

**Circumstances surrounding the death of a resident in Probation Service
Approved Premises in July 2004**

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

February 2005

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FOREWORD

This is a report into the death of a man who died from an apparent overdose of non-prescription drugs in July 2004. He was on life licence, resident in Approved Premises under the management of the Probation Service. The purpose of the investigation was to establish the circumstances and events surrounding the man's death, and to consider whether the quality of supervision and care provided to him by the Probation Service was adequate and appropriate.

Mrs Marian Morris and Ms Louisa Watkins from my office carried out the investigation with the assistance of, an Assistant Chief Officer (ACO). My thanks go to the ACO for facilitating the investigation, for providing procedural advice and for conducting a number of interviews. I am also grateful for the co-operation received from the Probation Area and from the staff of the Approved Premises.

The resident had spent many years away from his family but his death was no less painful for them. I offer the family my sincere condolences. I am especially grateful to them for agreeing to meet with my colleagues and for

welcoming them into their home. The information provided by the family was invaluable to the investigation. The man's parents wanted the answers to specific questions about their son's care and I have attempted to answer those questions in this report.

The man made choices about his own life and was clearly aware of the dangers associated with drug use. However, aspects of his supervision by the Probation Area while on life licence were frankly extraordinary, paying little heed to the risks to him personally or to society at large.

Investigation Procedures

The Investigators conducted formal interviews with the Manager and Operational Manager of the Approved Premises, with the man's Key Worker, with a previous Key Worker, another resident, a Probation Officer and a Senior Probation Officer all of whom were involved in supervising the man. The interviews were not recorded but the Investigating Officers' notes have been agreed and signed by interviewees.

The Investigators obtained information from a voluntary organization who worked closely with the man and from a Treatment Manager at a Drug Project. They also examined a variety of documents readily provided by the Probation Area and by the Drug Project.

The report is organised as follows. Part 1 provides some personal details about the man and information about the Approved Premises and its cluster house. Part 2 considers, as far as it is possible to do so, the circumstances surrounding the man's death. My conclusions and recommendations are presented in Part 3.

The Investigation uncovered discrepancies between the Approved Premises records and those of the supervising officer. Many questions arising from those discrepancies remain unanswered and aspects of the man's supervision left much to be desired, characterised by lack of communication and assessment. I draw several areas of poor practice to the attention of the Probation Area although I do not find that they contributed directly to the man's death. However, the failure of probation staff to identify the extent of his drug use and to take appropriate action was crucial.

**STEPHEN SHAW, CBE
PRISONS AND PROBATION OMBUDSMAN**

February 2005

SUMMARY

The man was released from a prison sentence in February 2003 on licence after serving 12 years of a life sentence for an offence of manslaughter by virtue of diminished responsibility. His family supported him throughout his sentence and his parents were happy for him to stay at their home on release. However, his offence had been committed in his parents' home area and a condition in his licence prevented him from returning there without the permission of his supervising officer. A further licence condition required him to reside initially at the Approved Premises and, thereafter, where directed by his supervising officer. The man remained at the Approved Premises until he was involved in a motor cycle accident and admitted to hospital with serious injuries.

It was known that he would have limited mobility for some time after his discharge from hospital and his parents asked if he could stay with them until he was fully recovered. However, because of the proximity of their address to that of his victim, permission was refused. When he was discharged, the man moved to a house under the management of the Approved Premises, where a ground floor room was converted for his use. He shared the premises with one other resident and was put in touch with a volunteer from a local organization who visited him weekly. There was a nightly telephone call from the Approved Premises and his allocated key worker was required to visit weekly.

In February 2004, a local police officer reported his suspicions that the man might be using drugs and he was tested. The test proved positive for cocaine and opiates and, when challenged, the man admitted cocaine use to his supervising officer. The supervising officer discussed the situation with the Lifer Unit and, as a consequence, the Assistant Chief Officer issued a formal warning to the man. Thereafter, weekly urine tests were negative for cocaine and positive for opiates. However, scant attention was paid to the possible indications of heroin use as it was assumed that this was accounted for by the man's opiate based medication for pain relief.

The man agreed to participate in a programme run by the a Drug Project and attended three times weekly from March to the end of May. During this time he shared information with the Drug Project staff about the extent of his ongoing use of and dependence upon heroin. He was worried that he might be recalled to prison if his supervising officer discovered the extent of his drug use. He had referred himself to the Drug Project, refused permission for information to be shared and, consequently, no information was disclosed to the Probation Service. Perhaps more significantly, none was requested.

In June, the man was allowed to visit his parents and they noticed a change in his looks, demeanour and behaviour. His visit ended with a family argument during which he was abusive to his mother. He returned to the Approved premises house on 28 June. Although the family was worried, they believed that the visit would not have been allowed if the Probation Service had any concerns about the man. On his return the man reported to his supervising

officer on 29 June. The contact notes recorded that all seemed well and that he talked about the possibility of finding accommodation, near his brother, but outside the exclusion zone. This was the last time that he was seen by anyone from the Probation Area.

On the evening of 5 July, the man watched the television with his fellow resident who said that he seemed 'fine'. The next morning, as the fellow resident left the house, he heard the man breathing heavily in his room but decided not to disturb him. When he returned some time later, he made the man tea and took it to his room where the door was ajar. There he found the man kneeling by the side of the bed, unconscious, with a syringe close by. The emergency services were called and, upon their arrival, the man was pronounced dead.

The circumstances and events surrounding the death of the Approved premises' resident.

PART ONE

Background Information

Section One – The resident

1. The resident was a man of 51 years, born and bred in the county where his family has a thriving business in which he worked for a time after leaving school. He married at the age of 20 and went abroad with his wife where their son was born and they made a good life for themselves. However, he returned to this country some three years later because of political unrest where they were living. After his return, the man became involved in illicit drug taking. His marriage foundered and he was divorced in 1981. Subsequently, he had little contact with his son.
2. Prison and Probation records indicate that the man had a long history of multi drug use. He was heavily dependent upon drugs and committed offences of dishonesty to finance his dependency. In 1990, when he had been depressed over the breakdown of a relationship, he was charged with murder after he stabbed a local man who was well known to him and to his family. Records indicate that he had taken LSD, amphetamines and methadone. The victim was stabbed when he attempted to prevent the man from robbing his shop.
3. In 1991, the man was sentenced to life imprisonment for manslaughter on the basis of diminished responsibility while under the influence of drugs. He said that he had wanted money for enough drugs to kill himself. Records indicate that during the early part of his sentence he was withdrawn and depressed. In 1995, on the anniversary of the offence, he made a serious attempt to end his life when he could not

come to terms with what he had done. However, his recovery led to a change in his behaviour.

4. Thereafter, he engaged in constructive work on his offending and related issues. The man also undertook a number of courses to improve his education and managed to wean himself off the anti-depressant drugs that he had been taking for some time. He was variously described as hard working, pleasant and co-operative.
5. He attended meetings of Narcotics Anonymous and, according to prison records, managed to become drug free. Perhaps most significantly, he demonstrated genuine remorse for his crime and was able to appreciate its effects upon the victim's family. When he was being considered for release on licence, the man appeared to understand and accept that he should not live in proximity to the victim's family.
6. Before his release, the man spent a number of home leaves at an Approved Premises in the Probation Area. In February 2003, he was released, with a condition of residence after spending more than 12 years in custody. The Home Circumstances Report, prepared some months earlier, suggested that monitoring of his drug and alcohol use should be the focus of his supervision as such use could indicate increasing risk. It was made a condition in his licence that,

"He shall comply with any reasonable requirements imposed by his supervising officer for the purpose of addressing his drug and alcohol intake."

Another condition of his licence was that,

"He shall not enter the areas identified on an exclusion zone map without the permission of his supervising officer."

7. The man was very positive during his first weeks at the Approved premises, giving himself challenging objectives. He gained full time employment and no concerns were expressed. In the Offender Assessment System (OASys) form completed by his key worker, in March 2003, he identified his contact with his family as being very important to him but said that he had severed all contact with previous acquaintances. The assessment also noted the previous suicide attempt and identified depression and return to previous lifestyle as possible triggers that needed to be closely monitored. The man was assessed as posing a low risk of harm to the public but medium risk of reconviction.
8. In March 2003, the man injured his leg in a motor cycle accident and was admitted to hospital for three days. He was discharged with medication and it was, again, noted in hostel records that he should be watched carefully for signs of depression, as he was suffering

considerable pain. He was off work for some six weeks, during which time the house log showed him as being on home leave at his parents' address for two weeks. His parents confirmed that their son was with them at home during this time. On his return to the Approved Premises, it was clear that his mood was low and he was bored. Subsequently, another resident alleged that the man had used drugs in the house. His room was searched but there was no evidence of drug use and he was warned of the possible consequences if it was found that he was using drugs. My investigators uncovered no evidence of any further monitoring at that time.

9. During the next six months there were several occasions when his key worker expressed and recorded his reservations about the man's choice of friends and particular concern that he could be led into drug use by a woman friend who was thought to be using heroin. The key worker warned the man of the dangers and shared his concerns with the supervising officer. Nevertheless, there was no evidence that the man had used drugs and, once he was fit enough to return to work, he had a more positive attitude. Hostel records indicate that there were further periods of home leave approved in April, May and for five days at the beginning of September although these visits were not recorded by the supervising officer.
10. At the end of September 2003, the man was involved in a second, more serious, motor cycle accident. He was admitted to hospital with a broken ankle, broken pelvis, broken arm, broken kneecap and head injury and the prognosis was that he would have limited mobility for some time after his discharge. During October 2003, when he was recovering from his injuries, there was considerable discussion about where he would stay when discharged. His room at the Approved Premises could only be held for five days and, in any event, would not be suitable for someone who was incapacitated by injury.
11. The man's parents indicated their willingness to nurse him at home with the assistance of their daughter-in-law but the supervising officer's line manager deemed that there were insufficient grounds to seek a variation of the licence conditions. The Investigators were of the opinion that such a variation was, in fact, unnecessary as the wording of the licence condition, "...without permission of his supervising officer", empowered the officer to make the decision.
12. My colleagues were surprised at the apparent inconsistency in allowing the man to return to his parents' address, within the exclusion zone, in March, April, May and September 2003, when, a few weeks later, permission was refused. Although the man then had a more serious injury, there had been no indication of heightened risk and no other change in his circumstances. My colleagues found references in hostel records that conflicted with those of the supervising officer, who denied having given permission for those periods of leave. There was a further anomaly in that the Approved Premises contact sheets record

the man as being "in at curfew" nightly during the time in June 2004 when his parents said he was at home with them.

These inconsistencies cannot be directly linked to the man's death, and I make no recommendation. However, they highlight areas of poor practice that I urge the Probation Area to scrutinise further.

13. In November 2003, after the man's father had complained to the Chief Officer and to his Member of Parliament about the refusal to allow his son home, the victim liaison officer was consulted. She said that the victim's widow was still badly affected and expressed her view that the family would be distressed if the man returned to the area. However, she did not consult the family as, unless there was likely to be a firm decision to allow the man to return she did not wish to upset the family by discussing the issue.
14. On the same day the Lifer Unit was consulted and the case-worker supported the view that,

"we should try all available avenues before considering a return to [the home area]."
15. The cluster house, with a ground floor kitchen and bathroom, was deemed to be the only premises suitable for the man's limited mobility and arrangements were made to convert a ground floor living room into a bedroom for him. His family and my colleagues were surprised to discover that the house is in an area notorious for drug use, close to a cafe where drug dealing is carried on openly. The Probation Area acknowledged that the location was far from perfect and the house has now been closed. Nevertheless, it seemed far from an ideal placement for someone, recently released from a lengthy prison sentence, whose index offence was directly drug related and who was known to have had difficulty in controlling his use of illegal drugs.

Background Information

Section Two – The Approved Premises

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

17. The Probation Area has four Approved Premises. The premises in question can accommodate 12 residents in the main premises and could take eight more in two cluster houses, one of which was a three bedroom terraced house, close to Premises A and approximately two and a half miles – a 20 minute drive - away from Premises B. The cluster house was, originally, managed by Premises A but was subsequently 'attached' to Premises B as, otherwise, with only 12 beds, Premises B would not have been viable and could have been at risk of closing.
18. Cluster houses originally came into being as move-on accommodation but in recent years they have become part of the Approved Premises Estate and subject to the same rules as main premises. These rules are governed by the National Standards for the Supervision of Offenders in the Community and by the guidance within the Approved Premises Handbook. In the Probation Area, cluster houses are used largely for those on licences who are assessed as needing a lower level of supervision and who are able to manage within the local community. Residents of both the main premises and the cluster houses are allocated a key worker to meet with them weekly, to identify any areas of difficulty and to manage these, on a day to day basis, under the direction of supervising officers.
19. The Manager explained that there were various difficulties in providing adequate oversight of residents at the cluster house, due to the distance of the house from the main premises and staff constraints. He said that one staff member had been visiting weekly, alone, to check that all was well with the house. The hostel was unable to provide double cover, but even the briefest visit involved the absence of a staff member from the main premises for more than two hours. The restrictions of the staff rota, and residents' availability, made it difficult to schedule weekly key work sessions. Like those in the main premises, residents in the cluster houses are subject to a nightly curfew but there is insufficient staff to enable evening visits. Instead, the curfew is managed by means of a telephone call, each night at 11 pm. Using a dedicated telephone that receives incoming calls, a member of staff in the main premises is required to speak to each resident individually.

PART TWO

Events leading to the resident's death

20. On 14 November 2003, the man moved into the cluster house although his transfer from hospital did not go as smoothly as expected. There was no one at the house to meet him and practical issues such as the buying and preparation of food had not been considered. His brother visited him and expressed dismay at the lack of facilities provided, but over the next few days arrangements were made such as the provision of meals on wheels. The hospital had prescribed opiate-based pain

relief medication for the man. According to the guidance in the Approved Premises Handbook, he would have been required to hand this in for staff to dispense in the main premises from where he could collect it each day. The Probation Area confirmed that this was area practice and the guidance was, subsequently, re-issued in Probation Circular 33/2004, 'The Handling of Medication of Residents of Approved Premises'. However, as the man was unable to make the journey from the cluster house to the Approved Premises, he was allowed to keep his medication.

21. The investigation found no evidence that the man's self-medication was monitored. As identified in this report, his situation was unusual and it is unlikely that every possibility can be covered by guidelines. Nevertheless, Circular 33/2004 requires Approved Premises to have a system in place for the collection, safe-keeping, recording and administering of prescribed medication. Although such a system was in place at the Approved Premises, it did not encompass the man's special circumstances and was absent in his case.
22. The Prison Service is developing an 'In-Possession Medication' policy that will provide a risk-assessed system for some prisoners to self-administer their medication, as they would do in the community. In the draft of this report I commented that, with the development of the National Offender Management Service (NOMS), it could be a retrogressive step if the governance of medication in Approved Premises were to become more restrictive than the system operating in prisons. When the draft report was disclosed to the National Probation Directorate (NPD), it commented that the environment in Approved Premises differs from that in prisons and the risk and management issues faced are different.
23. NPD believes there is a strong risk management and duty of care rationale behind the policy of strictly controlling the security and dispensing of medications. I agree that the issues involved in the management of risk in the community differ from those in prisons. Nevertheless, it is the intention of NOMS to join the work of the prison and probation services to provide a seamless, more effective service. It intends to do this by introducing end-to-end management of each offender, ensuring that work in custody is built upon in the community. If certain prisoners are to be encouraged to adopt a more reasonable attitude by being allowed to take control of their own medication in custody, it is appropriate that such encouragement should continue in the community, providing the risk is properly assessed. I trust that, in the fullness of time, NOMS may consider a joint procedure that will not only ensure offenders' safety, but will enable those who do not pose a risk to take responsibility for their own well being. Meantime, I hope that the NPD will seek ways of working jointly with NOMS Health Partnerships to ensure a seamless transition from prison to the community for those who require medication.

I recommend that the National Probation Directorate should review the current procedures for dealing with residents' medication and ensure there is a safe, secure system with which staff are familiar.

(At the draft report stage, the National Probation Directorate agreed that the monitoring of the man's use of medication at the cluster house was not adequate. The NPD has said that it intends to issue further advice to all Probation Areas and I trust they will do so in the near future.)

24. In December 2003 the man was put in touch with a volunteer from a local voluntary organisation who visited him weekly and continued to offer support throughout his residency. The man subsequently shared the premises with another resident and the two men got on well together. The resident said that he would often cook for them both and they would watch television together in the evenings. When the man was more mobile, the voluntary organization obtained a bicycle for him as he found it easier to cycle than walk. He was able to get out and he would occasionally visit a local public house with his fellow resident.
25. Between November 2003 and February 2004 the man appeared to make good progress although his leg was not healing well and his mobility continued to be limited. His father visited him during December 2003 but his request to spend Christmas with his parents was refused, "due to licence conditions". The key worker expressed no concerns in the notes sent regularly to the supervising officer who also visited the man in line with the requirements of National Standards. He continued to receive support from the voluntary organisation's worker who shared information with the supervising officer on a regular basis.
26. In February 2004, a Community Police Officer told the key worker that, by chance, he had seen the man in the street, associating with known drug dealers. The key worker reported immediately to the supervising officer and it was decided that the man should undergo urine testing to ascertain whether he had used illicit drugs. The test proved positive.
27. The supervising officer's contact sheet for 26 February 2004 records:

"Result of drug test showed positive for cocaine and opiates. Positive for opiates is of limited concern because he is also taking opiate based pain killers following his motor cycle accident. Worker from [the Approved Premises] will arrange to have more exhaustive tests done on the next sample."

Ongoing tests continued to show positive for opiates but the Investigators found no evidence of any in-depth analysis that might have established whether the amount was commensurate with the man's prescribed medication. There is no mention in the hostel records of any further analysis of the test results.

28. The man met with the key worker and the supervising officer and admitted that he had used cocaine on two occasions. He accepted that this was problematic and expressed the desire to address the problem. It was agreed that the key worker would take him to the I Drugs Project which he did on the same day although no formal referral was made. The man decided to participate in a Change Programme involving attendance three times weekly for eight weeks. The supervising officer had a warning letter issued, as he was advised to do by the Lifer Unit.

29. The supervising officer's report of 2 March, forwarded to the Lifer Section of the Sentencing Policy and Penalties Unit via the ACO, provided details of the man's lapse and the remedial action taken. The 'Areas of Concern' section noted,

"Further evidence of drug abuse will result in immediate action."

Despite this, the evidence of continuing opiate use in weekly drug tests prompted no further action.

30. My colleagues were given information by the Drug Project, indicating that the man attended regularly, between 3 March and 31 May, on Wednesdays, Thursdays and Fridays. He participated in 16 sessions of the Change Programme followed by 10 sessions at an Action Group with weekly goal setting meetings. He told workers at the drug project that he was using heroin and cocaine on a daily basis spending at least £20 daily.

31. On 2 April 2004, the man told the drug project worker that he had reduced his heroin intake to once in two or three days and that he had stopped using cocaine entirely. He said that he did not wish to participate in a methadone reduction programme as this would involve his G.P. knowing that he was using heroin. The man said he was frightened that he would be recalled if the Probation Service discovered his drug use. During the Investigation, the man's parents said they had recently discovered that his bank statements indicated he had received in excess of £10,000 compensation since his first accident and that he had, in fact, continued to spend in the region of £150 daily. They spoke of his bank balance standing at around £3 at the time of his death.

32. The man also told the drug project worker that, through his contacts, he had obtained a supply of a drug called Subutex that, he understood, was helpful as a heroin substitute. He sought advice about the drug's correct use, but was told it should not be used without the proper medical support that he was so reluctant to seek. None of the information given by the man to the drug project was shared with either his supervising officer or key worker because he had self-referred and had withdrawn his permission for information to be disclosed. Given that he was on life licence, many people would find this extraordinary.

The Probation Area's Hostels Manager has now taken steps to review the learning points from the man's death and has identified the shortcomings in the current information sharing and confidentiality agreement with the drug project. I was very glad to hear that steps are already being taken to review the agreement.

I recommend that the Probation Area reviews and, if necessary, re-negotiates its information sharing agreement with the Drug Project to ensure that information pertaining to the management of risk can be openly shared.

33. The Investigators were puzzled by the supervising officer's report to the Lifer Section of the Sentencing Policy and Penalties Unit dated 28 May. Although weekly drug tests continued to prove positive for opiates and the drug project told the Investigators that no information was shared with the supervising officer, the report states,

"I shall continue to monitor very carefully the man's drug use and he will continue to be tested for drugs on a weekly basis. The last three tests have all been negative since he received his warning letter...I shall continue to see the man monthly as well as receive regular weekly reports from his attendance at the Drug Project."

It seems reasonable to expect that, if such weekly reports had been requested, the drug project would have commented upon the man's refusal to allow the disclosure of information and this, in itself, would have raised concerns. There was nothing in the record of contact to indicate when such reports were received and the supervising officer did not refer to them during the Investigation.

34. On 5 May 2004, the man reported to the Drug Project that he had stabilised his heroin use but could not get beyond three days without the drug. He remained adamant that he did not wish to involve the medical profession due to his fears of recall, but expressed his desire to undertake a detoxification process, if possible away from the area. His final attendance at the Drug Project was on 29 June when he wanted to discuss ongoing support with the worker, saying that he had detoxified at his parents' home.
35. We cannot know for sure if the man had detoxified during his home leave although his parents said they noticed a difference in him during his visit between 21–28 June 2004. They described him as having lost weight and being unable to eat. They thought that his behaviour was more aggressive than usual and, after an evening's drinking with his brother, there was an argument during which he was abusive towards them. His mother found her son's behaviour both bemusing and distressing. She said that after his return to the Probation Area he telephoned every day asking for forgiveness.

36. On 29 June 2004 the man reported to his supervising officer who noted that he appeared to be happy following his visit home. He talked about the possibility of working with his brother, in the away from the exclusion zone. In the time up to his death, seven days later, the man was not seen again by his supervising officer or by any member of staff from the Approved Premises.
37. The man's fellow resident could not say at precisely what time he left the house on 6 July although he thought it was "mid-morning". He said he could hear the man breathing heavily and considered knocking to wake him. However, he decided not to disturb the man and went to the Approved premises to get various things needed for the house. On his return, as he took his coat to his room, he noticed that the man's bedroom door was open and thought he must be up and about. He shouted, asking if the man wanted tea. Although there was no reply, he made the tea, knocked on the man's open door and went in.
38. The resident described the man kneeling next to the bed, unconscious, with a syringe beside him. The resident said that, from the man's position and his lack of response, he feared that something was very wrong. An ambulance was called and the man was pronounced dead.

PART THREE

Consideration & Conclusions

39. It was my role to examine the quality of supervision and care provided to the man as a resident in Approved Premises. 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.
40. The circumstances in which the man was placed at the cluster house were very unusual and derived in a large part from the serious accident that he had suffered. Nevertheless, the arrangements left much to be desired. The decision to accommodate a man with such serious injuries in a house, with one other offender, when daily contact with staff in the main premises was by telephone only, was far from ideal. Leaving aside its unsuitable location for offenders (especially those with a history of drug use), amenities in the house were basic and the Investigators were informed that it had been without hot water for a lengthy period while repairs were negotiated with the landlord. The Approved Premises estate in the Probation Area seems ill-equipped to cope with disability and ill-prepared for the requirements of the Disability Discrimination Act (DDA). I appreciate that, nationally, much of the estate is not purpose-built and that improvements have considerable resource implications. However, I suspect for that reason that other areas are also unprepared.

I recommend that the National Probation Service undertakes an audit of Approved Premises, with a view to taking remedial action if there are not premises in each Probation Area suitable for those with disability.

(This recommendation has already been addressed. Having seen the report in draft, NPD has said it has undertaken DDA assessments of all Probation Board managed Approved Premises and has commissioned surveys of those under voluntary management. Given the difficulties of making each site fully accessible, the approach being adopted initially is to ensure that provision is available in each region and this is consistent with the requirements of DDA.)

41. The distance of the cluster house from the Approved Premises caused management problems, as reported to the National Probation Directorate in a memorandum sent electronically by the Manager in November 2003. Section 12 of the Approved Premises Handbook states that daily contact should be made with each resident and that this may be combined with curfew checks. Although the nightly telephone call made to each resident at the cluster house fulfilled this requirement, I question whether such a call could provide the same safeguards as personal contact.
42. Since the man's death, the cluster house has been closed together with a second cluster house. A larger house, within quick walking distance of the Approved Premises has replaced both premises. It is anticipated that this will be much easier to manage but the Probation Area must ensure that it can fulfil its supervisory responsibilities towards those accommodated in Approved Premises.

I recommend that the Probation Area reviews its management of the new Approved Premises cluster house, to consider if there are alternative methods of managing curfew requirements, achievable within resource constraints.

(Since reading this report in draft, the Probation Area has commented that the new cluster house is less than five minutes walk away from the main premises and is visited daily by members of staff, in addition to the telephone curfew check.)

43. Communication between all those charged with the supervision of offenders is crucial for the identification and management of problem issues. In this man's case, communication between the Approved Premises and the supervising officer appears to have been neither regular nor meaningful. Key work visits to the man at the cluster house should have been weekly but there were four occasions when the visits were cancelled, recorded as being for reasons of resources. I accept that the Approved Premises had been carrying two staff vacancies for some time. These had been covered by relief staff, who were less experienced than permanent staff and it is understandable that the

Assistant Manager was reluctant to leave relief staff alone. Nevertheless, I find the lack of direct contact unacceptable.

- 44.** The quality of recording in key work pro-formas and Individual Programme Plans that were on file at the Approved Premises was inadequate. The pro-formas were repetitious, stating that the man was doing well and testing negative for cocaine, with no mention of opiates. The Individual Programme Plans were also repetitious and, from 2 February 2004 to 28 June 2004, were not signed by the man. There was no mention of drug issues. I am surprised that the Approved Premises Operational Manager did not bring this to the key worker's attention after record inspections.
- 45.** The man's parents commented upon the draft report in a letter to Mrs Morris. They stated,
- "All the key worker pro-formas say [our son] was fine, doing ok, they are all very repetitive, and I can tell you that [our son] complained constantly to us about the lack of communication and help that he had and felt very vulnerable on release from hospital. However, he was scared of complaining himself for fear of any backlash and let us do his complaining for him."
- 46.** The Approved Premises Operational Manager supervises key workers every six weeks and file checks are undertaken at the end of each month. However, to a large extent, the Manager must rely upon staff members managing their own workloads and, he acknowledged, it would be possible for three key-work visits to be missed in a short space of time, without his knowledge, as happened in this case. With hindsight, in the Manager's opinion, the reasons given for three of the four missed visits were not acceptable.
- 47.** A supervising officer is responsible for the overall management of each offender and it is the role of Approved Premises staff to pass on information to the supervising officer for review, action and decision. Written recordings of key-work sessions should be sent to the supervising officer to provide regular information about progress or problems but no action was taken when notes did not arrive.
- 48.** The Investigation has raised a number of questions over the level of supervision afforded to this man and whether there was any meaningful consideration of his needs. In interview the supervising officer acknowledged that, "on many occasions the Key Worker had missed the man at his accommodation." Given that the man was thought to have mobility problems, I am surprised that alarm bells did not ring and that no effort was made to ascertain why the key worker failed to make contact. I am also surprised that no action was taken over the lack of contact, particularly since the record of contact log indicates that between 20 April and 7 June 2004, the man had missed two appointments with the supervising officer. However, it was noted

that one of these absences was deemed acceptable, as the appointment letter was not received.

I recommend that the Probation Area reviews the procedures for recording, monitoring, disclosing and acting upon information and observations from key-work sessions, with a view to issuing further guidance to key workers and Case Managers if necessary.

(Since reading the report in draft form, the Probation Area has commented that protocols are being developed in respect of the interface between key-workers and case managers. Various standards are being set such as the requirement for key-work information to be placed in the case record within a time frame.)

49. In a previous report into the death of a young hostel resident from a drug overdose, I recommended that the National Probation Directorate (NPD) should issue further guidance about the required level of information sharing between those who are variously involved in an offender's supervision.

I recommend that the National Probation Directorate reviews its information sharing protocols and issues guidance to all Areas to ensure the effective care and management of offenders.

(Since reading the draft report, NPD has said it will address issues of communication between supervising officers and case managers. The new version of National Standards, currently in draft form and issued for consultation, puts a requirement on all probation staff to ensure that relevant information is properly communicated.)

50. Before he moved into the cluster house, responsibility for the man's supervision was transferred from the supervising officer to a senior practitioner who transferred to the resettlement team, in October 2003, on a temporary basis. He was responsible for managing around 40 cases of high-risk offenders and life licencees whilst also providing an advisory function for other members of the team. The senior practitioner commented that in his view, at that time, the provision for lifers in the Area was less than satisfactory. A significant number of life licencees were supervised by the acting Senior Probation Officer who also had a great many other responsibilities. Many of these cases had been transferred from other teams without OASys risk assessment, due to a reorganisation that occurred at the same time as a move into a new office.
51. The assessment and management of risk fulfill crucial roles in the supervision of offenders, especially those who must work to re-establish themselves in the community having spent long periods in custody. A full 'OASys Two' form was completed by the man's key worker at the Approved Premises, in March 2003 and reviewed in June

2003. Although, at that time, there were no current concerns about self-harm, it was noted that the risk could increase if the man became depressed or returned to drug use. In the review it was also noted that the man had been keeping company with women believed to have, "connections with drug misuse" and that he had been warned about this. The supervising officer had also prepared an OASys risk assessment on 3 March 2003 but accepted that there had been no further formal reviews or screening during the ensuing 12 months.

52. In April 2004, the man's supervision was transferred back to his original supervising officer. When interviewed the officer stated that when the man was seen in April, the officer thought he was, "looking good and his state of mind was good." However, the officer also said that when he was seen in May the officer was "shocked" as he had, "regressed, was heavily reliant on his crutches again and had lost weight." The officer expressed the view that a number of negative factors had contributed to the man's condition. Among these were his apprehension about the possibility of a further operation, his concerns about his father's health, and boredom as his limited literary skills meant he mainly watched television throughout the day.

53. It was for those reasons and their possible impact upon the man's frame of mind that, the supervising officer said she permission was given for a period of home leave. The officer did not mention any concerns about possible drug use and none of the concerns expressed in interview were reflected in the record of contact. The entry for 17 May stated,

"Saw [the man] progressing slowly after accident more mobile as he is on crutches. Support worker is helping him considerably"

The next entry dated 7 June also indicated no problems.

54. During interview, the officer explained that while the man was being supervised, the supervisor was acting up as a Senior Probation Officer and holding 31 lifer cases in addition to 35 other, mainly high risk, resettlement cases. The officer explained that lifer cases have always been viewed as a separate category and said, "...even now fewer lifer cases have either OASys or regular reviews. Instead, the officer said, reports to the Lifer Unit, that were available on file, constituted case reviews. I have commented elsewhere in this report upon the surprising content of one such report.

55. I have no wish to impugn the integrity of any ASPA employee but there was a clear failing in recording and communicating decisions. I readily accept that the supervision of those released on life licence presents unique challenges that need to be managed within limited resources. Nevertheless, I question the practice of forgoing a system of risk assessment in use throughout the Prison and Probation Services, and regular review of that assessment.

I recommend that the Probation Area reviews its handling of Life Licences to consider if standards of assessment and supervision are sufficient to ensure effective offender management.

(Since reading my draft report, the Probation Area has embarked upon a Life Licence review.)

56. By far the most worrying aspect of this case was the abysmal failure of any employee of the Probation Area to properly identify and address the extent of this man's drug use. Assumptions were made but not tested and on the one occasion when further investigative action was suggested, it was not undertaken. On 26 February, when a drug test showed positive for cocaine and opiates, the record of contact sheet notes that the key worker was to arrange to have, "more exhaustive tests done on the next sample." No exhaustive tests were undertaken, no reminders were given, no results were requested and thereafter, although urine tests continued to indicate opiate use, this was apparently ignored.
57. The fact that the man received compensation following his first motor cycle accident appears to indicate that the fault was not his. Nevertheless, when he was involved in a second, serious, motor cycle accident within a year, speculation as to whether there was anything more than bad luck involved might have been expected. When the man admitted using illicit drugs, although he was introduced to a Drug Project there was no formal referral to the organisation and, according to the project, no formal feed-back, despite there being a condition in the man's licence that he should comply with his supervisor's requirements to address his drug intake.
58. Thereafter, there seems to have been an assumption that the drug Project's intervention had been successful and there was no further, meaningful, assessment of the man's drug use by the Probation Area. No one questioned whether the amount of medication that he was taking should decrease as his condition improved. The Supervising Officer assessed factors that might have contributed towards the deterioration in the man's condition that were observed in the short period between April and May 2004, but, despite all the clues, the officer did not consider his use of drugs.

I recommend that the Probation Area should conduct an in-house inquiry to assess training and competence issues for those members of staff responsible for the management of the man's licence.

(The Probation Area has said it is currently seeking the assistance of an external consultant to undertake a review of training and competence issues.)

59. All those involved in the management of offenders know how high the risk associated with the use of class 'A' drugs can be. Although the

man was, ultimately, responsible for his actions, the Probation Area had a duty of care towards him. Closer supervision and assessment from those fulfilling that responsibility could have identified the extent of his drug use and enabled decisions to be made about how best to ensure his safety.

60. Although this investigation leaves questions to be answered, it has revealed a lamentable lack of communication between the Approved Premises, the Case Manager and other agencies involved in the care of this man. Although it will be of scant consolation to his family, I hope that the lessons learned from his sad death will help prevent such events occurring in the future.

STEPHEN SHAW
OMBUDSMAN
17 February 2005

RECOMMENDATIONS

National Offender Management Service Recommendation

I recommend that the National Offender Management Service should review the policies of the prison and probation services for the handling and dispensing of offenders' medication and give consideration to developing a joint system.

National Recommendations

I recommend that the National Probation Service undertakes an audit of Approved Premises, with a view to taking remedial action if there are not premises in each Probation Area suitable for those with disability.

I recommend that the National Probation Directorate reviews its information sharing protocols and issues guidance to all Areas to ensure the effective care and management of offenders.

Area Recommendations

I recommend that the Probation Area reviews and, if necessary re-negotiate its information sharing agreement with the Drug Project to ensure that information pertaining to the management of risk can be openly shared.

I recommend that the Probation Area reviews its management of the new Approved Premises cluster house, to consider if there are alternative methods of managing curfew requirements, achievable within resource constraints.

I recommend that the Probation Area reviews the procedures for recording, monitoring, disclosing and acting upon information and observations from key-work sessions, with a view to issuing further guidance to Key Workers and Case Managers if necessary.

I recommend that the Probation Area reviews its handling of Life Licences to consider if standards of assessment and supervision are sufficient to ensure effective offender management.

I recommend that the Probation Area should conduct an in-house inquiry to assess training and competence issues for those members of staff responsible for the management of the man's licence.

N.B. The Probation Area has confirmed that all my recommendations have been accepted and implemented.