensurate with the requirements for all such hostels as defined in the Approved Premises Handbook.

The young man was interviewed in prison in April 2004 by an experienced officer responsible for assessing and supervising offenders subject to Drug Treatment & Testing Orders. Before meeting the young man, the officer had seen the OASYs assessment and the Pre Sentence Report (PSR) prepared for the court and she found nothing to concern her in either document.

She was aware of a previous incident when the young man had overdosed but he was vague about it, recalling only that it was accidental and he had been in hospital for a matter of hours. She knew that he had remained drug free in prison and he had a positive attitude.

The officer indicated to the Investigator that accidental overdosing is relatively common amongst offenders with a history of intravenous drug use. Therefore, during the interview she discussed safe practices with the young man together with the risks of lapse and relapse. She particularly reminded him that his tolerance to drugs would be reduced after a period of abstinence.

The Approved Premises Drug Management Team Protocol states that the induction of all new residents should commence within 24 hours of their arrival at the hostel and that the process will include an explanation of hostel rules, an introduction to the hostel programme and a briefing on health and safety issues with particular reference to the dangers of drug use and overdose, and support to maintain abstinence. During the induction process residents are required to sign a number of forms but there was no evidence in those documents that these warnings about tolerance and overdose were repeated to the young man.

I recommend that a form should be devised and included in the induction pack for residents to sign, indicating that they have been given the necessary warnings and advice.

There are clear procedures in place at the Approved Premises for daily events of note to be recorded in the hostel log. The members of staff interviewed were familiar with these procedures and ensured that entries were kept up to date. The daily hand over process enables colleagues to share information and ensure that both events and their assessments of situations are made known.

However, the young man's disclosure of drug use during a group meeting was neither recorded nor shared with his Key Worker and the Investigator found a lack of instruction for various areas of work. Members of staff interviewed were unclear about how some tasks should be undertaken. For instance staff were not certain whether room doors should be opened either when waking residents in the morning, or when carrying out a routine hostel check. Expectations did not appear to be clarified and the Investigator could not identify a clearly defined, structured process for the induction of new staff. Much of what is required appears to be relayed by word of mouth from others doing the job, which can lead to a lack of consistency.

The Investigator was subsequently informed that an induction procedure for new staff was introduced shortly before the young man's death but staff members who had been in post for some time did not know of it.

I recommend that the Probation Area reviews its procedures for the induction and instruction of all staff with a view to providing clearer written guidelines.

My Investigation revealed that most DTTO assessments would be undertaken during a custodial remand with the assistance of drug workers and healthcare staff in prisons. If there is any element of doubt about the level of an offender's commitment, then a further period of bail assessment is used as it was in the young man's case.

When an individual is released from prison on bail with a short supply of naltraxone, the expectation is that the Specialist Drug Service will provide a fast-track service to re-prescribe. My Investigator was told that the expectation is often not fulfilled. As the medication cannot be renewed without the Specialist Drug Service's involvement, individuals are put at increased risk. Although the young man had stopped using naltraxone, the lack of an appointment with the Specialist Drug Service during the bail period deprived him of specialised assistance.

Funding for the Specialist Drug Service is provided through the Joint Commissioning Group of the Area Drug Strategy team and it is possible that there is an under fund. The Service is funded to provide 93 commencements of DTTOs during 2004/05 financial year but the Area DMT target is 141 commencements. The agreement for the Specialist Drug Service to see those on bail is not yet ratified by a Service Level Agreement (SLA) although the Investigator learned that a draft SLA is currently being discussed with a view to ratifying it as soon as possible.

Although it is not for me to prescribe the agreements that the Probation Service should reach with its partnership agencies, it seems clear that the services purchased for the provision of drug treatment should be available to all offenders for whom the area has a duty of care, whether or not they are subject to DTTOs.

I recommend that the Probation Area draws this report, and my view that treatment providers should be funded to the level necessary to meet national targets, to the attention of the Area Drug Strategy Team.

There is one final issue that I wish to bring to the attention of the Probation Area. The events in the Approved Premises on the night of the young man's death were unforeseen and potentially explosive with two residents causing considerable problems for the experienced Night Supervisor. I have no doubt that he dealt with those difficulties in a thorough, professional manner but in doing so he was unable to give his full attention to the young man.

In the job description, one role of the Night Supervisor is described as

"To alert the on-call duty Assistant Manager to any emergency situation in accordance with the handbook."

My Investigation discovered that, in practice, Assistant Managers are rarely woken and that the circumstances in which they should be called by Night Supervisors are open to interpretation. The Investigator was told that the sleeping-in person would only be woken if there was an unmanageable situation but that such situations are likely to be defined differently, according to the level of confidence and experience of the Night Supervisor.

I recognise that it would not be possible to define precisely what constitutes an unmanageable situation as the competence and confidence of individuals varies. I am concerned, however, that there may be different reasons why a Night Supervisor would not wake a colleague even if a situation was getting out of hand.

I recommend that the Probation Area considers whether it is necessary to develop clearer guidelines for staff on duty in hostels overnight.

Recommendations

I recommend that the hostel should take steps to establish a procedure requiring information pertaining to risk, however it is acquired, to be recorded and made available to relevant members of staff.

I recommend that a form should be devised and included in the induction pack for residents to sign, indicating that they have been given the necessary warnings and advice.

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**STEPHEN SHAW
OMBUDSMAN**

SEPTEMBER 2004