Investigation into the circumstances surrounding the death of a male resident at an Approved Premises in the Warwickshire Probation Area, in August 2006

Report by the Prisons and Probation Ombudsman for England and Wales

March 2007

This is the report of an investigation into the circumstances of the death in August 2006 of a man at an Approved Premises in Leamington Spa. The cause of his death was a drugs overdose. He was 26 years old, and had a long history of misusing drugs.

I would like to extend my condolences to the man's family and friends for their loss.

The man had been released on home detention curfew from HMP Stocken to the Approved Premises in Leamington Spa. The prison and Warwickshire Probation Area had worked together with the man to make plans for his return to the community. His arrival went smoothly, and he was welcomed by one of the Assistant Wardens who gave him a comprehensive induction. After spending five days at the Approved Premises, the man left in the afternoon, having been challenged by staff regarding medication he had in his possession in contravention of the hostel's rules. He then failed to return, and the following day staff were told that he had been found dead in an empty building in Rugby.

One of my colleagues conducted this investigation, and I am grateful for the assistance he received from staff of the Warwickshire Probation Area and from the local police and from HMP Stocken.

I judge that the Leamington Spa Approved Premises is managed by caring and committed staff, and in accordance with Approved Premises guidelines. I do not believe that the man's actions could have been predicted, or in that sense directly prevented. However, I have identified two learning points from this investigation which are reflected in my report.

Stephen Shaw CBE
Prisons and Probation Ombudsman **March 2007**

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SUMMARY

The man at the centre of this report was released from HMP Stocken on 25 August 2006 on home detention curfew (HDC). He was required to live at an Approved Premises in Leamington Spa. He was fully inducted by the staff at the Approved Premises, and his licence and HDC conditions were also fully explained (the HDC licence required him to wear an electronic tag). The conditions of his licence had already been explained to him by his field probation officer, prior to his release from prison. The man signed the relevant papers to show that he fully understood what was expected of him whilst residing in the Approved Premises.

On Wednesday 30 August, the man attended an appointment with the Approved Premises' General Practitioner at the doctor's surgery. He returned to the Approved Premises some time later, and it was apparent to staff that he was either intoxicated or under the influence of drugs. The usual procedure of searching all bags brought into the premises was carried out, and it was discovered that he had been given a prescription for medication from the doctor. He had then collected the medication from the local chemist. This was contrary to the Approved Premises policy which stipulates that all residents' medication is handed over to staff and kept locked away in their office. On checking in the man's bag, staff found the prescription slip and saw that there was a shortfall of medication but the man said he had not been prescribed them. His speech was slurred and, although he admitted to having drunk two pints, staff believed he might have been under the influence of another substance.

Staff telephoned the doctor's surgery and established that the doctor had prescribed 28 sleeping pills, as well as other medication, which the man had failed to hand in to staff at the office. The chemist was also contacted, and confirmed that all the medication on the prescription sheet had been dispensed to the man that day.

The man was asked to speak to the Deputy Manager of the Approved Premises. During the interview he admitted to drinking five pints, and selling the sleeping tablets after collecting them. Staff told him his behaviour was unacceptable and that, as his previous offences were linked to drug abuse, he would be recalled to prison. He was told to wait in for the police to come and collect him, but he decided to leave. He then failed to return before his HDC curfew time of 7.15pm, and also failed to return by the 11.00pm premises curfew.

The paperwork was completed for the man's recall to prison, and the police were informed of the circumstances and that the man was now absent without authority. The police were able to establish that the man had telephoned his family to tell them that he was being recalled to prison and wanted to see his children. At 5.30pm, his stepfather collected him from outside the Approved Premises and took him to the family home. Whilst with his family, the man

removed his tag. He left the family home at around 8.00pm that evening.

The police confirmed that at around 9.30pm that evening, he met another man and visited an empty building in Rugby. He had in his possession half a bag of heroin and a rock of crack cocaine, and the two men consumed the drugs.

Later, at around 9.54pm, the police were contacted by Warwickshire Ambulance Service who requested assistance to enter the building following information received. The police discovered the man's body. He had apparently overdosed on drugs. He was aged 26.

CONDUCT OF INVESTIGATION

1. The investigation was conducted by my investigating officer with the co-operation of the Warwickshire Probation Area. I am especially grateful for the assistance that my investigator received from the manager and staff at the Approved Premises in Leamington Spa. Although those interviewed were coming to terms with the man's death, they made facilities available and participated fully in the investigation.

2. My investigator visited Warwickshire Probation HQ as well as the Approved Premises. He studied records, and interviews were conducted with staff, as well as with the man's field probation officer. Transcripts of the interviews are attached as annexes to this report.

3. One of my Family Liaison Officers contacted the man's family and explained the investigation process to them. They were invited to raise any concerns or questions they might have for the investigation to consider. The man's mother said that he had originally been happy at the Approved Premises and was looking forward to future appointments, such as with the college. However, he contacted her on the Tuesday before his death and told her that he did not want to live there anymore. He had concerns that a drug dealer was living there, which he thought would put temptation in his way.

BACKGROUND

The Approved Premises in Leamington Spa

6. Approved Premises, formerly known as Probation and Bail Hostels, are approved by the Secretary of State within Section 9 of the Criminal Justice and Court Services Act 2000. They provide accommodation for people granted bail in criminal proceedings and also supervision and rehabilitation for those convicted of offences. Hostels provide a supportive, structured environment in the community for high risk and difficult to manage offenders. The purpose of the period of residence is to ensure that the individuals concerned are subject to close oversight in the community. Their supervision within the Approved Premises is governed by the National Probation Service's Standards for the Supervision of Offenders.

7. Referrals for a place at the Approved Premises in Leamington Spa are made by the field probation officer. Four weeks before someone arrives, a pro forma is faxed to their prison's healthcare centre to request information about medication, physical and mental health, and any self harm issues. The form also asks for information about the medication they are on likely to be discharged with. The information is asked for on behalf of the Approved Premises' designated doctor.

8. Referrals to Warwickshire's Approved Premises are processed through a central admissions unit. The area probation manager officer decides whether or not a place can be offered. There is no contact between the staff at the hostel and a prospective resident until the day they arrive, and all contact is by their home probation officer who retains responsibility for supervision during the period of residence.

9. There are two Approved Premises in the Warwickshire area, one being this one in Leamington Spa. This is a 19 bed unit can accommodating men from the age of 18. It has a mix of shared and single rooms.

10. Approved Premises are primarily a resource for managing high risk of harm offenders, who have either been released from prison on licence or bailed from court. If a prisoner has been released on licence, it means they are still a serving a sentence, but they can live in the community instead of being in prison. There are rules or conditions attached to each licence.

11. Breakfast and dinner are provided each day at this Approved Premises. A doctor is available locally. The hostel has links with a number of community organisations.

12. The Approved Premises in Leamington Spa has ten members of staff,

including a manager and a deputy manager. The manager of this Approved Premises is also the Area Manager for Approved Premises in the Warwickshire area, with responsibility for the other hostel too. There is a full time administrator, five assistant wardens and two night waking permanent staff. There is also a pool of relief staff who cover periods of sickness, annual leave, and training. In addition, a cleaner and a cook are employed.

13. The manager and deputy manager are qualified Probation Officers. The Assistant Wardens and night waking staff are not professionally qualified, but they all have had a formal induction into the Approved Premises. Where appropriate, they have linked into Probation Service Officer modular training, but there is no specific training programme for Approved Premises staff. Staff have attended a suicide awareness course and training events on raising awareness about mental health issues. They also have had the opportunity to attend joint Prison Service training events. All Approved Premises permanent staff have a minimum of the basic first aid training.

14. Unless a resident is subject to individual curfew arrangements imposed by a court, they must be on the premises between the hours of 11.00pm and 6.00am. This man's tagging curfew was between 7.15pm and 7.15am.

15. The Approved Premises in Leamington Spa has an established routine for inducting new residents which is carried out by staff on duty at the time. It is good practice that an admission/induction procedure document is used as it ensures that staff provide a consistent message for all residents. Staff also reiterate information about the rules regarding the use of drugs, and include advice to those who have just been released from prison and may have reduced tolerance.

16. Like most Approved Premises, this hostel has a policy on alcohol and drugs. The possession or use of alcohol, solvents and controlled substances is not allowed either in the Approved Premises or within the grounds. The one exception will be medications which are currently prescribed to an individual. These must be notified to staff and stored securely in the main office.

17. There is a clear protocol about when and how, and under what circumstances, staff would alcohol and/or drug test. Oral testing will take place when there are reasonable suspicions that a resident has been using illegal drugs or alcohol. With regard to alcohol testing, this would occur when there was suspicion that a resident had consumed a quantity of alcohol and is in denial that alcohol is a problem or has a previous history of alcohol misuse linked to offending.

18. Room searches are undertaken on a regular basis. Residents are also required to show all their belongings each time they return to the Approved

Premises so that staff can identify what is being brought into the building. If alcohol or drugs are found during a room or bag search, immediate action is taken. Before arrival at the Approved Premises, each prospective resident is asked to sign that they agree to comply with the standard rules of the premises. The rules specify the drug and alcohol testing regime in operation, and that if an individual arrives with drugs or alcohol, appropriate action will be taken.

19. There is an arrangement with a local doctor's surgery to provide medical and prescribing facilities to the residents, for which an additional premium is paid. All residents must attend an initial medical examination with the doctor. Part of the agreement with the surgery is that residents are not to be handed prescriptions directly. The prescription should be collected by the local pharmacy, and then the medication delivered to the Approved premises. The duty Assistant Warden issues any prescribed medicines, noting the dosage in a register to be signed by both the resident and the duty Assistant Warden.

KEY FINDINGS

Prior to Friday 25 August

20. On 22 July 2005, the man pleaded guilty to two offences of burglary and two offences of theft in March and April 2005. In June 2005, he had been further charged with failing to appear at court in relation to these offences. A pre-sentence report was prepared by the man's field Probation Officer. She described his long history of drug use and long term offending to fund his habit. He was given a 37 month custodial sentence by Warwick Crown Court which he served at HMP Stocken.

21. The man was eligible for release on HDC licence from 25 August 2006. In preparation for his release, his field probation officer referred him for accommodation at the Approved Premises in Leamington Spa. The referral also mentioned that the man wished to be assessed for HDC. The manager, in her role as Manager for Warwickshire Approved Premises, asked that the following additional licence conditions be added to the man's licence:

    (1) Not to seek or approach any of the victims related to his crime
    (2) To comply with requirements specified by his supervising officer for the purpose of addressing his drug and re-offending problems including attendance at Community Drug Team and attendance on a drugs accredited programme
    (3) Report to deputy manager on day of release.

22. The manager also asked the man to sign the Approved Premises rules documentation, and arranged for a cheque for £47.40, payable to the Approved Premises in Leamington Spa, to be sent for the weekly rent.

23. On 11 August, the man's field probation officer returned the signed copies of the rules to the Approved Premises manager, and she also mentioned that the man would have contact with his children either at their home or at his mother's house.

24. Staff at the Approved Premises contacted Stocken's healthcare department on 23 August, to ascertain what medication the man was currently being prescribed and what he would be given upon his release. The prison responded with the following information, which also went to the Approved Premises' doctor:
    Salbutamol 100mcg inhaler (for asthma)
    Beclomethascone 1000mcg inhaler (for asthma)
    Zopiclone 7.5mg (for insomnia)
    Dothiepin 100mg (for depression)
    Naproxen 500mg (for foot pain).

The prison informed the doctor that the man would be provided with sufficient medication for nine days, plus one of each inhaler.

Friday 25 August and afterwards

25. The man was released from Stocken on Friday 25 August. The clinical records show that he was prescribed the following medication, which was given to him over a period of ten days before his release. On 15 August, he was given a Salbutamol 100mcg inhaler, a Beclomethascone 100mcg inhaler and Naproxen 500mg (28 tablets). A week later he was given Zopiclone 7.5mg (7 tablets), Dothiepin 25mg (7 tablets) and Dothiepin 75mg (7 tablets). The day before his release, he was given Zopiclone 7.5mg (7 tablets), Dothiepin 25mg (7 tablets), Dothiepin 75mg (7 tablets) and Naproxen 500mg (28 tablets).

26. The man's licence should have read that he should report straight to the Approved Premises in Leamington Spa. The licence was incorrect, and told him to report to his probation officer at the Rugby probation office. The man followed the instruction and reported to his probation officer's office.

27. The man's probation officer checked that he was well, to which he responded positively. He was concerned that one of the conditions of the licence was attendance at a drug misuse programme, although he had completed a similar programme in prison. His probation officer said she would check and let him know the outcome at their next meeting. She explained that, whilst in residence at the Approved Premises, he would have weekly meetings with the deputy manager and his assigned key worker twice a week. The man was happy with the arrangement, and told his probation officer that he had already arranged an interview at a local college. She gave the man money for public transport to Leamington Spa, together with a map and directions. She then telephoned the Approved Premises to tell them that the man would be late arriving.

28. The man arrived safely at the Approved Premises in Leamington Spa around 5.00pm, which was later than expected, because he had gone to see his probation officer first. Although he smelt of alcohol and, when challenged by staff, he admitted having drunk a couple of pints on the way. He was given a full induction by an assistant warden, and admitted that he liked a social drink but that it was not a problem to him. The man had some medication in his possession, and said that he suffered from depression, asthma and sleepless nights. He told the assistant warden that he only had enough medication to last until the following Tuesday, and had lost the Zoplicone tablets. My investigator was told that staff do not routinely challenge any difference between the expected medication and what a resident hands in on arrival. The assistant warden recorded on the

medication sheets the following medication:

Dothiepin - 4 tablets x75 mgs 1 to be taken at night
Dothiepin - 5 tablets x 25 mg 1 to be taken at night
Naproxen - 25 tablets to be taken daily.

No mention was made of either inhaler.

29. The assistant warden noted the discrepancy in the medication, and said that staff would contact the surgery on Tuesday (the next working day as Monday was a Bank Holiday), and request an urgent appointment. The man told her that he had once been a user of crack cocaine, but said he had not used drugs for the last 18 months. He was given a drugs test by the assistant warden, which was negative.

30. The assistant warden explained the licence conditions again to the man. As he was subject to HDC he was to be tagged, but his late arrival at the premises meant that he had missed the security company, SERCO, who would fit it. Afterwards the man was shown around the Approved Premises to familiarise himself.

31. The next day, Saturday 26 August, the man's key worker contacted SERCO to enquire when they would return to fit the man's tag. She was told that it would be some time later that evening. In the meantime, the man attended an appointment at the Department of Work and Pensions and was told to return on 31 August to sign on for social security benefits.

32. Around 1.00pm, the man met his key worker, who administered the routine literacy and numeracy test used to identify whether a resident would benefit from adult learning. He told her that he was a little nervous about staying at the Approved Premises, and had had a disturbed first night. He was reassured by the key worker that, once he settled in, things would be better. He told her that he had been diagnosed as having post traumatic stress disorder (PTSD), and was prescribed Naproxen, Dothiepin and Zopiclone. The man's key worker confirmed that the man understood the information from his induction the previous evening, and he said he had no problems with staying there. His key worker then checked his records to ascertain whether any risks were highlighted, but none had been identified. Despite this, she took the opportunity to talk through some issues about drugs, explaining that having been in prison his tolerance level would be very low. As a matter of routine, the man was also asked to register with the local drugs and alcohol team when their offices opened after the Bank Holiday.

33. Over the course of the weekend, the man's mother and partner collected him from the Approved Premises to take him to the family home. His

mother described him as being very well and in good spirits. He also contacted the mother of his children and arranged to meet them. On Saturday evening, around 7.00pm, the tagging company attended the Approved Premises and the man was fitted with a tag.

34. The man's key worker described him as a model resident on his first day. He adhered to everything staff had asked him to do such as house chores, and presented no problems.

Tuesday 29 August

35. Approved Premises staff contacted the doctor's surgery and made an appointment for the man for the next day. He went out during the day, and returned to the Approved Premises around 5.55pm. Staff again smelt alcohol on his breath and asked if he had been drinking. He replied that he had two pints, which was noted, and he was allowed in as he was not deemed to be a management problem.

Wednesday 30 August

36. The man went to his doctor's appointment at 11.00am, and returned to the Approved Premises just after 3.00pm. As usual his bags were searched, on this occasion by his key worker, who was on duty at the time. The search took place at the office hatch, which is just inside the entrance of the premises. His key worker found medication and tobacco, and so asked the man how he came to be in possession of the medication and whether he was given a prescription from the doctor. The man told her that the doctor had given him a prescription which he had taken to the chemist. When asked by his key worker if he still had the counter slip from the prescription, he searched his pockets and produced it, screwed up into a ball. His key worker proceeded to check the medication in the man's possession against the medication slip. She found that the Zopiclone was missing, and asked him where it was. He said that he had not been given the tablets. His key worker repeated the question and again the man denied having it. He became agitated and confused, saying that he really needed the tablets and that the doctor had made a mistake with his medication. The key worker told my investigator that she believed the man was under the influence of illicit substances as he was slurring his words and did not smell of alcohol.

37. The man's key worker asked the man to step into the office where the deputy manager was also present. The deputy manager had observed the key worker talking to the man at the hatch, and was aware of the items found in his bag. She also challenged him about the whereabouts of the missing medication. Again he denied having been given the Zopiclone.

38. The deputy manager told my investigators that she and the man's key worker were surprised that the man had any medication on him and even more surprised to be told that the doctor had given him the prescription. The man told them that the doctor had not given him his sleeping tablets (Zopiclone), or the correct dose of another one. Once in the office, he was asked if he had been drinking and again he said that he had had two pints. The deputy manager instructed the man that she would investigate further. He told her that he had to go out again, and she told him to return by 3.30pm.

39. In the meantime, the deputy manager and the man's key worker began to make enquiries about the medication. The key worker telephoned the doctor's surgery to confirm that they had given the prescription, and what it was for. The surgery staff confirmed that the man was given a prescription and the medication was:

    Beclometasone (inhaler)
    Salbutamol (inhaler)
    Zopiclone 7.5mg (28 tablets)
    Dosulepin 25mg (28 capsules)

40. The deputy manager reminded the member of staff at the surgery that handing prescriptions to residents was against their agreed procedure. She also said that the man said he had not received the listed Zopiclone tablets, and did not have them in his possession on his return to the Approved Premises. The surgery confirmed that the man had been prescribed 28 Zopiclone tablets 7.5mg, and advised the deputy manager to telephone the chemist to check whether the medication was actually dispensed. The deputy manager confirmed with the chemist that the man had in fact been given the prescribed Zopiclone tablets.

41. The deputy manager was aware that the man's previous offending behaviour was drug related and wondered whether he had sold his medication. This was something she knew was often done by drug users. The seriousness of the man's actions began to be evident. First, he had lied to staff. Secondly, he was building up a possible pattern of alcohol use. Thirdly, prescribed medication had gone missing.

42. The manager of the Approved Premises was not available, and so the deputy manager sought advice from an Assistant Chief Officer (ACO). She explained the situation, knowing that the man had to receive an official warning or be recalled to prison. It was agreed with the ACO that, if the man admitted receiving the medication and handed it to staff, he would receive a warning. However, if he no longer had the medication in his possession he would be recalled to prison. The deputy manager began to check the information thoroughly in preparation for the man's return at

3.30pm.

43. The man did not return at 3.30pm as required, thus committing another breach of the rules. He eventually returned after 4.00pm, by which time the man's key worker had gone off duty. The deputy manager and the assistant warden interviewed him. His demeanour was described as calm, but he smelt of alcohol. He was told that both the surgery and chemist had been contacted and confirmed he had been given all the medication listed on the prescription. The man was asked again what he had done with the medication and whether it was still in his possession. He admitted having drunk five pints earlier in the day, and said he had sold the tablets to get the bus fare to go and visit his family and children.

44. The deputy manager told the man that his situation was serious, reminding him that he had signed an agreement about possession of all medication. She told him he had not adhered to the agreement, had lied to staff and had sold his medication. She then explained that, under the circumstances, proceedings would be started to recall the man to prison. As he was not assessed as a high risk offender, the deputy manager thought it was safe and appropriate to inform him of the recall decision. She told my investigator that the man appeared to accept the reason for his recall.

45. The deputy manager explained the recall procedure to the man, saying that he would be arrested and returned to prison where he would have a review after four weeks. She wanted to make it clear to him that he could return to the Approved Premises in Leamington Spa as, apart from this incident, he had presented no real concerns. She advised the man to use the time in prison to seriously think about his behaviour, his life, his children and giving up drugs.

46. During their conversation, the man asked the deputy manager if he could leave the premises to return his brother's bike. She told him that she could not stop him from leaving the building, however it would be silly of him to go missing to try to evade arrest. The man said he had no intention of doing this, but wanted to return the bike and say goodbye to his children. He was completely calm when listening to the deputy manager, and she thought that he understood the consequences of absconding. The man left the building after 4.15pm. Both the deputy manager and the assistant warden believed that, although he had been drinking, he would return to the premises as instructed.

47. The deputy manager waited a short while to complete the recall papers, primarily because she knew the appropriate section of the Home Office changed shifts at 5.00pm, and the paperwork would take a while to complete. She informed the man's probation officer that the man was to be recalled. The deputy manager's own shift ended around 5.30pm and,

before leaving, she told colleagues that she would telephone around 7.15pm to check that the man had returned and then commence the recall procedure.

48. The police told my investigator that the man was collected from the Approved Premises by his step-father at around 5.30pm and taken to the family home. His mother said his mood was different on this occasion. He was down in spirits, and she thought he had taken some of his medication, and been drinking. However, he had arranged to see his son, which lightened his mood a little. The man told his mother that he was being recalled to prison because of confusion with his medication. He was upset about being recalled, and this, along with the fact that he wanted to see his son, resulted in the man removing the tag from his ankle.

49. Between 7.00pm and 7.15pm, the deputy manager completed the recall papers and then telephoned the assistant warden at the Approved Premises to confirm that she had done so. She told the assistant warden to contact the police as well as SERCO.

50. The man had not returned to the Approved Premises by 7.15pm, and the assistant warden contacted the police to let them know that a resident on tag and licence, and due to be recalled, had not returned for his curfew time. She also telephoned SERCO to inform them that the man was not back in the building for his curfew time, and that recall action had been commenced.

51. The man remained at his mother's house until around 8.00pm. When he left, he told his mother that he did not know where he was going. The police confirmed that, at around 9.30pm that evening, he met another man and visited an empty building in Rugby which was known to be used by drug users. He had in his possession half a bag of heroin and a rock of crack cocaine. The two men consumed the drugs.

52. At around 9.54pm, the police were contacted by Warwickshire Ambulance Service who requested assistance to enter a property in Rugby. This was following a report of a heroin overdose by someone within the building. The police discovered the man, who was unconscious. Despite attempts by the paramedics to revive him, he did not regain consciousness and was pronounced dead where he was found.

Thursday 31 August

53. Staff at the Approved Premises in Leamington Spa were unaware of the man's fate, and still waiting for him to return. At about 2.40pm on 31 August two police officers, also unaware, arrived to collect the man following his recall. The assistant warden informed that them that the man was missing, and that the information had already been passed to the police.

54. Later that evening, the man's key worker was informed by one of the residents that the man had been found dead in a basement, apparently from an overdose. The resident had received this information via a telephone call from a friend.

Friday 1 September

55. The deputy manager came on duty that morning, and the man's key worker told her what the resident had said. The deputy manager confirmed the information with the resident, and then telephoned the Police Public Protection Unit to ask whether it was correct. She received a telephone call from the police shortly afterwards and was told that a body had been found which had not yet been identified. The deputy manager telephoned the manager of the Approved Premises to inform her, and she in turn told an Assistant Chief Officer.

56. At 11.00am, the police telephoned the Approved Premises and confirmed the man's death. They said they would inform the man's family and would visit the Approved Premises later in the day to collect his belongings.

57. Another resident told staff that he had heard the man had been found dead, and that all the other residents were talking about it. He said that the man had been taking strips of Zopiclone tablets, eating them like sweets, and had been drinking alcohol.

58. Later that evening, at around 5.10pm, the police arrived at the Approved Premises to collect the man's belongings. They explained to the staff how the man had visited the family home, broken his tag off, and later been found in a squat, apparently having overdosed on crack cocaine.

Events following the man's death

59. On 4 September, the manager of the Approved Premises wrote to the practice manager at the doctor's surgery. She expressed her concern that agreed procedures had not been followed, and a doctor had given a resident a prescription for medication, which should only have happened in consultation with the Approved Premises staff. Apparently, this was the second occasion where a resident had been given a prescription from the doctors. The practice manager later replied, acknowledging the error.

60. The man's probation officer was told of his death by staff at the Approved Premises. She wrote to the man's mother offering her condolences and providing contact details should she wish to get in touch with her. The man's mother telephoned his probation officer a couple of days later and thanked her for the help she had given her son.

61. The Approved Premises manager also wrote to the man's mother, offering condolences on the loss of her son. The man's mother telephoned the manager on 21 September to thank her for the support the hostel had provided her son. She confirmed that the man's funeral had taken place already, a week earlier. She said that the man was initially happy at the hostel, but was worried when a drug dealer had arrived at the premises. He was worried it would tempt him into using again. The manager said that staff were unaware of the man's anxiety. Had they known, they would have looked into the matter and made extra support available.

62. In the week after the man's death, senior managers from the probation area contacted the manager by telephone and visited the Approved Premises to ask about the welfare of staff and offer their support. The manager also ensured staff received individual support with either her or the deputy manager. All staff interviewed by my investigator considered that these arrangements more than met their needs. I would go further than this and say that the actions of the manager and her more senior colleagues represented very good practice.

63. On Thursday 14 September, the manager held an emergency residents' meeting. The man's death was discussed and residents were told that, should they have any information which could be of some relevance, they should speak to any member of staff or to my investigator.

64. The toxicology report received from the Coroner's officer shows that the man tested positive for Zopiclone, Dothiepin, Naproxen, opiates, alcohol and cocaine.

ISSUES RAISED IN THE INVESTIGATION

Checking medication after release from prison

65. Four weeks before the man's release from prison, the Approved Premises confirmed with HMP Stocken what medication the man would be given upon his release. However, when he arrived at the Approved Premises, he possessed less than was stated and one medication was missing.

66. Staff at the Approved Premises told my investigators that HMP Stocken had not given any additional information as to what medication the man was actually released with. This was confirmed by the Approved Premises manager, who also said that staff were unlikely to verify the information as residents routinely arrived with either no supplies or less than was expected.

67. My investigator confirmed from prison documentation that the man was issued with the correct amount of medication. What exactly happened to it is not known and there is no documentation within the Approved Premises which highlights the discrepancy.

68. Again this is a learning point for the staff at the Approved Premises who, where necessary, could contact the releasing prison to ascertain if there has been any change in medication upon a prisoner's release. This is essential to staff assessing new residents for the first time as it would help in assess and identify risks. In this case, on two occasions the man had been given Zopiclone which subsequently went missing. My investigator found that staff took positive action on the second occasion, which resulted in the man being challenged about the medication.

When a resident arrives after release from prison, and it has been established that there is a discrepancy in their medication, it is good practice to contact the prison and ascertain whether the medication is correct.

Protocol with the doctor's surgery

69. The agreed protocol between the Approved Premises in Leamington Spa and the doctor's surgery states that no resident should be given a prescription unless it has been previously agreed with the Approved Premises. The actions of the surgery on this occasion do not conform to the protocol. According to the Approved Premises manager, it was the second occasion when the error occurred.

70. The practice manager for the surgery has since replied that the doctors and surgery staff have been reminded of the protocol. I reiterate the importance of this and suggest the chemist is also made aware of it.

CONCLUSION

71. It is my view that the man's probation officer and the staff of the Approved Premises in Leamington Spa provided the man with the appropriate care and information both before and after he became a resident. The licence conditions and the premises rules were fully explained to him by more than one member of staff. Staff were diligent in dealing with the man when he returned with medication in his possession. They were also compassionate and gave him the opportunity to return, should circumstances permit at a later date. This demonstrates the open and fair way in which staff deal with residents.

72. It is unfortunate, however, that the man was able to receive prescribed medication which he used to obtain cash. Whether he used the money for travel expenses, or for drugs, we will never actually know. However, my investigator found no indication that the man deliberately intended to harm himself.

LEARNING POINTS

Where a resident arrives after release from prison, and it has been established that there is a discrepancy in their medication, it is good practice to contact the prison and ascertain whether the medication is correct.

Good Practice

In the week after the man's death, senior managers from the probation area contacted the manager by telephone and visited the Approved Premises in Leamington Spa to ask about the welfare of staff and offer their support. The manager also ensured staff received individual support. The actions of the manager and her more senior colleagues represented very good practice.