Investigation into the circumstances surrounding the death of a man at Weston Approved Premises, in the Dorset Probation Trust area, in June 2011

Report by the Prisons and Probation Ombudsman for England and Wales

February 2012

This is the report of an investigation into the death of a man who was found dead in his room at Weston Approved Premises in June 2011. He was 35 years old. An investigator conducted the investigation. I extend my condolences to the family, friends and all those affected by his death.

The man had a long history of alcohol and illicit drug use. A few weeks before his death, he had spent time at a local drug rehabilitation/after care centre, but following a relapse back into illicit drug use he had moved to Weston Approved Premises. He had previously been a resident there, was known to the staff and seemed to be content. During his time at Weston, staff had no concerns about his physical health.

One morning in June, the man failed to sign the Approved Premises register and staff assumed that he was sleeping. However, when he again failed to sign later that morning staff went to his room and discovered him lifeless. When ambulance paramedics arrived, they confirmed that he had died.

The post mortem indicated that the man died from pulmonary oedema (fluid on the lung) resulting from pneumonia. Toxicology tests carried out after his death have identified methadone in his system, but it is not clear what, if any, affect this had on him prior to his death.

I am satisfied that staff could not have foreseen or prevented the man's death. However, the report makes clear that there is scope to learn lessons from this tragic case for the benefit of both residents and staff. Accordingly, it is recommended that Dorset Probation Trust ensure that Approved Premises staff at Weston have appropriate first aid training and access to effective drug testing equipment. We have also made a broader recommendation to the National Offender Management Service about the need for improved guidance for staff dealing with next of kin after the death of a resident in an Approved Premises.

Following sight of the draft report, two of the recommendations were accepted and the recommendation made to the National Offender Management Service was rejected. Feedback to all the recommendations is included on page 18 of this final report. Feedback from the man's family is added to paragraph 72.

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

Nigel Newcomen CBE
Prison and Probation Ombudsman **February 2012**

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SUMMARY

1. The man was 35 years old. Probation staff found him dead in his room at Weston Approved Premises in June 2011.

2. He had a long history of illicit drug and alcohol use that had led to him offending and being imprisoned on a number of occasions. He was known to police and probation staff in the Dorset area, and had been identified as a prolific offender.

3. In November 2010, the man was released from prison and given a place at Carlton House, which provides residential care and a recovery programme for those with drug or associated addictions. Initially, he progressed well and remained drug free. However, in April 2011, he relapsed and this led to him being moved out of Carlton House, as he no longer met its criteria.

4. The man moved into Weston Approved Premises and, although he said that he wanted to get back on track, the evidence was that he was drinking heavily and still using drugs. On 20 May 2011, he failed to return to Weston and was away for a few days, during which time arrangements were made for his recall to prison as he had breached his licence conditions. When he finally handed himself in to staff at Weston on 25 May, he was returned to HMP Dorchester, for a period of 28 days.

5. On 20 June, he was released and returned to Carlton House to begin treatment again. Unfortunately, he was only there for one day. He returned to Carlton House on 21 June after he was supposed to be at a meeting. He was intoxicated and told staff that he had used drugs. As a result, he was refused entry and told that he should go to Weston.

6. The man moved back into Weston. Over the next few days, he spoke with staff and said that he was ashamed that he had let himself down again. He engaged with the local drug service and arrangements were made for him to begin a Subutex programme. However, he had told staff that he did not want to be on Subutex and would rather deal with his drug issues himself.

7. He spent the evening at the Approved Premises and was last seen at 8.00pm, before he went to his room. The following morning, he was required to sign the register at 9.00am, but failed to do so. Staff decided to allow him to sleep, as it was the weekend. At 10.00am, a member of staff went to his room to check on him and saw him lying on his bed, so was not concerned.

8. At 12.30pm, he had still not been seen, so another member of staff, an Approved Premises Assistant, went to his room with the intention of waking him up. As he entered the room and approached the bed, it was clear from his appearance that something was wrong. The assistant could also see that he had been sick. He called his name, but he did not respond, so he went to the office and telephoned an emergency ambulance. The ambulance arrived at around 12.40pm and, following assessment by the paramedics, it was confirmed at 12.43pm that he had died.

9. The post mortem and toxicology tests have indicated that the cause of the man's death was pulmonary oedema resulting from pneumonia. He had methadone in his system, but the pathologist was unable to say what effect this may have had on his respiratory system prior to death. He had not been prescribed methadone in the community.

10. There are two recommendations about drug testing equipment, and first aid training as well as a national recommendation about guidance for Approved Premises staff in dealing with next of kin following the death of a resident.

THE INVESTIGATION PROCESS

11. The investigator visited Weston Approved Premises on 1 July. He met several of the staff, including the manager of the premises.

12. Notices about the investigation and its terms of reference were displayed around the premises which invited staff and residents to contact the investigator should they wish to do so. No residents came forward.

13. The investigator contacted staff at Carlton House and Weston who provided him with information to assist the investigation. He also provided written feedback to the Approved Premises manager following his initial visit.

14. HM Coroner for Western Dorset was informed of the nature and scope of the investigation and his office provided a copy of the post mortem. A copy of this report will be sent to him to assist with his enquiries into the man's death.

15. A family liaison officer (FLO) contacted the man's ex-partner and nominated next of kin. The FLO and investigator subsequently visited his ex-partner at her home. She asked a number of questions about his time at Weston. The investigator was able to provide some answers at the meeting. However, she also asked why staff at Weston did not carry out checks on residents' rooms, why they had not tried to wake him earlier and also questioned the reliability of the drug testing equipment in use. The report seeks to address these issues and it is hoped that the findings of the investigation provide the ex-partner with a better understanding of the events leading to his death. A copy of the report was made available to the family. The family's response to the report is added to paragraph 72.

Carlton House

16. Carlton House was opened as a residential care home in 1986. It provides an abstinence-based recovery programme for drug, alcohol, and associated addictions. Referrals can be made from any source, and the centre can accommodate up to 15 male residents, who must be drug free.

17. There are trained staff on duty at the centre 24 hours a day. To support residents, the centre provides one to one counselling, art therapy, workshops, and has links with local training colleges to enable residents to continue with their recovery. After 12 to 14 weeks, residents are given the opportunity to move to Worcester House.

Worcester House

18. Worcester House is the extended care centre. It provides a service to those residents who have trouble reintegrating into the community, due to their varied histories, abilities, and backgrounds. The centre supports residents as they work towards independent living. While at Worcester House, residents are responsible for their own rents paid through their earnings, employment benefit, housing benefit etc.

Weston Approved Premises

19. The purpose of an Approved Premises is to provide an advanced level of residential supervision in the community, alongside a supportive and structured environment. Whilst residents have to comply with their individual licence or bail conditions, curfews, and the Approved Premises' house rules, they are essentially free to come and go from the building.

20. Weston Approved Premises is one of around 100 in England and Wales. It is located in Weymouth and run by Dorset Probation Trust. The premises provide a service to the South West Region and, additionally, Hampshire. It normally provides for 24 residents but can take up to 26. This is the first investigation by this office at Weston.

KEY EVENTS

21. The man was 35 years old. He had regularly used amphetamines, cocaine and alcohol for a number of years, which had led to repeat offending. He was well known to drug treatment and probation services in Dorset.

22. On 7 November 2008, the man was sentenced to four years imprisonment for burglary at Crown Court. He was released on conditional licence on 15 November 2010. While in custody, he had been addressing his offending behaviour, including his drug and alcohol use. Probation and drug treatment services had arranged a place for him at Carlton House rehabilitation centre in Weymouth, where he was to stay for the first six months of his licence. His licence was due to expire on 8 November 2012.

23. The man was being managed under the DIVERT scheme. This is an integrated offender management (IOM) scheme with a multi-agency approach. The criterion for inclusion in the scheme is that an individual is, has been, or potentially could become a prolific or priority offender. For those who are identified as potentially becoming such offenders, it is believed that a more intensive multi-agency approach may divert them from this path. The multi-agency team consists of Probation, Police, Prisons, Drug intervention programmes, and other agencies as required. The probation staff who made up his team were his probation officer/offender manager and his Probation Service officer/Offender Supervisor (OS).

24. As part of his licence, the man had to engage with Avon and Somerset Prolific Offender Scheme, stay at Carlton House, comply with drug testing requirements, and address his alcohol, drug, and offending behaviour. He also had to attend any appointments that his offender manager instructed him to.

25. Staff at Carlton House said that the man hite had initially remained drug free and had not used alcohol. This was confirmed by regular tests conducted as part of his treatment. He successfully completed the programme and progressed from Carlton House to the extended care centre, Worcester House in February 2011. He continued to make positive progress and probation staff were pleased with this. He enrolled in a course at a local college and was involved in voluntary work. In addition, he continued with one to one work as part of his continuing rehabilitation.

26. Unfortunately, he relapsed in April 2011. Due to his resumed drug and alcohol use, he was asked to leave the rehabilitation centre. He was discharged and given a place at Weston Approved Premises in Weymouth. Staff at Carlton House said that after he had moved to Weston, they saw him occasionally, and it was obvious to them that he was once again becoming more involved with drugs and alcohol. He had stopped attending college, doing voluntary work, and had less contact with his friends from Carlton House, who had supported him during his time there.

27. The investigator was told that the reason for his relapse was due to a personal relationship that he had developed with someone who had the same addiction problems. However, this is not substantiated.

28. The investigator asked the manager at Weston why, at the point the man had been asked to leave Worcester House, he had not been recalled to prison for breaching the terms of his licence. She explained that all cases are considered when a breach occurs. Individuals are risk assessed in order to decide whether they can continue to be managed in the community or return to custody. She said that at that time, he was a risk to himself with his continued drug use, but he had been making progress and it was felt that he could continue treatment in the community.

29. As part of the Weston Approved Premises rules, residents are subject to frequent drug and alcohol tests. Weston is not what is referred to as a 'dry house', which means that residents are not prevented from drinking while off the premises. However, all residents must remain under the drink driving limit. In the United Kingdom, the alcohol limit for drivers is 80mg of alcohol per 100ml of blood, 35mcg per 100ml of breath or 107mg per 100ml of urine. The exception to this would be if a resident had it imposed as part of their licence or bail conditions that they are not to consume alcohol or enter licence premises. The man had no such restrictions, but he was required to address his alcohol/substance misuse.

30. Cozart, a company that manufactures and supplies drug and alcohol testing kits and provides a testing service, supplies the tests that are used at Weston and other probation premises in the South West region. The alcohol test is a hand held breathalyser, much like that used by the police. The drug tests are oral swabs, which require staff to use their judgement if the result is not clear. This can lead to inconsistent results. The manager said that the results from the oral test are instant, but occasionally positive results for opiates and benzodiazepines will be sent for a further confirmation test. However, this is only done if a decision is required about possible recall to prison. She added that if the individual admitted using and was engaging with treatment then the test would not be sent away.

31. The manager also told the investigator that the drug tests are not considered by staff to be very reliable and that other premises in the South West had experienced similar problems with the accuracy and reliability of the testing kits. The investigator asked her whether she had heard rumours that if a person drank UHT milk before the test, it would give a negative reading. She said that she had heard this, but the claims had never been verified.

32. On 22, 23 and 24 April, staff tested the man for alcohol. The tests indicated that he was below the drink drive limit. However, it was recorded on 22 April that he smelt strongly of alcohol, despite telling staff that he had not had a drink since the morning. The Approved Premises Assistant (APA) recorded that he should be tested at different times of the day to get a true picture of the amount he was drinking.

33. She spoke with him at length on 25 April, as she was his appointed key worker. He told her that he felt that he had turned a corner, and did not want to re-offend. She recorded that he had provided negative drug tests and was attending Narcotics Anonymous (NA) meetings twice a week. She also discussed his health and well-being with him, and he told that he felt under weight and had not been eating due to having no money. She told him that he would be able to eat at the premises until he had sorted out his benefits. He said that he was aware that his self-esteem was low and welcomed and valued any support.

34. He continued to be tested for alcohol on a regular basis throughout April and was just below the limit each time. On 2 May, another assistant at the premises tested him at around lunchtime, and the reading was above the required level. When asked about the reading, he said that he had a couple of drinks as he was feeling down. When tested later that day, his alcohol reading was once again below the drink drive limit.

35. The following day, his keyworker spoke with him again at length and recorded that he was very distressed and emotional about personal issues. She listened and offered him support as well as encouraging him to continue with counselling. She said that he was looking frail, his eyes were permanently red, and he looked drawn and stressed. He provided an alcohol test, which was below the required level, but she recorded that he smelt strongly of alcohol. He also provided a negative drugs test.

36. Over the next few weeks, the man was spoken to about the possibility of moving on from Weston into his own accommodation, and was pleased about this. The results from his alcohol tests, however, continued to be erratic. On 19 May, an assistant at the premises tested him and the reading was 0.61 with the limit 0.35. The assistant recorded that he was very emotional and said that he was feeling depressed. He asked him whether he would like to see the doctor the following day, but he said no.

37. The next day, the keyworker gave him a warning for the high alcohol reading, but he failed to attend for a pre-arranged appointment with her. He telephoned later and said that he was running late and would return at 6.15pm. However, he failed to return for the 11.00pm curfew, and the police were notified. Over the next two days, he failed to return to the Approved Premises and on 23 May, the Probation Service made a request for his recall back to prison. He finally handed himself in to probation staff on 25 May and was sent to Dorchester prison for a period of 28 days.

38. Prior to his re-release his offender manager, his offender manager and staff from the Dorset Drug Intervention Programme (DIP) made a request for him to be given a place at Worcester House upon his release. It was agreed, but stipulated by staff at Carlton House that he must have in place a care plan and be clean of both alcohol and illicit drugs. He agreed to these requirements.

39. Dorset DIP service is provided by Turning Point who offers advice, information, support, and access to treatment for drug users. The service adopts a multi-

agency approach to ensure that all those needing help can access it anywhere within the Criminal Justice System. DIP services can be accessed from the point of arrest, throughout drug rehabilitation and during resettlement following a prison sentence.

40. A member of staff from Carlton House collected the man on 20 June at around 9.30am when released from Dorchester, and drove him back to Weymouth. On his arrival at Carlton House, he provided a urine sample and was tested for drugs, which was negative. Staff said that both his manner and attitude were positive, but he was 'fed up' at being back at the beginning of the recovery process.

41. That afternoon, he went with a member of staff to report to the duty officer at the Weston, as required under his licence conditions. (He was escorted as Carlton House does not allow residents to leave the premises unescorted in the first few weeks). He also attended a meeting with the DIP team, as this was part of the care plan drawn up prior to his release from custody, and went to the local job centre. During his first evening back at Carlton House, he attended a Narcotics Anonymous meeting along with other residents.

42. It is a national requirement for anyone released from prison to be seen on the day of release, or within one working day, by his or her offender manager. When the offender is not available, arrangements are made for the person to report to another member of staff. Weston operates a reporting centre and this is the reason that the man was instructed to report there.

43. The following day, he went to a meeting, as part of the DIVERT scheme, at the local probation office. Representatives attended from probation, police, and Weymouth aftercare. However, the local DIP team did not attend and said that this was because he had not used illicit drugs for 30 days or more and no longer fitted their criteria.

44. The investigator was told that the meeting was positive and plans to support the man were discussed. The service manager at Carlton House said that during the meeting both he and his manager could smell alcohol but could not be sure that it was the man. However, later that same afternoon when they had returned to Carlton House, it was clear that he had been drinking and a member of staff spoke to him. That evening he attended another meeting elsewhere, but staff were told that he had left early. When he returned later, he was drunk and told staff that he had also used cocaine.

45. He told the investigator that in view of the man's condition and his admission that he had used drugs and alcohol, he was told that he could not be accepted back into Carlton House. He was told to report to Weston and explain to them what had happened. He was further advised that if they could not help, he should return. At about 10.30pm, the manager from Weston Approved Premises telephoned Carlton House and spoke with him. She said that the man had been to the premises. She had asked him to wait, but he had left while she was on the telephone to the senior probation officer. He said if the

man returned to Carlton House he would provide him with accommodation until the following morning. However, he did not return that evening.

46. At 9.00am the following morning, the man returned to Carlton House and spoke with the service manager. The service manager said that he was tearful and apologised for the previous evening. He explained that he was having problems in his personal life and he felt low. Despite this, he said that he was going to speak to his probation officer and visit the DIP team to get some help.

47. The service manager told the investigator that when the DIP team were told about the man's relapse they were of the opinion that he should be recalled to prison. However, his offender manager told staff at Carlton House that it had been decided to try one more time to get him back on track, and he moved into Weston. She spoke with him in the afternoon and discussed the events that had led to his return to Weston. He said that he was aware that further problems would result in him being recalled to prison. She advised him that he needed to concentrate on addressing his drug and alcohol problems, which seemed to be compounded by problems in his personal life. She confirmed with him the conditions he had to follow and he agreed to abide by them.

48. While at Weston, the man's offender manager set additional requirements to disrupt his movements and for staff to be able to monitor him more easily. These required him to sign at the office at 9.00am, 1.00pm, 4.00pm, and 7.00pm daily, he was also under curfew at the premises between 8.00pm and 7.00am. In addition, he had also agreed to be drug tested three times per week as well as daily alcohol testing.

49. The man stayed in touch with the staff at Carlton House. He went there on 23 June to show them the new drug testing and reporting regime that had been worked out for him, and he appeared positive. He also told staff that it had been agreed he would begin a methadone programme from the Friday. The service manager told the investigator that he asked him why he had chosen the methadone programme and he had replied 'because I need something'.

50. Methadone is one of a number of synthetic opiates that are manufactured for medical use and have similar effects to heroin. Methadone and buprenorphine (Subutex) are used to treat heroin and other stronger opioids.

51. On the morning of 24 June, his keyworker spoke with him and discussed with him the events that had led to him returning to Weston. He told her that he wanted to 'ride it out' and not be given a Subutex prescription. He said that he had gone into self-destruct mode and would have done anything to get drugs. She recorded that he had very low self-esteem and self-image. He told her that he wanted to build himself up by going to the gym, and she advised him to slow down, but he said that he knew what was good for him

52. Later that day, the man attended an appointment with community drug and alcohol services (CADAS) who later telephoned Weston and told staff that he was to begin a prescription for Subutex that evening. As Subutex is a

controlled drug, residents are required to give this type of medication to staff so that it can be stored securely.

53. When he returned to Weston, he gave staff three tablets in a packet. He had been prescribed four and staff assumed that he had already taken one. However, his ex-partner told the investigator that after his death she had been given his property and had found a tablet, which turned out to be Subutex in the pocket of his jeans. As stated above, he had mentioned to the manager that he did not wish to be on Subutex.

54. On Saturday 25 June, the man left Weston at 2.00pm to go into the town and returned at 3.25pm. He is recorded as going out again 20 minutes later, telling staff that he was going for a walk. He was required as part of the conditions imposed by his offender manager to sign the register at 4.00pm, and he returned at 4.15pm and did so. He remained in the Approved Premises for the remainder of the evening. It is recorded in the signing sheet that he was asleep at 7.00pm in the television room when he was required to sign. He then signed at 8.00pm before going to his room. He did not indicate to staff that he was feeling unwell, but had told another resident that he was feeling really tired.

55. During the night, there are two members of staff on duty. The staff take it in turns to patrol the building hourly, to ensure that the premises are secure and there are no problems. They do not enter individual rooms. During the night of 25 June, the staff had no reason to go to the man's room and were not alerted to any problems.

56. During weekdays, residents are expected to be up by 9.00am and breakfast is available until this time. At weekends, the rules are relaxed and breakfast is available until 10.00am and residents can stay in bed. That morning two Approved Premises Assistants (APA), were on duty. The man was required to sign at the office at 9.00am, but failed to come down. APA 1 said that, as it was known that he was in the building and detoxifying it was decided to let him sleep. At around 10.00am, APA 2 went up to his room to check on him and saw him lying in his bed, so did not rouse him.

57. The man was not seen during the morning and at 12.30pm, APA 1 decided to go up to his room again so that he could wake him up in time to sign at 1.00pm. He said that when he went into the room and approached his bed, it was clear from his appearance that something was wrong. He could also see that he had been sick. He called out to him, but he did not respond so he went to the office and telephoned for an emergency ambulance. There is no indication that any first aid was attempted prior to the arrival of the paramedics at around 12.40pm. Neither of the staff on duty on 26 June had been first aid trained. When the paramedics arrived, they carried out further checks on him however, at 12.43pm they confirmed he had died.

58. The police notified the man's ex-partner, his nominated next of kin. The manager later spoke to her and arranged for her to visit Weston.

ISSUES

Drug testing

59. The investigator was told that the current drug testing kits used by Weston and other premises in the South West region are considered by staff to be unreliable. It is a concern that staff required to use the tests and make crucial decisions about an individual's future, based on the results, feel this way.

60. There are known disadvantages to saliva drug testing. For example, contamination of the mouth can lead to a false reading and if there is a low concentration of saliva then testing becomes difficult. While it is appreciated that costs may be one of the main reasons for use of the current type of tests, their apparent ineffectiveness requires an appropriate response from the Dorset Probation Trust.

    The Chief Executive of Dorset Probation Trust should ensure the effectiveness of drug testing equipment used in the area's Approved Premises.

Welfare checks

61. There is no requirement for staff to enter residents' rooms to count or check on them, other than at the 11.00pm curfew. All residents are required to sign in and out of the premises and go through a controlled door. As staff do not generally go into rooms, this means that potentially someone who is ill or in need of help would go unnoticed.

62. The manager said that at the time of the man's death welfare checks were not routinely carried out. Instead, staff were mindful as to whether a resident had been seen or whether their jobs around the premises had been done. However, she reported that since his death, after consultation with residents, a new system had been implemented.

63. Staff will now make welfare checks at 9.45am on any resident who has not already been seen that day. This means the staff member will enter the resident's room and wake them if they are asleep. Any resident that advises staff that they are unwell will be checked on a regular basis, depending on the illness. Staff have been advised that these checks should be every two hours, unless the resident is experiencing chest pain, or breathing problems. In such circumstances, an ambulance will be called, and on return from hospital, staff will agree the frequency of checks with the resident. In view of these positive changes, no recommendations are made on this issue.

First aid

64. Neither staff who were on duty that morning had been trained in first aid procedures. There is no evidence that any attempts were made to resuscitate the man before the arrival of the ambulance staff, or that any routine checks for

signs of life, such as breathing or pulse were made.

65. Paragraph 17 of Probation Circular PC2006-35, entitled "Preventing Deaths of Approved Premises Residents" considers the issue of first aid. It says:

> "Both PPO [Prisons and Probation Ombudsman] reports and correspondence from coroners following inquests have highlighted the importance of staff having appropriate and up to date first aid skills. Probation areas should refer to the Health and Safety Risk Assessment "Approved Premises Management Guidance" which has been circulated to Areas and is also available on EPIC. This states that 'all supervisory staff must be trained, as a minimum, in basic first aid'. "

66. In addition, paragraph 12.21 of the Approved Premises Manual 2011 says the following:

> "All staff must receive training in first aid, including CPR, appropriate to their grade, and at all times at least one member of staff on duty must be first aid trained. Nominated staff should be trained to hold the First Aid At Work certificate which will need updating regularly. Supervisory staff and managers should be trained in, at least, basic first aid to include resuscitation. Residents can be encouraged to participate in first aid training."

67. Staff at Weston may have responsibility for up to 26 residents within the premises and it is a concern that there is no requirement for at least one member of staff on duty, to be adequately first aid trained as per national guidance. Although, earlier intervention is unlikely to have been of benefit to the man, Dorset Probation Trust should review this as a matter of urgency.

The Chief Executive of Dorset Probation Trust ensure that staff at Weston Approved Premises are appropriately trained in first aid, so that all supervisory staff and at least one member of staff on duty have up to date training. Staff should also be made aware of the expectation that they should attempt resuscitation, if appropriate.

Contact with next of kin

68. The National Offender Management Service provides guidance to staff working in Approved Premises on the procedures to be followed after the death of a resident. However, these national guidelines do not include advice on notifying a resident's next of kin of their death or what staff should do when dealing with them. The manager of Weston told the investigator that after the man's death she was contacted by his ex-partner, but she was unsure as to what information she was permitted to give her. She said that she would have benefited from having such guidance available to her.

The National Offender Management Service should ensure that there is comprehensive guidance on the actions to be taken following the death of

a resident in Approved Premise, including advice on notifying and dealing with next of kin and/or other interested parties.

CONCLUSION

69. The man had a long history of drug and alcohol use, but had shown a desire to address his problems. Those who knew him said that, unfortunately, whenever he made progress, problems in his personal life set him back and even led to him returning to custody. They also said he was well liked and despite his own problems, helpful to others. Just before his death, he had indicated that he wanted to deal with his problems and had made no secret of the fact that he had been using drugs again and drinking.

70. Toxicology test have indicated methadone in the man's system, which had not been prescribed to him in the community. Methadone can affect the respiratory system, but it is not clear what if any affect it had on him prior to his death.

71. The results of the post mortem indicate that the man died from pulmonary oedema resulting from pneumonia. Those with a history of illicit drug use are more likely to develop such problems. His death could not have been foreseen by staff at the Approved Premises. However, the investigation has identified several areas where improvements in practice could be made for the benefit of staff and other residents.

FAMILY FEEDBACK TO DRAFT REPORT

72. In response to the draft report, the man's family raised concerns about him being asked to leave Carlton House after he had been consuming alcohol. The family said that may have resulted in him 'sleeping rough' and wondered whether this would have contributed to his ill health. They wished to know what Carlton House policy was on residents who breach the rules.

73. The investigation heard that Carlton House has strict criteria to help and encourage residents to deal with their problems, and while at the hostel will have access to support. However, residents are made aware that any breach of rules will result in them being asked to leave for the benefit of other residents. It is understood that the man had been made aware of a zero tolerance approach to alcohol, but had also been given opportunities to assist him, before the final decision was taken to ask him to leave.

74. On the evening the man was asked to leave Carlton House he was advised to report to Weston Approved Premises and if they were unable to assist him, he was told to return to Carlton House. If he had returned, the investigation was told that he would have been provided with accommodation until the following morning.

75. The family have also asked questions about the medication the man had been prescribed, namely Subutex, and were concerned that a Subutex tablet was found in his clothing after it was returned to them.

76. When the man returned to Weston on 24 June he handed his medication into staff, as is the policy at the premises, it was recorded that there were three

tablets, and staff assumed that he had taken one already. It is clear from information obtained during the investigation that he did not want to be on a Subutex programme and had possibly only agreed to take part as a way of demonstrating that he was attempting to address his problems. Therefore pretending to take his medication and placing it in his jeans pocket would account for the item found by the family.

77. Finally, the family have asked why the man was not made to sign in at the office and I am assuming that they refer to 25 June. He signed the previous night at 8.00pm, before going to his room, and staff noticed nothing unusual and he reported no problems. The investigation heard that since his death, new processes had been implemented at Weston for monitoring residents and the requirements for them to sign the register have been strengthened. In view of this I am unable to comment further.

RECOMMENDATIONS

1. The Chief Executive of Dorset Probation Trust should ensure the effectiveness of the current drug testing equipment used in the area's Approved Premises.

   Accepted. The Head of Dorset Local Delivery Unit is conducting a review with the DIP team, who provide Cozart for community-based Drug Rehabilitation requirement orders, in relation to drug testing in Weston AP. The Cozart machine is used in both APs and the review will include The Pines in any change of provision. The option agreed and implemented will be both efficient and cost-effective and will be in place by no later than end of January 2012. Any Hostel budget pressures will be discussed with the Head of Corporate Services.

2. The Chief Executive of Dorset Probation Trust ensures that staff at Weston Approved Premises are appropriately trained in first aid, so that all supervisory staff and at least one member of staff on duty have up to date training. Staff should also be made aware of the expectation that they should attempt resuscitation, if appropriate.

   Accepted. The current First Aid Training Provider is being approached by the Head of Corporate Services to identify an ongoing training programme and to ensure that enough places are available so that all staff are trained and maintain their accreditation on an annual basis. These courses will include sessional AP staff as standard. All Agency staff, should we use them, are first aid trained. The Training Provider is also being approached to accommodate staff who have knee problems, who cannot kneel down for training purposes but who would do so in an emergency and undertake resuscitation. In the event this cannot be agreed alternative providers will be commissioned. Dorset's Training Co-ordinator will ensure sufficient courses are provided and that records are maintained in line with current expectations. AP rotas will be drawn up to consider the first aid status of staff following this training, to ensure that there is always a trained person on duty. This will apply to both APs.

   NOMS adds: the need to have first aid trained staff in duty at all time was reinforced in the PPO's report into the death of another resident, finalised in September 2011. NOMS OMPPG is planning to amend the instructions given in the AP Manual to ensure that at least one person on duty has a <u>current</u> first aid qualification.

3. The National Offender Management Service should ensure that there is comprehensive guidance on the actions to be taken following the death of a resident in Approved Premise, including advice on notifying and dealing with next of kin and/or other interested parties.

   Not accepted. NOMS has already issued guidance on notifying next of kin. It was contained in Chapter 12 of the AP Handbook (published in 2009) and repeated in Chapter 23 of the AP Manual (published in April 2011). The need

to deal sensitively with next of kin at such a distressing time is obvious but we do not think it has to be spelled out in order to provide guidance, especially in the AP environment where staff are aware of the need to act with sensitivity in this and many other respects.

Our understanding is that the man was asked to nominate next of kin, in line with this guidance. Unfortunately, records do not show who the nominated person was. In any event, we do not believe it is possible to give comprehensive guidance on how to deal with people who may be connected with the deceased but are not their nominated next of kin. The range of possible connections with an AP resident is so wide that guidance is likely to amount to reminding staff to use their discretion and good sense, which we do not believe would be a valuable addition.