

**CIRCUMSTANCES SURROUNDING THE DEATH OF A MAN AT LUTON
APPROVED PREMISES IN THE BEDFORDSHIRE PROBATION AREA IN
NOVEMBER 2005**

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

APRIL 2006

This is the report of an investigation into the death of a man, who was aged 49, who died in his bedroom at Luton Approved Premises, in the Bedfordshire Probation Area, in November 2005. The man died four weeks after his release from prison on licence. The post mortem and toxicology reports indicate that the cause of death was an overdose of heroin.

I would like to offer my sincere condolences to the man's family and friends on their loss. I know that the staff and residents at Luton share those sentiments.

The aim of my investigation was to discover whether the level of care provided by Luton Approved Premises was appropriate, and whether any lessons could be learnt to help prevent a similar death in the future. I am pleased to record that, since The man's death, Bedfordshire Probation Area has extended the daily routine checks of residents in their Approved Premises.

An investigator from my office carried out the investigation. I am grateful for the co-operation my investigator received from Bedfordshire Probation Area, from Bedfordshire Police and, in particular, from the manager, staff and residents of Luton Approved Premises.

I make only one formal recommendation. However, while there are limits on what any Approved Premises can do in practice to prevent residents using illegal drugs, I believe there are a number of lessons to be learned from the circumstances of the man's death. I reflect upon these issues in the Conclusions section of this report.

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

STEPHEN SHAW CBE
PRISONS AND PROBATION OMBUDSMAN

APRIL 2006

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Summary

1. The man was born in 1956. He died in his bedroom at Luton Hostel Approved Premises in November 2005, apparently from an overdose of heroin.
2. The man had a number of criminal convictions including drug related offences. On 8 October 2000, the man was sentenced at Crown Court to eight years imprisonment.
3. On 21 October 2005, he was released on licence from prison. As a condition of his licence, he was required to reside from that date at Luton Approved Premises. The man was described as popular who interacted well with staff and other residents.
4. When staff discovered the man in his room during an evening in November, they acted quickly and appropriately in calling an ambulance. None of the staff was trained as a first aider, so they did not attempt resuscitation. Paramedics arrived very quickly and confirmed that the man had died.

The Investigation Process

5. My investigator visited Luton Approved Premises on 23 November 2005. He formally opened the investigation and met the, Senior Probation Officer and manager of the Approved Premises.
6. The terms of reference for the investigation and notices to staff and residents were issued and displayed. The facts relating to the man's residence were outlined. The investigator was given unrestricted access to the man's records and to the Approved Premises. He liaised with the police, who have now completed their enquiries, and with the coroner's officer.
7. One of my Family Liaison Officers has spoken to the man's next of kin whose main concern was to know the exact cause of the man's death.
8. My investigator spoke to staff and residents and carried out formal interviews with staff

Luton Approved Premises

9. Luton Approved Premises is a large detached house on three floors. It is situated in a residential street and can accommodate 20 residents. The main communal areas of the hostel and the doors to the bedrooms are monitored by closed circuit television (CCTV), with digital images recorded onto a computer hard drive. Residents share bathroom and dining facilities. The general internal fabric of the building is looking tired, and it is the view of the investigator that it would benefit from refurbishment. I make no formal recommendation but draw this to the attention of the Bedfordshire Probation Area.
10. Approved Premises were formally known as Probation and Bail Hostels. They are approved by the Secretary of State within section 9 of the Criminal Justice Act 2000. Approved Premises provide a supportive, structured environment in the community for high risk and difficult to manage offenders. The management of those accommodated in Approved Premises is governed by the National Standards for Supervision of Offenders and the guidance contained in the National Approved Premises Handbook.
11. Luton is one of two Approved Premises managed by the Bedfordshire Probation Area. They accept offenders on bail and subject to community penalties or prison licences. Residents must be over 18 years of age and male. The Approved Premises will consider any type of offender, depending on the level of assessed risk of the resident group at a particular point in time.
12. Over the past ten years, the profile of the Approved Premises population has shifted very markedly towards those assessed as posing a high risk of harm to the public. Approved Premises no longer simply offer accommodation to those who have nowhere to go. The purpose of Luton Approved Premises 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 11:00pm to 6:00am. Staff physically check all residents' rooms and speak to each resident in occupancy at 7:00am daily. Since The man's death, procedures for checking residents have been reviewed and have resulted in additional checks throughout the day.
13. Residents' medication is securely stored within the office. It is handed to residents by staff according to the medication instructions. Each resident has a drug dispensing chart which a member of staff signs when the medication is dispensed.
14. Self-evidently, illicit drugs are not allowed on the premises. Staff have the authority to search a resident's room if it is suspected that he is breaking the hostel rules.

15. Each resident has a dedicated key worker to assist in meeting their specific needs. Key workers hold regular one to one meetings with their residents, and liaise with other agencies to monitor and facilitate as appropriate the residents' reintegration back in to the community.

16. The staffing complement is:

- One Senior Probation Officer (Manager)
- One Deputy Manager
- One administration assistant
- Four hostel wardens
- Five waking night staff

17. There is a minimum requirement for two staff to be on duty at all times. There is a frequent need for relief cover and consequently there is a pool of relief staff who are regularly called upon.

18. Each new resident is given an information booklet which outlines information about the Approved Premises and the hostel rules.

Events leading to the man's death

19. The man was released on licence from prison on 21 October 2005. The conditions of his licence required him to reside at Luton Approved Premises.
20. The man arrived at Luton Approved Premises on 21 October. The rules were explained to him. He met his key worker, and settled quickly, interacting well with staff and residents. He initially shared a room with another resident and was subsequently allocated a room on his own. The room was sparsely furnished with a single bed, wardrobe and the man's personal belongings.
21. One of the hostel staff suspected that the man might have been drinking or taking drugs whilst he was at the Approved Premises, and recorded his suspicions in the staff handover book. However, the man was not challenged over the suspected behaviour, although staff continued to monitor him
22. The man's probation officer, said that she offered the man an appointment on 1 November at her office in Luton, which he did not keep. She made enquiries at the Approved Premises and established that the man had forgotten his appointment. He attended a further appointment on 3 November, and was warned that failure to attend in future would be unacceptable. The man was offered a further appointment on 15 November, but did not attend and, in accordance with Probation National Standards, a warning letter was sent out requesting an explanation for his absence.
23. The man called the next day to explain that he was confused about his appointment times and it was agreed that they would be discussed at his next appointment. The man expressed some difficulty in adjusting to life back in the community. It was agreed that he would begin a calendar to help him.

Sunday 20 November 2005

24. An assistant warden at the Approved Premises, started work at 8:00am and finished at 5:00pm. The assistant warden described the man as a friendly and approachable man who was able to discuss things in a civil way. The assistant warden recalled seeing the man during the morning of his death chatting to another resident in the dining room. He remembered the man saying that he had not slept because of people banging their doors, and that he was going to go and lie down. The assistant warden said, the man seemed his normal self. He then got up, picked up the newspaper and walked up the stairs, and the assistant warden presumed he was going to his room. The assistant warden recalled that it was before lunch and that was the last time he saw him. The assistant warden also told my

investigator that, since the man's death, staff now physically check the rooms of residents who do not come for their meals.

25. Ms A started work at the Approved Premises at 8:00am and finished work at 3:30pm. She recalled seeing the man outside the hostel at 8:30am. He told her that he did not get much sleep because of the noise being made by other residents. She said she told him to try and get some sleep when all the other residents were up, and he told her that he planned to do so. She did not see him again.
26. Ms B started work at 5:00pm and was due to finish at 10:00pm. At 9:30pm, B and her colleague, Ms C commenced a fabric check of the building. As residents had remarked that they had not seen the man, they decided to check his room. When they opened the door, Ms B said that they saw him on the floor, in a crunched position, with his glasses twisted upright off his face. Ms B observed that he looked purple and both she and Ms C felt for a pulse in his neck. Ms B said that she formed the opinion that he was dead.
27. Ms C is on sick leave and has not been interviewed for this investigation. Ms B said that Ms C called for an ambulance using the mobile phone that she regularly carried. The paramedics arrived a little later and confirmed that the man had died. The police were then contacted and also attended. A syringe was found under the man.
28. The hostel manager, arrived at the hostel shortly after The man was found. He spoke to the man's mother on the telephone after the police had informed her of her son's death. The hostel manager arranged for additional staff to come to the Approved Premises to assist with the support and care of staff and residents. Those staff interviewed thought the support they and residents had received had been excellent.

Events after the man's death

29. A post mortem examination was carried out on 21 November. Amongst the findings, a needle mark was found on the right dorsal aspect of the man's hand in between his thumb and index finger. The toxicology report showed that the man's blood contained morphine and commented that it was consistent with a fatal heroin overdose.
30. The post mortem report concluded the cause of death was a heroin overdose.
31. The man's Probation Officer, was informed of his death on 21 November. She said that, during her contact with him, there was no evidence that he used drugs. She said that the man had said that he had reached an age where drugs were no longer attractive to him.
- 32., A hostel resident, wrote the following letter to my investigator:

"I am writing in response to your letter which all residents received. I can only tell you what I know about the man. The last time I had seen and spoken to him was at 10:30pm on Saturday. I asked him if he was okay, he said yes thank you but I can not get rid of a heavy cold. He had terrible flu, pneumonia, and a sore throat, that he got over and then the flu returned. He was also suffering from his left neck, and shoulders with pains. He told me all of this as he used to do heavy work before he went into prison.

"He was very well liked here and no one had anything against him and no one would hurt him.

"All residents and staff were always concerned for his health and made sure he was okay. It was not unusual for the man to have an afternoon sleep. He always sat by the dining hall to have cups of tea, smoke normal roll ups and happily chat to anyone. I have lost a very good friend he will always be remembered. That's all I have to say."

Conclusions

33. The man had been a resident at Luton Approved Premises since October 2005. He went there as a condition of his probation licence, settled in very quickly and interacted well with staff and residents.
34. During the morning of Sunday 21 November, The man spoke to staff, complained of feeling tired and went to his room. He was found some hours later at 9:30pm in his room, and appeared to have died. An ambulance was called and his death was confirmed. A syringe was found under his body, and the post mortem found his death was due to an overdose of heroin. The police have now concluded their investigation.
35. It is not known how the man came by the syringe or the heroin. Manifestly, there are limits on the ability of any Approved Premises to prevent residents gaining access to illicit substances. Nevertheless, the sad death of the man should act as a reminder of the need for staff to be bold in challenging hostel residents when there are suspicions about their behaviour.
36. Hostel staff need to be especially vigilant, not only because drug use may be associated with other serious offending but also because many former prisoners will have a much reduced tolerance to the effects of drugs. Educating residents about the dangers of intravenous drug use – especially after enforced abstinence in prison – is an important responsibility of hostel staff.
37. I have judged in this case that there are no formal recommendations I could usefully make relating to these issues. However, in light of the man's death, I trust they are matters that will be considered by the Chief Officer and the Bedfordshire Probation Board as a whole.

Recommendations and Good Practice

40. 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 harm or a fatality. Although the staff who found The man acted appropriately at the time, they did not refer to the Circular or to a local policy for dealing with the death of a resident, and they had not received any training on the subject.

I recommend that the Bedfordshire 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.

41. It is good practice that the Probation Area has extended the daily checks of residents in its Approved Premises. The actions of the Manager on the night of the man's death are also to be commended.