

**Circumstances surrounding the death of a man at
an Approved Premises in the London Probation Area, in August 2005**

**REPORT BY THE PRISONS AND PROBATION OMBUDSMAN FOR
ENGLAND AND WALES**

January 2006

This is the report of an investigation into the death of a man who was released from prison on licence. He died in his bedroom at an Approved Premises in London, three weeks after his release from prison.

He spent many years addicted to a variety of drugs and had been in prison several times. On release from his final prison sentence, he was given a place at the hostel. Sadly, he appears to have been unable to avoid drugs and died from an overdose of morphine.

I offer my sincere sympathy and condolences to the man's family and friends for their loss. I know that the staff at the hostel who knew the man who died share these sentiments.

My office investigates the deaths of all prisoners in custody and residents in Approved Premises. In this case the investigation was carried out by one of my investigators. I am grateful to the Manager and Deputy Manager of the hostel for their assistance during the investigation.

I make four recommendations.

Stephen Shaw CBE
Prisons and Probation Ombudsman

January 2006

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Summary

1. The man who died was born in 1968. He died in his bedroom at the Approved Premises on 17 August 2005, apparently from an overdose of morphine.
2. The man began using drugs at the age of 13 and was first convicted of a crime two years later. For the rest of his life, he continued to use drugs and commit crimes to pay for them. In October 2003, he was sentenced to 30 months imprisonment for burglary and possession of a class A drug.
3. In November 2004, he was released on licence and given a place at a Probation Hostel in London. However, he breached the curfew there and failed to report to his probation officer. He was recalled to prison and served a further four months. On 5 July 2005, he was punished for trying to cheat during a mandatory drug test.
4. Three weeks later, he was again released on licence and went to another Approved Premises. During the three weeks he spent there, he breached the evening curfew three times and staff had reason to suspect that he was using drugs. However, there is no record of any action being taken to address these problems.
5. The man's long-standing involvement with drugs was not addressed as a matter of urgency by any of the agencies that had dealings with him on his release from prison. The prison drugs worker referred him to the local Drug Interventions Programme Team, but at the time of his death he had not received an appointment. Although hostel staff suspected that the man was taking drugs, they took no action. While he was at the hostel, staff were not testing residents for drug use. His probation officer was not informed of his curfew breaches, neither was she aware of his attempt to avoid the prison drugs test.
6. When staff discovered the man in his room on the morning of 17 August, they acted quickly and appropriately in calling an ambulance. None of the staff were trained first aiders, so they did not attempt resuscitation. Paramedics arrived very quickly and treated the man, but were unable to save his life. Currently the hostel has no trained first aiders and only half the staff have attended a first aid awareness course. The manager is taking steps to remedy this.

The investigation process

7. My investigator visited the Approved Premises on 22 August 2005. She spoke to the manager who had only taken up post that morning. She also spoke to a number of the staff and was given copies of all the hostel's records relating to the man. She spoke to the Deputy Manager on duty that day, and briefly discussed the man's records. She was shown around the hostel and saw his room. On a subsequent visit she was given copies of the CCTV footage for the 24 hours surrounding the man's death. A further visit was made and four members of staff were interviewed, including the person with management responsibility at the time of the death. She also spoke by telephone to a resident of the hostel who occupied the room next door to the man who died and was his friend.
8. My investigator spoke briefly to the man's probation officer, by telephone and discussed the work she was undertaking with him. Arrangements were made to interview her, but she was unable to attend and the senior probation officer who was her line manager, replaced her.
9. One of my Family Liaison Officers contacted the man's next of kin to ask if they wanted to raise any issues about his time at the hostel. No issues were highlighted.

Background

The man who died

10. The man died in his bedroom the hostel on 17 August 2005, apparently of an overdose of morphine. He had been released on licence from prison only three weeks before.
11. According to his police records, the man was born in 1968. In his contact with the authorities, he used numerous aliases and dates of birth and his records contain a number of different names and dates. In an interview with a probation officer, he described his early life as unsettled. The absence of his father meant that he had few boundaries imposed on him. He began smoking cannabis when he was 13 years old, moving on to heroin four years later. At 22, he started using crack cocaine, and at 27 he began to take Valium tablets. To fund his drug habit, he turned to crime and was first convicted at the age of 15. In addition to non-custodial sentences, he spent many periods in custody, beginning in 1984 when he served three months in a detention centre. The majority of his offences were of theft and burglary.
12. On 27 July 2003, the man pleaded guilty to burglary and possession of heroin and was remanded in custody while pre-sentence reports were written. The judge asked for him to be assessed for his suitability to be given a Drug Treatment and Testing Order (DTTO) and for residential rehabilitation funding to be considered. The assessment included a drug test for which the man apparently provided a urine sample that was not his own. Because of his lack of co-operation and commitment, he was not recommended for a DTTO. The judge sentenced him to 30 months imprisonment.
13. He was released on licence from HMP Brixton on 19 November 2004, with a condition of licence that he resided at a Probation Hostel in London. On 21 January 2005, recall proceedings were initiated as he had breached the hostel's curfew and failed to report to his probation officer. He returned to prison in April and transferred to a prison in Dorset.
14. On 12 April, the man was assessed by a prison drugs worker from the Counselling Assessment Referral Advice Throughcare (CARATS) Team. He told the drugs worker that he wanted help to remain drug free when he was released. The prison drugs worker recorded on the care plan that they were referring him to the Hackney Drug Interventions Programme Team.
15. However, on 4 July, during a mandatory drugs test, the man provided a sample of urine that was not his own. At an adjudication on the following day, he pleaded guilty to disobeying a lawful order and received 16 days loss of earnings and privileges as punishment.

The Approved Premises

16. The hostel is the largest in England and Wales. It has 41 single bedrooms spread over three units and includes four self-contained flats for residents near the end of their time in the hostel. At present, approximately one-quarter to one-third of residents are on bail, but increasingly those in residence have been convicted of serious offences.
17. There is a CCTV system for monitoring purposes. However, staff are also expected to have regular and close contact with residents. Those who live at the hostel are subject to a curfew and staff carry out a series of checks to ensure that this is complied with.

Key findings

Events leading to the man's death

18. The man was released from prison on 27 July 2005. His period on licence was to run from that date to 12 March 2006. He was told to report to his probation officer in London between 2:00pm and 3:00pm that afternoon. When he did so, he was told that his next appointment at the office was in five days' time when he would have his induction to the licence. The National Probation Service has a National Standard that offenders released on licence are seen on the day of release, and again within three working days. The arrangements for the man therefore did not comply with the National Standard.
19. He arrived at the hostel at 4:15pm on the afternoon of 27 July. The hostel rules and regulations and the drugs test policy were explained to him. He also read and signed the Residents' Information Booklet. The requirements to observe the hostel's curfew from 11:00pm to 6:00am and to pay rent for his room were emphasised. He told staff that he was on Income Support and the necessary paperwork was completed to allow him to claim his benefit. A doctor's appointment was arranged to obtain a doctor's certificate for the benefit.
20. In the hostel's contact log, the man is described as an ex drug addict who had used various drugs, including Class A drugs. He told staff that he was not currently using drugs and agreed to be referred to the drugs agency working at the hostel if necessary. No such referral was ever made.
21. Later that first night, he went out and did not return until 11:28pm. His explanation for being late for curfew was that, when returning to the hostel, he lost his way as he was unfamiliar with the area. No action was taken over this breach of curfew. On 30 July, he was again late for evening curfew. He called the hostel at 10:40pm to notify staff that he would be late. He explained that he needed to get into his mother's home before returning to the hostel, but that he was locked out and she had not yet returned home. He eventually returned at 12:20am. Again, no action was taken. On 1 August, he did not keep the doctor's appointment that had been made for him. A second appointment was made for the following day, but he did not attend that one either.
22. On 1 August, he attended the induction group meeting at the probation office with other people beginning their licences that week. He was uncooperative and did not participate in the group activity. His main concern was said to be his fares for public transport. However, he did sign the contract with the Probation Service and was given an appointment with his probation officer for 9 August.
23. On 8 August, he reported to the probation office for his appointment with his probation officer. The reception staff told him that he was a day early and to return the following day. Again, he expressed concern about his

travel costs. Staff then realised that his probation officer was on holiday for a week, and the appointment was changed to 16 August. When he returned to the hostel, he told staff that he would be reimbursed for his fares at that meeting.

24. Also on 8 August, the man requested weekend leave for the following weekend. He wanted at least one night away from the hostel in order to spend his birthday with his child. On 12 August, when a reply had not been received, staff at the hostel faxed papers relating to this request to the duty probation officer. The deputy manager at the hostel then spoke to the duty officer and told her that the hostel policy was that no leave was granted until a meeting with the resident, his key worker at the hostel and his probation officer had taken place. The man had not yet had this three-way meeting. The duty officer consulted the senior probation officer who told her to check the address that the man had given to ensure it was acceptable. The duty officer telephoned hostel staff later that day to say that the request had been refused because the three-way meeting had not taken place and she was not satisfied with the address.
25. When told that his request had been refused, the man was unhappy. He telephoned the duty probation officer and told her how angry he was at the decision. He later spoke to the senior probation officer, who confirmed the decision. He was told that the date of birth on his records was not for 12 or 13 August and that there were additional concerns about the address. He was asked to provide documentary evidence of his date of birth. During their conversation the man was agitated and rude, and then abruptly put the phone down. Because of the man's manner during the telephone call, the senior probation officer sent him a manager's warning letter about his behaviour. The letter also warned him that, "My decision not to permit this extended curfew remains and should you find yourself unable to accept this decision, it will be conveyed to the Home Office with a recommendation for an immediate recall." He added that, if the man breached the curfew arrangements, he risked being evicted from the hostel and recalled to prison. A copy was faxed to the hostel staff and it was placed on the man's file.
26. That evening, the man was absent at the 11:00pm curfew check. He returned at 11:15pm, but when a member of staff tried to speak to him he rushed past him and went straight to his room. No action was taken over this third breach of evening curfew.
27. Two days later, on Sunday 14 August, the man returned to the hostel after the evening meal had been served. As he entered the hostel, the cook was leaving and he asked her for some food. She took him to the office to speak to staff there about getting something to eat. A member of staff took some bread and butter from the staff room to give to the man. However, this did not please the man who demanded cheese, not butter, with the bread. He complained about how bad the hostel was and then refused the food. The member of staff told my investigator that he attributed the man's shouting and rudeness to being under the influence of drugs at the time.

Events of 16-17 August

28. The man who died had a meeting with his probation officer on Tuesday 16 August. He was said to appear well, to have participated in the discussion and to have told the probation officer that he was not using drugs. However, he said that he had not received the warning letter from the senior probation officer. The probation officer told him that a three-way meeting had been arranged for the following day at the hostel and weekend leave would be discussed then.
29. A resident at the hostel who had the room next to the man who died, spoke to my investigator. He told her that, on 16 August, he met the man in the corridor outside their rooms at about 9:30pm. They talked for a short time and the man who died offered him some of the cake he was eating. They then said goodnight and each went to their room. The other resident could hear the man's television, but it did not make much noise. The other resident did not hear any other noise during the night. It was as quiet as it normally was, and he slept soundly.
30. Three staff were on duty that evening. At approximately 11:00pm, two of them were doing the evening curfew check when they met the man who died and the resident in the next room in the corridor outside their rooms. This is later than the resident's recollection, but both staff set the time at 11:00pm because they were doing the curfew check. The resident only referred to one conversation in the corridor with the man, after which both men went to their rooms for the night. In light of this, I am content that there was only one meeting in the corridor at 11:00pm that night.
31. The female member of staff asked the man if he had been given the weekend leave that he had asked for. He replied that he had not. He then told her that the three-way meeting with his key worker and probation officer was taking place the following day. Both she and her colleague felt that the man was quite calm and accepting of the fact that he had not been given leave and was no longer upset about the matter. The man went on to talk about getting leave after the three-way meeting and how he was looking forward to visiting his child. Both staff felt that he was concentrating on the future rather than dwelling on the past. The male member of staff was of the opinion that the man was under the influence of drugs at that time, but that he had not taken a lot. The female member of staff did not think that he had taken any drugs. When the conversation ended, the man went into his room and the female member of staff locked the door. She explained that she did this because at curfew check it is the practice to unlock the bedroom doors and go into the rooms to check on the residents. Then, on leaving, the door is locked by the member of staff to save the resident having to do it. That ensures no resident can walk into another's room.
32. At 6:00am, the staff began the morning curfew check. It is the policy that, at this time, staff speak to each resident and, if there is no reply, go into

the room. When the male member of staff called to the man, there was no reply so he entered the room. He saw the man half lying on the floor at the foot of the bed, in a crumpled position. From his position it looked as if he had been sitting at the foot of the bed and had then toppled forward onto the floor. He was dressed only in the shorts he had been wearing the previous evening. He had a length of electric cable around his left upper arm, and above and below his right knee brown cord was loosely tied. There were syringes in the room, one containing fluid. A drawer from the chest of drawers had been removed and then replaced upside down to provide a flat surface and there was drug equipment on it. The television was on and the bed did not look as if it had been slept in.

33. The male member of staff called again to the man, but there was no response, even though his eyes were open. Then he noticed that there was a dried tear at the edge of the man's eye. His lips were blue, as were the palms of his hands and soles of his feet. He called to his colleague and she came and looked into the room.

34. Probation Circular 40/2004, "Strategy for preventing sudden deaths in approved premises" sets out in an annex what must be done in the event of an incident of significant self-harm or a fatality. However, the staff on duty did not use a hostel or area policy for dealing with the death of a resident as a reference point, and they had not received any training on the subject. They began to take steps to respond to the man's death, and later when the assistant manager checked with the Assistant Chief Officer, he said that she confirmed that he had taken all the necessary actions.

I recommend that the London Probation Area ensures that all staff in approved premises are reminded of the requirements of Probation Circular 40/2004, and that their knowledge is regularly reinforced at staff meetings and supervision meetings.

35. The female member of staff went downstairs to the office and rang for an ambulance before returning to the man's room. Because neither member of staff was trained in first aid and there were syringes in the room, the staff did not attempt to move or resuscitate him. The duty assistant manager was summoned and he joined the others at the man's room.

36. Shortly afterwards, at 6:28am, an ambulance arrived and three paramedics moved the man to the floor and began cardio-pulmonary resuscitation (CPR). They used a defibrillator, which is a machine that monitors the heart and gives electric shocks if appropriate to restart the heart. They also injected him several times to try to restart his heart. Unfortunately, although they worked for about 30 minutes, the attempt to resuscitate the man was unsuccessful.

37. While the paramedics were working, the assistant manager drew up a list of the hostel's known drug users and asked the male member of staff to check that they were all well. His concern was that the drugs the man had taken might have been a bad batch and that others may have taken them

too. However, all the others residents were fine. I commend the assistant manager's for his prompt action in checking the health of the other residents known to use drugs.

38. The paramedics called the police and two officers arrived at 6:55am. Then a police doctor arrived and he pronounced the man dead. The staff gave statements to the police before they left the hostel. Staff told my investigator that they were supported by managers and given the telephone number of the counselling service available to Probation Service employees.

39. When the staff were notified of the date of the man's funeral, the assistant manager decided to attend. He felt that he was going in a private capacity and not as a representative of the hostel or of the Probation Service. However, no one else volunteered to go with him. On the day of the funeral, he felt unable to face it on his own, so did not attend. Later that day, he did visit the grave and placed flowers on it. The man's probation officer did not attend the funeral as London Probation Area policy is that there is no expectation of probation officers attending funerals. It is a step that would only be taken after carefully talking the issue through with the family.

I recommend that the London Probation Area reviews its policy for dealing with the death of a resident of an approved premises, and considers whether and how the area should be represented at the funeral.

40. The other residents did not hear the news of the man's death from hostel staff. The resident in the next room went to investigate the noises in the corridor outside his room and was informed by a police officer that the man had died from an overdose of drugs. Other residents were aware of the unusual activity at the front of the hostel. Later that day, an emergency meeting was held at which staff requested the residents not to ask detailed questions about what had happened to the man who died. They also advised them of the support that was available for those who needed it. The residents subsequently held a collection and bought a rose bush that they planted in the hostel garden in memory of the man.

Issues considered during the investigation

The man's use of drugs

41. When the man was jailed in 2003, he had been using drugs for over 20 years. In 2001 he had been given a DTTO, but completed only three months of the order. The man's actions and records reveal an ambivalent attitude to drugs taking. He told the prison drugs worker that he wanted to stop using drugs and that he would like to spend time in rehabilitation. He wanted to get a job so that he could lead a stable and useful life and be a good father to his child.
42. Sadly, his actions did not reflect these good intentions. In October 2003, while being assessed for a further DTTO, the man provided a urine sample that was not his own. The senior probation officer carrying out the assessment concluded that this indicated a lack of co-operation and commitment to a DTTO. In his CARATS assessment in April 2005, the man listed the periods when he was not using drugs as:
- October to December 2003 and
 - April to November 2004.
- This excludes the period from January to March 2004, whilst he was in prison. It also excludes the first time that he was released on licence, in November 2004. By excluding these periods, the inference is that he was continuing to take drugs. In July 2005, during a mandatory drug test in prison, he did not provide a fresh and unadulterated sample of urine. We do not know why he did this, but again the inference must be that he was trying to hide evidence that he had taken illegal substances.
43. On arrival at the hostel, the man told hostel staff that, when he was in prison, he had attended a drug dependency programme. The CARATS assessment recorded that he was referred to the local Drug Interventions Programme (DIP) and that they would arrange an appointment for him. However, the referral had not been followed up at the time of his death and no appointment had been made for him.
44. The man also told hostel staff that he was not using drugs. The staff explained that a drugs worker from the Criminal Justice Interventions Programme (CJIP) worked with some hostel residents. They assess residents who are drug users and, if they cannot offer appropriate support, they will refer them to other agencies. The man agreed that, if necessary, he would be referred to the worker and that drugs tests might be part of the process. However, he did not see the CJIP worker during his time at the hostel.
45. Two members of the hostel's staff told my investigator that they suspected the man of taking drugs. The assistant manager saw the man wearing a particular belt one day, and the next day he saw another resident wearing the same belt. The assistant manager knew that both men were drug users and he assumed that the belt was payment of some kind. He did not talk to the man who died about it directly, but said to him that there were a

lot of identical belts being worn around the hostel. He felt that the man understood the point he was making. The male member of staff felt that, when the man was rude to him about the food, his attitude was because he had taken drugs. He also thought that the man had taken drugs when he saw him at 11:00pm on 16 August. There is no reference to any of these events in the hostel records.

46. The deputy manager told my investigator that drug use is discussed at induction and at key worker sessions, especially if the resident has a history of drug use. Hostel staff have a high level of contact with residents and drug testing should be carried out by staff. This year there had been some training for staff to use drug testing kits. Unfortunately, not many people were on duty and a mop-up training session was planned but never happened. As a result, drug testing has not been carried out by staff at the hostel. The policy is for staff to talk to the probation officer and link with the drug agency. In October, the hostel manager met the CJIP manager and they drew up a fresh protocol between CJIP and the hostel. Since then, the CJIP worker has visited the hostel and his work will involve testing the residents.
47. The deputy manager also explained how room checks are carried out. When rooms are checked, staff have a quick look at the rooms of drug users and look for obvious equipment such as foil and bent spoons. Occasionally, a full search is carried out but this is a rare event as staff regard the hostel as the residents' home. One member of staff interviewed as part of the investigation commented that some staff would not know what drugs and drug using equipment looked like, and so lacked confidence in their ability to carry out a search.

London Probation Area's contact with the man

48. Before the man's release from prison on 27 July, the Probation Service had spoken to him and prepared a full Offender Assessment System (OASys) screening. This considers all aspects of an offender's life and assesses the risks they present to the community. It also highlights their needs and the challenges they face in addressing their offending behaviour. the man's needs were assessed as having contact with a drugs worker, addressing his basic skills and working on cognitive thinking and his offending behaviour. It was also felt that his need for accommodation was a priority and staff concentrated on that.
49. Staff at the prison told probation staff that they had concerns about accommodation for the man on his release. The CARATS assessment had highlighted that, prior to the current prison sentence, the man's associates were all drug users. He had told them that the only people he knew who were not using drugs were his ex- partner and his mother. The prison drugs worker felt that he should not return to his former neighbourhood, but should be accommodated in a probation hostel in another part of London. He was therefore given a place at the hostel for six months. The prison drugs worker recorded on the care plan that they

were referring the man to the local Drug Interventions Programme Team. This had not been actioned by the time of the man's death.

50. It is of concern that there was not a timely referral to drug support services for the man prior to his release back into the community. Given the subsequent closure of the prison concerned, I am not sure that there is a sensible recommendation I can make on this point. But it is manifest that, if resettlement planning is to be effective, prison drug workers must ensure an appropriate and timely referral of prisoners to community drug support services to ensure seamless care, management and support.
51. The man's records at the hostel included a referral form that was completed during the process of finding him a place in a London hostel. Although the adjudication was noted on the form, the details incorrectly said that he refused to obey an order after being refused a change from a Category B to Category C or D prisoner. No mention is made of a drugs test or the man's attempt to deceive the staff administering the test. It is unfortunate that his probation officer did not know about the man's prison adjudication for providing a false sample of urine during a mandatory drugs test. The senior probation officer told my investigator that, had the probation officer known about the adjudication, she would have taken action over it. Because the man's actions during the prison drugs test so closely reflected his action during the DTTO assessment in 2003, it would have been included in the risk management plan.

Breaches of curfew

52. When my investigator interviewed the deputy manager at the hostel, she described the hostel's policy for dealing with breaches of curfew. When a resident breached the curfew, the staff on duty should find out the circumstances of the breach and verify the information given by the resident. A first breach would be followed up with a verbal warning. A second breach would be followed with a letter containing a strong reminder about the conditions of licence. She said that the hostel expects to work with residents so that they can complete their sentence and be reintegrated into the community, but that where necessary residents were breached. She said that the man should have been issued with a warning and she was not clear why this did not happen when he breached his curfew. She explained that there had been a shortage of senior managers in the hostel over the summer.
53. She also said that breaches of the curfew have to be enforced, but that the hostel has to achieve the occupancy target which is determined by the National Probation Directorate. Also, the hostel has a target for successful completions of sentence. Decisions whether to breach a resident are influenced by these targets and by the extent to which a resident's order or licence has been breached. The hostel's failure to take action regarding the man's breaches of licence suggests that the targets for occupancy and completion of sentence were given precedence.

54. In the three weeks that the man spent at the hostel, he breached the evening curfew three times. The hostel contact log recorded the first two breaches and noted the reasons given by the man, but did not mention anything further. In particular, there was no indication that staff had spoken to him on the morning after the third, unexplained, breach. The assistant manager told my investigator that he spoke to the man the morning after one of the curfew breaches but could not recall the date. The man told him that he had been running late and had missed the bus. When asked about what action had been taken over the breaches, a deputy manager replied that they had been discussed at the morning staff meetings but that it was decided not to take any action. There are no records of these discussions or the decisions to take no action.

The Manager of the hostel should remind staff to follow the hostel policy on dealing with breaches of curfew.

55. Although hostel staff recorded the man's three breaches of curfew, this information was not made available to his probation officer as the hostel staff did not inform her. The senior probation officer told my investigator that, had they done so, the probation officer would have spoken to the man and reinforced the need for him to comply with the curfew. At the time the man was resident at the hostel, hostel staff and probation office staff used different computerised case management systems. The information on the systems could not be shared electronically. The senior probation officer informed my investigator that the hostel and probation office staff now both use a new, unified case management computer system. I note this fact and trust that it will encourage a smoother and more constant flow of information between those working in approved premises and field office staff.

First aid training for hostel staff

56. First aid training for hostel staff has been raised as a matter of concern at previous inquests into deaths of approved premises' residents. In November 2004, managers at the National Probation Directorate (NPD) responded to these concerns by writing to chief officers and others to highlight the concerns. Chief Officers were required to:

- i ensure that the coroner's observations are drawn to the attention of all staff working in approved premises;
- ii review the adequacy of first aid training for all approved premises staff, particularly in respect of drug overdoses; and
- iii ensure that local operational guidance covers the points made by the coroner in respect of commencing mouth-to-mouth resuscitation in suspected overdose incidents.

The NPD is planning to address the issue of first aid training for hostel staff in a future Probation Circular that will also deal with wider issues.

57. Following the Coroner's note, the London Probation Health and Safety Department set up a working group to look at how staff should respond to medical emergencies, including drug overdoses and heart attacks. The group has stated that, "in no case should staff on duty be expected to make quasi medical decisions or diagnosis relating to the health of a resident." They then make five recommendations about first aid training and equipment for approved premises:
- I. The minimum requirement for approved premises is for at least one member on duty being a current certified First Aid trained member of staff – having attended an approved 4 day first aid course. Support from an appointed person – one who has attended a one day course is recommended where another trained first aider is not available.
 - II. This training to be provided, ideally prior to commencement, but as soon after commencement of their role at the premises.
 - III. That all assistant managers should be trained as above to provide resilience in terms of cover.
 - IV. That consideration is given to provision of a defibrillator within each premise and staff are trained on this piece of equipment.
 - V. That each hostel is equipped with Rescu Vac – a piece of equipment which can clear vomit from the airway as well as the hand operated ventilator which pumps air into the person without the need for mouth to mouth
58. However, as mentioned earlier, Probation Circular 40/2004 gives guidance to staff on what to do in the case of a death in a hostel. It includes the following points:
- Call an ambulance
 - Every possible effort should be made to save life in accordance with the limited skills of approved premises staff in first-aid and resuscitation techniques
 - Staff must be aware of own safety (bodily fluids and physical dangers such as electricity and glass).
59. When the two members of staff discovered the man in his room, they immediately called for an ambulance but they did not attempt to resuscitate him. The emergency operator asked if they could move him, but it would have needed both staff to do so. They told my investigator that the presence of needles in the room meant that they felt their safety would be endangered if they had attempted to move the man.
60. Neither member of staff had received first aid training. A deputy manager told my investigator that the hostel currently had no members of staff who had received first aid training. However, approximately half the staff had attended a one-day first aid awareness course. The member of staff who had been the first aid representative had left and the role had not yet been taken over by some else.
61. In early October, the manager of the hostel met with the health and safety officer for the London approved premises and discussed the training needs

of the staff at the hostel. They agreed that first aid training would be provided at the hostel to ensure that that as many staff as possible can take part.

I recommend that the Manager of the hostel ensures that the planned first aid training covers dealing with suspected drugs overdoses. Also that consideration be given to providing more advanced first aid training for the assistant managers.

Recommendations

- 1. I recommend that the London Probation Area ensures that all staff in approved premises are reminded of the requirements of Probation Circular 40/2004, and that their knowledge is regularly reinforced at staff meetings and supervision meetings.**
- 2. I recommend that the London Probation Area reviews its policy for dealing with the death of a resident of an approved premises, and considers whether and how the area should be represented at the funeral.**
- 3. The Manager of the hostel should remind staff to follow the hostel policy on dealing with breaches of curfew.**
- 4. I recommend that the Manager of the hostel ensures that the planned first aid training covers dealing with suspected drugs overdoses. Also that consideration be given to providing more advanced first aid training for the assistant managers.**