# Circumstances surrounding the death of a resident in Probation Services Approved Premises in June 2004

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

**October 2004**

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## FOREWORD

This was among the first investigations that my office has undertaken into a death of an Approved Premises' resident. It was occasioned by the death of a resident at a Railway Station in June 2004.

The purpose of my investigation was to discover whether the level of care provided for the resident by the Approved Premises was sufficient and, in particular, whether the likely risk of self-harm had been properly assessed and managed. My full terms of reference are attached at Annex 1.

A senior member of the Prisons and Probation Ombudsman's Office, carried out the investigation with the assistance of a District manager from the Probation Area. I am grateful to the District Manager for facilitating the

investigation, for providing policy advice and for interviewing members of staff. I am also grateful for the co-operation that the Investigators received from the Probation Area and, in particular, from the Manager and staff at the Approved Premises. Very helpful comments were also received from the National Probation Directorate and from the Probation Area when the report was sent to them in draft.

The death of a son is a devastating experience for parents, no matter what has gone before, and the death of their son in such shocking circumstances was particularly distressing for the resident's parents. I am especially grateful to them for meeting with the Investigator at what was a very emotional time for them. Their grief over the loss of their son was evident and I offer my sincere condolences to them and their family.

The Investigators conducted formal interviews with the Hostel Manager, a member of the hostel staff, a Probation Officer who prepared a pre-sentence report on the resident, and with his supervising officer. The interviews were not recorded but the Investigators' notes have been agreed and signed by interviewees.

The Investigators obtained information, by telephone, from a hostel resident and they examined a variety of documents provided by the Probation Area.

The report is organised as follows. Part 1 provides some personal details about the resident and information about the Approved Preemises. Part 2 considers, as far as it is possible to do so, the circumstances surrounding the resident's death. My conclusions and recommendations are presented in Part 3, and two Annexes complete this report. As the reader will discover, it is a dismal story of breakdown in communication and lack of offender management.

**STEPHEN SHAW**
**PRISONS AND PROBATION OMBUDSMAN OCTOBER 2004**

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## SUMMARY

The resident was 22 years of age when he died. He began experimenting with drugs when he was a teenager and became a multi drug user over the ensuing years. He appeared to understand the dangers of his lifestyle but seemed powerless to change it, funding his drug use through acquisitive offending.

On 14 May 2004, the resident was due to be sentenced at Crown Court for offences of residential burglary and was facing a custodial sentence. Following a custodial remand, he was thought to be drug free and he was bailed for a period of residence at the Approved Premises to be assessed for a possible community sentence.

The process by which the resident was admitted to the hostel was confused and chaotic. Initially, he had been found unsuitable for residence, but the decision to refuse him a place was not conveyed to the referring officer nor to the Court. The Approved premises was informed that he was to reside there when he was actually on his way.

The young man arrived at the hostel during a very difficult period but settled well and, initially, gave no cause for concern. On 11 June at Crown Court, he was sentenced to a 12 months' Drug Treatment and Testing Order (DTTO).

Over a short time, the members of Approved Premises staff in closest contact with the resident came to suspect that he was continuing to use drugs and he confessed as much to those supervising him in the Drug Treatment and Testing team. Very regrettably, the information was not shared between the two teams and a risk management plan was not put into place.

On a morning in June 2004, after an altercation with a hostel worker over an incorrect benefit payment, the resident left the hostel and did not return that day. At 24:00 that night, the hostel was informed by telephone that he had died from an apparent drug overdose at the local Railway Station earlier in the evening.

The investigation has revealed an appalling series of breakdowns in communication between the Court, the hostel, the drugs agency and the DTTO team responsible for this man's supervision and treatment. While better communication might not have prevented his death, there are significant lessons to be learned. The Probation Area has acted promptly following these sad events. However, I have identified areas where communication systems could be improved and have made four recommendations that can be found in Part 3. Section 2.

## THE CIRCUMSTANCES AND EVENTS SURROUNDING THE RESIDENT'S DEATH

### PART ONE - Background Information
### Section 1: The Resident

The resident was brought up within a loving family environment but despite this, he began using drugs during his teenage years, and experimented with whatever drugs he could obtain. His parents described how information pamphlets, designed to educate young people about the dangers of drug use, only made him more curious and increased his consumption. When he was aged 14, he was excluded from school.

He funded his drug use through offending and he received his first custodial sentence when he was aged 16, around the time he first used heroin intravenously. Thereafter, he admitted that he used heroin, cocaine, cannabis and at times, alcohol, on a regular basis.

It was beyond his parents' best efforts to help the man despite sending him to stay with his paternal grandparents, away from his home area, from time to time. His drug use continued and his behaviour deteriorated to the extent that everything of any value in the home had to be locked away. Finally, when the police called at the house, with dogs, looking for drugs, his parents felt they could no longer put their other family at risk and, consequently, their son was asked to leave.

By the time he appeared in Court, during April 2004, charged with domestic burglaries, the man had acquired some 30 previous convictions for offences of dishonesty, all committed to fund his drug use. He was regarded as a persistent offender and had changed from an ordinary young boy into someone his family could hardly recognise.

The man was remanded in custody for the preparation of a pre-sentence report and was interviewed by a Probation Officer in prison in May 2004. He told the Probation Officer that he knew he needed help to overcome his habit of drug abuse. He said that during the remand period he had detoxified and was drug free but he worried that upon release he could return to his old ways. The Probation Officer was impressed with the man's insight into his drug use. The Officer thought that the man knew what he needed to do to stop using drugs but was struggling with the fact that he could not actually do it. It was the officer's opinion that the man needed to be away from his home area and his drug-using friends.

The report suggested that the man should be remanded on bail for four weeks with a condition of residence at the Approved Premises where he could be further assessed as to his suitability for a community order and the Court agreed. It was a further condition of his bail that he should not go to the area where many of his drug contacts congregated.

The man was on bail at the Approved Premises from 14 May 2004 until 11 June 2004, when he was sentenced to a 12 months' Drug Treatment and Testing Order (DTTO). The Approved Premises Manager said that, as there can be no condition of residence in a DTTO, it was made a requirement of the man's treatment package that he reside at the Approved Premises. The condition of bail excluding him from his home area no longer applied.

**Section 2 - 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. Approved Premises can provide a supportive, structured environment in the community for high risk and difficult to manage offenders. The management of offenders accommodated in Approved Premises is governed by the National Standards for the Supervision of Offenders.

The Approved Premises is one of three within the Probation Area. There are eighteen beds in fourteen single and two shared rooms one of which, on the ground floor, is equipped for special needs.

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

Over the last ten years or so, the profile of Approved Premises' residents has changed from low risk to high risk. Premises no longer simply offer accommodation for those who have nowhere else to go, and the purpose of the Approved Premises in this case is to provide an enhanced level of supervision for some of the most difficult and high-risk offenders in the community.

There is a curfew from 10.30pm to 10am (for those not working) but earlier curfew hours can be accommodated if made by the court. There is a rota of jobs for residents designed to improve their social skills. The housekeeper checks the satisfactory completion of these each morning before residents are allowed to leave the premises.

There is no full daytime programme of activities but there is a weekly group-work session that residents are required to attend, together with a monthly residents' meeting chaired by the Manager.

The staffing complement is:
Manager
Support Services Officer (contracts side, admin etc.)
5 Residential Services Officers who work a five-week shift pattern
2 night waking cover (there is one sleeping and one waking staff member each night)
Residential Administrative Services Officer
Housekeeper/Cook

Breakfast and cooked evening meals are provided.
Probation representatives at Court make referrals for straightforward bail beds to the two Residential Services Officers on duty. Prompt decisions are required and the Manager is only consulted if the two Residential Services Officers cannot agree upon the suitability of a referral. For those subject to orders or licences, who are likely to present a higher risk, the Manager makes decisions about suitability, after careful consideration, on the basis of information available from a variety of sources.

## PART TWO - EVENTS LEADING UP TO THE RESIDENT'S DEATH

### Section one: The resident's time at the Approved premises

The process by which the man was admitted to the hostel was chaotic. It has not yet been possible to unravel the confusion completely but I set out below what I think occurred.

The man was referred for a bail placement on 10 May 2004, by telephone, to a relief member of staff who took the required details and completed a referral form. The form noted that there were, "*2 x suicide attempts - overdose last year*" but, perhaps surprisingly, stated that he was not at risk of suicide/self harm. There was no evidence of further risk assessments undertaken during his stay at the premises. The man was refused a place as he had several convictions for residential burglary to fund his drug use and the Manager was concerned about the risk of re-offending to local residents. There was no decision noted on the referral form but on a separate 'Reasons for Refusal' form the decision is clearly indicated in the box marked 'risk to the community too great to be managed'.

Nevertheless, the pre-sentence report (PSR) put before the Court states at paragraph 17, "[*the hostel] is holding a bed available for [ this man] and would require a condition of bail……*".

The Manager told the Investigators that the PSR author was simply mistaken, as beds cannot normally be reserved. The procedure is for the referrer to be told that they should telephone on the day to check that a bed is still available. However, the referring officer was sure that he had made no mistake about the decision, as he was surprised that the Approved Premises had agreed to take the resident. It would be good practice for the Court duty officer to check with the premises that a bed is still available before bail is granted but, due to the wording in the report, this did not happen.

Accordingly, on Friday 14 May 2004, the Approved Premises was informed by the Court duty officer on the telephone that the resident was actually on his way to the hostel having been bailed by the court. As he was already on his way and there was a vacancy in a single room, the Manager took the view that he should remain over the weekend and the position could be clarified the following Monday. If the resident had posed a problem over the weekend, his bail could have been withdrawn but in fact he did not.

The man arrived at what was described as a very difficult time for the Approved Premises as there had been some adverse publicity in the local area and members of the public had staged a demonstration outside the premises.

Although the premises was fully occupied when the man arrived, moves were arranged for some residents and no new referrals were taken until the situation calmed down. Despite all the difficulties, the man settled in well over the weekend, complied with rules and was described as being "*pleasant about*

*the place*". He was not aware of the mix up over his referral and he was allowed to remain.

However, when the Manager subsequently received a copy of the man's bail form, she was surprised to learn that he had been bailed for a Drug Treatment and Testing Order (DTTO) assessment. The PSR also stated that, previously, the man, "*had the opportunity to use the Drug Treatment and Testing Team* " but had failed to attend as required. The view of the DTTO team was that, as the man had been unable to demonstrate motivation to change in the community and was doing so only when in custody, he was not yet suitable for consideration.

The Manager explained to the Investigators that the Approved Premises has been accepting residents for DTTO assessment and subject to DTTOs for about a year and that all such referrals should be considered by the Manager. At the time of the man's admission the referral form had been revised but the old form was also still in use. It has been recognised that this could, and probably did, cause confusion. To redress the situation, a new form has been devised for use within the Probation Area and is soon to be distributed around the area, as the old form is removed from the system. I commend the Probation Area for taking such prompt action to improve practice and avoid confusion over future referrals.

The man went through the induction process when the rules and safety regulations of the premises were explained to him. An appointment was arranged with the local GP who prescribed Amitriptyline to help the man sleep. The Approved Premises has an arrangement with the doctor and with the local pharmacy that prescriptions for hostel residents are delivered directly to the hostel. Medications are kept in a secure cabinet and dispensed to residents by hostel staff according to the doctor's instructions. The Investigators were satisfied that the man's medication was safely dispensed in this way.

The resident was given an introductory letter to the Benefits Agency to claim sickness benefit as a recovering drug user. He met his Key Worker when she came on duty two days after he arrived. She described him as a polite young man who impressed her as sincere and motivated. He cited his relationship with a young woman as an underpinning motivator and the Key Worker impressed upon him the importance of keeping to his bail conditions. The Man seemed sincere when he explained that he would meet his girlfriend elsewhere rather than going to his home area.

The purpose of the remand was to assess the man's suitability for a DTTO, at the Court's request, but there was no requirement for him to seek any treatment during the remand period. The Investigators were told that residents on bail assessment would usually have had an initial assessment, perhaps in custody, and would thus be known to the local DTTO team. They would be directed towards community resources during the bail period and supported by the Drug Management Team. This was not the case for this man who had not been referred to the DTTO team before arriving at the

Approved Premises, as the author of the pre-sentence report had not considered him suitable for assessment.

At a second key work session a few days later, the man appeared to have settled in and did not seem at all concerned by the problems of the 'mob'. He talked about the support of his parents and the need to prove himself to them, particularly to his father. However, given the lack of contact with the DTTO team, the Key Worker advised him to attend one of the local drug and alcohol advisory agencies on a voluntary basis although he was not obliged to do so.

Early in June, the man arrived back at the hostel some 20 minutes after curfew and was clearly worried about the possibility of breach. He provided an explanation about train times that the Key Worker was able to verify but she was concerned about his demeanour. The Key Worker had also noticed that the man had been spending time with other residents suspected of being drug users and recorded her suspicion that he was using illegal drugs.

The first available appointment that the Probation Officer in the DTTO team could give to the man for an assessment interview was on the day before his Court appearance and 27 days after he arrived at the hostel. The man told the officer he had been drug free for some nine weeks and demonstrated an awareness of the steps he needed to take to remain so, such as staying away from his home area where he would be more likely to be tempted by old acquaintances. Despite the earlier, negative assessment by another DTTO team, the DTTO team Probation Officer assessed him as suitable for the Order and wrote to the Court accordingly. It is expected that an offender’s motivation before and during the early stages of an order may not be very high. The National Probation Directorate (NPD) has confirmed that low motivation is not in itself a reason to find an offender unsuitable for a DTTO as motivation can increase when the offender is engaged during the programme. Nevertheless, with hindsight, the Probation Officer recognised that the man's motivation may have been the avoidance of a custodial sentence rather than a sustainable desire for a DTTO.

In Court the man was sentenced to a DTTO for twelve months. The first date for the Court to review his progress was set for one month's time. A programme was set up in which, in addition to keeping appointments with the Probation Officer in the DTTO team he was to be tested on Tuesday and Friday of each week. He was also required to attend a drug and alcohol treatment agency sub contracted to provide contact hours and treatment for DTTOs - three times weekly for treatment and counseling sessions.

About a week later, when his Key Worker returned to duty after a short period of planned absence, she noticed a significant difference in the man's behaviour and it seemed clear to her that he had used drugs. The man admitted to cannabis use but minimised it by saying that the Order had been a relief and he had briefly lapsed. The Key Worker arranged for a three-way meeting with the man and his Case Manager to take place 7 days later, to discuss and reinforce the requirements of the supervision plan.

My investigation has revealed that practice varies from Probation Area to Probation Area but, in line with health service policy locally, the Probation Area does not operate a policy of complete abstinence for those subject to DTTOs.

The expectation is that there will be a gradual move away from illegal to prescribed drug use and that illicit drug use will reduce over time. A progress report is presented to the Court on the review date and the Court will decide whether to allow the Order to continue on the basis of progress made. If there is no improvement and/or a lack of commitment, then the DTTO team may propose that the Order should be revoked.

There is no legal requirement for an offender subject to a DTTO to be abstinent and breach proceedings on the grounds of positive tests alone cannot be initiated. Although breach action in itself does not automatically lead to the termination of an order, as courts will usually take into account the chaotic nature of drug misuse, I am surprised that there is not greater standardisation in respect of the management of DTTOs across the country.

In my draft report I said I would be interested to know how many offenders die drug-related deaths while subject to a DTTO. The NPD has explained that, since April 2004, Probation Areas have been required to provide information as to how many DTTOs are revoked due to the death of the offender, although the cause of death is not recorded. Between April and August 2004 there were 27 cases recorded as “offender died” from a DTTO caseload of approximately 8000.

On 16 June 2004, the man told his allocated worker at the drug agency that, since being released from prison, he had used heroin and cannabis when he had returned to his home area and had contact with friends there. My investigation found no evidence that this information was relayed to the Approved Premises.

Two days later, on 18 June when he attended at the drug agency for testing, the man said he had used heroin intravenously the previous day, had accidentally overdosed and been taken to hospital by ambulance. The worker advised him about reduced tolerance to drugs after a period of abstinence but the information was not passed on to staff at the Approved Premises. Also on that day, the man's Key Worker described him as appearing "*under the weather*" and failing to return for dinner. She did not learn of the previous day's events until after his death when the man's mother confirmed that she had collected him from the hospital after the overdose and returned him to the hostel.

On 22 June 2004, when the man attended the treatment project for testing, he was given further advice about the need to use minimum amounts of drugs if he could not abstain completely and to use them in a safe environment. There was no evidence that this information either was relayed to the hostel.

My investigation identified a further significant issue over the assessment of risk. At the PSR stage, the Probation Officer commented that the man had taken two overdoses in recent years, "*one of tablets, the other of heroin.*" He did not give the source of his information but stated that the man was no longer suicidal as, he said, "*too many people would be upset if he took his life*". On that basis and using the OASys assessment tool, he assessed the man as being at medium risk of self-harm.

The PSR author completed the OASys form electronically as he was required to do but, at that time, the Approved Premises staff were not trained in the use of the electronic form and were unable to access it. No paper form was sent to the hostel. The District Manager confirmed to the Investigator that, subsequently, one member of staff at the premises has been trained to access and use the OASys form electronically. The Area is also working towards getting all SPOs, administration managers and Residential Services officers trained in the use of e-OASys and printing off the form for use in hostels at the earliest opportunity. I am glad that a problem area has been identified and dealt with swiftly.

I cannot say if a similar problem exists in other Probation Areas and I have no recommendation to make. Nevertheless, I hope that the National Probation Directorate will take whatever steps are necessary to ensure that such a useful tool as OASys is made easily available to all those within the Probation Service for whom it is appropriate and that they are familiar with the method of accessing it.

Since the man's death, the Probation Area has embarked upon the production of “Sudden Deaths” guidelines and a revision of the “Self Harm and Suicide” policy. Although these are in draft form as yet, I commend the Area for taking speedy action to review and improve its policies.

**Section two: The events of 23 June 2004**

In the morning post on 23 June 2004, the man received a giro-cheque for £12.59 from the Benefits Agency, from which he was required to pay £6.92 to the hostel for two days' rent and amenities. The payment was much less than he had expected and he became somewhat agitated. The cheque was accompanied by a letter stating that the man was not entitled to benefit after 3 June 2004 as he had not provided an ongoing sickness certificate. A member of the hostel staff tried to calm the man and explained to him that the Agency must be mistaken as there was a certificate on file to 24 June.

The man became very angry and verbally abusive towards the member of staff, despite her reassurances that she would intervene with the Benefits Agency on his behalf. The altercation ended when the man took the cheque from her and left the house, still in an agitated state. The staff member described him as, "*storming off."* For a time he was seen opposite the hostel talking to another resident but he did not return and he was not seen alive again at the Approved Premises.

At 21:40 there was a telephone call from a police officer to inform staff that the man would not be returning. No further details were given and it was not until 24:00 that the Approved Premises received information that, at the local Railway Station, the man had been found dead from a suspected heroin overdose.

## PART THREE: CONSIDERATION AND CONCLUSIONS

It was my role to examine the level of care provided to this man during the period of his residence at the Approved Premises and in particular, to consider if the risk of self-harm had been properly assessed and managed. In doing so I also considered whether any change in operational methods, policy, practice or management arrangements could help prevent a similar death in future.

The circumstances of the man's referral and admission to the Approved premises leave questions unanswered. My investigation has not discovered exactly how the misunderstanding over his suitability occurred, but it could have been avoided if the decision of the hostel had been clearly recorded and confirmed to the referring officer in writing. Although I am satisfied that the confusion itself did not have a direct bearing on the events of 23 June 2004, it is my view that the interests of offenders and those working with them in hostels would be better served if decisions about referrals are more clearly conveyed.

**I recommend to the Probation Area and to the National Probation Directorate that all decisions concerning the admission of residents to Approved Premises should be recorded and confirmed either electronically or by fax to the referring office. A copy of the email or fax should be kept in the Approved Premises' file.**

The assessment and management of risk have a crucial role to fulfill in the supervision of offenders, the more so when members of staff are in constant contact. It is something of an anomaly that those who may get to know most about an offender through their regular daily contact are not usually those responsible for the case management and authorised to make decisions.

My investigation confirmed that there are clear procedures in place at the Approved Premises for daily events to be recorded in the hostel log and 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. I have no doubt that the staff of the Approved Premises are dedicated, caring individuals who do their very best for the residents in their care, within the limits of their responsibility.

However, although the Key Worker's suspicions and concerns about the man's drug use were recorded and shared with her colleagues, they were not shared with the DTTO team as there was no recognised procedure for doing so. It was the Key Worker's intention to inform the DTTO officer at a joint meeting scheduled for 28 June 2004 but by then it was too late.

Those in the DTTO team had more than suspicions as the man had confessed his continued drug use to them but the knowledge was not relayed to the hostel. Consequently, although both groups of professionals working with the man were aware that all was not well, there was a failure to communicate, and the lack of shared knowledge prevented a joint risk management plan from being devised and implemented. I can only speculate as to whether the existence of such a plan could have helped prevent the man's death although I suspect that his reliance upon heroin at that time was considerable.

My investigation revealed that there are no national protocols for the arrangement of DTTO teams, which have developed in response to local need. In this area, the Probation Officer works in a multi-agency team with Health Service professionals based in Health Service premises, sharing a common file on each offender referred to the team. The Probation Officer speculated that Health Service staff might have lacked understanding about the nature of Approved Premises and, consequently, assumed that as information is readily available to the Probation Officer in the team, it was not necessary to inform the Approved Premises.

Whether or not that was so, the Probation Area has acted quickly to improve the levels of communication between staff in Approved Premises and the DTTO team. It has been agreed that the Approved Premises and the DTTO team will operate a policy of open communication and that offenders will be advised of this practice when they are assessed. Information about changes of circumstance such as positive drug test results or assessment of increased risk will be conveyed immediately by telephone and recorded. A weekly feedback form has been devised which will be completed by both DTTO Probation staff to the hostel and by hostel staff to the DTTO team.

Additionally, it is now expected that all individuals who are to be assessed for a DTTO with a condition of residence at the Approved Premises will, first, be required to undergo a four to six week period of bail assessment at the hostel, before a DTTO is proposed to a court. This will enable issues of concern to be addressed and a risk management / treatment plan to be implemented. I commend the Probation Area for quickly taking steps to improve practice in response to an identified omission. I suggest that further action should be taken to identify and prevent similar omissions should they exist elsewhere.

**I recommend that the National Probation Directorate issues guidance to all areas about the requirements of communication systems between Approved Premises and Case Managers, and considers carrying out an audit of compliance within 12 months of the guidance being issued.**

Drug taking is a risky activity at all times and better communication between those responsible for this man's treatment and care might not have prevented his death. However, this investigation has revealed a lamentable lack of communication between the court, the hostel, the drugs agency and the DTTO team together with an absence of purposeful offender management. If

lessons can be learned then I hope that at least some good may emerge from these sad events and the sorry loss of life.

**I recommend that a copy of this report is tabled for consideration by the Probation Board and that the Area sends copies to the DTTO team and the Management Committee of the drug agency. I understand that the Area is already implementing this recommendation, which they first saw in draft.**

**I further recommend that my comments on the need for greater standardisation in the management of DTTOs and the need for research into drug-related deaths of those subject to the Order be drawn to the attention of the Director General of the National Probation Service.**

I am aware that the National Standard for DTTOs sets out enforcement requirements and the NPD has said that it routinely monitors Probation Areas' compliance with the standard. I am pleased to say that, having seen this report in draft, the NPD has agreed to issue a reminder to all Probation Areas about best practice to prevent drug-related deaths.

**RECOMMENDATIONS:**

**I recommend to the Probation Area and to the National Probation Directorate that all decisions concerning the admission of residents to Approved Premises should be recorded and confirmed, either electronically or by fax, to the referring officer, and a copy of the email or fax kept in the Approved Premises' file.**

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**STEPHEN SHAW**
**OMBUDSMAN**

**October 2004**