PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the death of a man at Nelson House Approved Premises, Durham Tees Valley Probation Trust, in July 2012

Report by the Prisons and Probation Ombudsman for England and Wales

January 2013

The man died in July 2012, as a result of respiratory failure, resulting from the toxic affects of morphine. He had been resident at Nelson House Approved Premises in Middlesbrough since 8 June 2012. I offer my condolences to his family and all those affected by his death.

The man had a long history of substance misuse. Drug tests taken before his release from prison, and when he arrived at the approved premises, were negative. However, staff at Nelson House became concerned about his behaviour. Further tests on 26 June, and on the day of his death, indicated that he had been using illicit drugs. On the afternoon of the man's death he was found unresponsive in his room when a drug assessment worker arrived to see him. It was apparent that he had been dead for sometime before he was discovered so resuscitation was not attempted.

No evidence of drug paraphernalia was found in the man's room. However, results of a drug test performed on the morning of his death, and received by Nelson House on 7 July, indicated the presence of a small amount of opiates. It remains unclear when he took the fatal dose of morphine.

I am satisfied that the man was appropriately managed at Nelson House and that, when staff found out that he had returned to using drugs, they acted promptly to put appropriate measures in place and help him. I conclude that staff at Nelson House could not have reasonably predicted and prevented the man's tragic death.

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 prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **January 2013**

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SUMMARY

1. The man was released on licence from HMP Stocken, on 20 April 2012. His offender manager (previously known as probation officer) arranged a place for him at Kirk Lodge Approved Premises in Leicester. The man had only lived in the Leicester area for a short while before his arrest, and was keen to move back to Middlesbrough to rebuild his family ties. On 8 June 2012, he moved to Nelson House Approved Premises in Middlesbrough.

2. As soon as he arrived at Nelson House, the man began visiting his family frequently, often leaving early in the morning and not arriving back until just before his curfew. On several occasions, he failed to attend residents' meetings which he was required to do and he consequently received warnings. Despite intervention by premises staff and his offender manager, the man's behaviour continued to cause concern. He admitted to the use of cannabis and a drug test, carried out on 27 June, confirmed this.

3. On 1 July, staff noticed that the man seemed under the influence of either drugs or alcohol. They reported this to his offender manager, who visited him on the morning of the man's death to discuss the concerns. He was again tested for drugs and arrangements made for him to be seen by a drug worker later that day. After the meeting with his offender manager, he left Nelson House. He returned at 10.30am and went to his room.

4. At 3.20pm, the drug assessment service worker arrived to speak to the man as arranged. After the man failed to report to the office, a member of staff went to his room and discovered him in a kneeling position on the floor, unresponsive. Staff did not attempt cardiopulmonary resuscitation, as rigor mortis was present. Paramedics were called and they pronounced him dead.

5. The investigation found that staff reacted appropriately to concerns about the man's drug use and did all that could have been expected. After an initial delay, the Probation Trust offered the family assistance with the funeral expenses in line with national guidance.

THE INVESTIGATION PROCESS

6. The investigator visited Nelson House Approved Premises on 6 July 2012. He spoke to the deputy manager and the Director of Durham Tees Valley Probation Trust. Notices were issued informing both staff and residents of the investigation, asking anyone who had relevant information to contact the investigator. No responses were received.

7. The investigator later liaised with staff at HMP Stocken to gain some background about the man's time in custody.

8. One of our family liaison officers contacted the man's family to explain the purpose of our investigation and to offer them the opportunity to ask any questions or express concerns that they would like to be addressed. The family raised a number of points:

    - Was there any CCTV footage of the man, inside or outside Nelson House, on the day the man died, and did anybody visit him on that day?

    - When and what roll checks were done at Nelson House and were there any curfew restrictions in place?

    - Who was the last person to see the man alive and how did he appear at that time?

    - Whether the man had any appointments on the day he died?

9. The man's family received a copy of the draft version of the report as part of the consultation period. Having considered the investigation findings, his family indicated to my family liaison officer that they had found the report informative and helpful. They will take forward any remaining questions to the inquest.

NELSON HOUSE APPROVED PREMISES

10. Approved Premises (AP), formerly known as probation and bail hostels, are managed by probation trusts. Their purpose is to provide an enhanced level of residential supervision in the community, within a supportive and structured environment, for offenders assessed as presenting a high risk of harm and others charged with offences. While residents have to comply with their individual licence or bail conditions, curfews and the AP's rules, they are essentially free to go in and out of the building.

11. Nelson House AP is in Middlesbrough and is managed by Durham Tees Valley Probation Trust. It can accommodate up to 23 residents and is staffed by Probation Service Officers. The building has CCTV, residents are required to hand in their key on departure from the AP and are signed in and out of the building by AP Staff and follow curfews determined by their offender manager. (At the time of the man's death, the company responsible for maintaining the CCTV had taken it for the morning period on the day the man died. This was later requested and viewed by the police but showed nothing significant.)

12. Each resident has a dedicated key worker, a trained member of staff who works closely with him to offer support and guidance to comply with their licence conditions. Residents are responsible for their own health and usually register with a local general practitioner (GP).

13. There have been no previous deaths at Nelson House.

KEY EVENTS

Background

14. The man received a four-year prison sentence in July 2010. While in custody, he attended programmes to address his drug addiction. Despite doing well initially, he was removed from a course in October 2011, after a positive drug test. Apart from this, comments about his general behaviour were good and a drug test taken shortly before his release was negative.

15. On 20 April 2012, the man was released from HMP Stocken to Kirk Lodge AP in Leicester. He was not from the Leicester area. Shortly after his arrival at Kirk Lodge, his offender manager applied to Durham Tees Valley Probation Trust for a place at Nelson House Approved Premises in Middlesbrough. The man moved to Nelson House on 8 June 2012. This was intended to be a resettlement placement and he would then move on to live with his mother. The aim of the placement was to enable him to have a stable base to facilitate resettlement into the community, to address relationship and trust difficulties he had with his family and to ensure that he had addressed his drug problem, as it had contributed to his offending.

16. The man had standard licence conditions on his release from custody. These required him to liaise regularly with and abide by any requirements set by his offender manager. In addition to his licence conditions, the man was required to comply with the rules of Nelson House, which included a curfew to remain on the premises between 11.00pm and 6.00am. There was no requirement for the man to attend any offending behaviour courses, although he was required to attend daily residents' meetings and appointments with his key worker. He also had to provide an OMT (oral mouth test) at the discretion of AP Staff and his Offender Manager. The man was aware that failure to comply with these conditions or reoffending could result in him being recalled to prison. His licence was due to expire on 21 April 2014.

The man's time at Nelson House Approved Premises

17. The man's was expected to meet his key worker at Nelson House regularly to discuss his progress in gaining employment and any concerns. However, she was not on duty when he arrived, therefore another member of staff held an induction meeting with him. The man signed to confirm he accepted Nelson House's rules. He also met his offender manager. Later that evening he went to visit his family, and returned at 10.52pm. Staff recorded that it was apparent that the man had consumed alcohol, but he was not a management problem.

18. The deputy manager explained to the investigator that there are three senior residential workers, each with a caseload of up to eight residents. In conjunction with the individual's offender manager, they identify a resident's needs, potential risks and a plan of intervention. He said that it was normal practice for duty staff to complete a resident's induction in the absence of the key worker.

19. Over the weekend of 9/10 June, the man visited his family again. He registered with a local doctor in line with the requirements for all residents at Nelson House.

20. On Monday 11 June, the man attended a residents' meeting during the morning. His offender manager visited him. They discussed what was expected of him as well as his previous drug and alcohol use. The man told his offender manager that he was happy to be back in the area. On the same day, the man's key worker arranged her first meeting with him for Wednesday 13 June.

21. The man did not attend the residents' meeting on 13 June and was given a verbal warning. Later that day, he did not attend the prearranged meeting with his key worker which resulted in a written warning about his conduct. The man also failed to attend the residents' meeting the following day, and received a further verbal warning. The documents given to residents informs them that failure to comply with certain rules will result in one of three levels of warning (verbal, written or final) depending on the seriousness of the breach.

22. Due to his poor start, the deputy manager and the man's offender manager held a meeting with him on 15 June. They discussed their concerns about the number of warnings he had received in the short time that he had been at Nelson House and explained the consequences of breaking the rules. The man apologised for his behaviour. He told them that he had not seen his family for sometime, and now he was back in the area they all wished to see him and this had 'battered' his head. He said that he wished to progress at Nelson House and use the services available to him.

23. The man's offender manager recorded that the man's mother was in the process of moving house and that he might not be able to move in with her, as planned. She also noted that Nelson House should monitor any potential alcohol misuse and the residents with whom he associated.

24. On 16 June, the man had a meeting with his key worker. They discussed possible courses and his plans to find his own accommodation. The man agreed to visit the local housing association and report on his progress at the next meeting scheduled for 21 June. Later that day he was nine minutes late for his curfew, which resulted in another verbal warning.

25. When not attending meetings within the building, the man spent the majority of his time away from the premises, believed to be visiting his family. He returned just before 11.00pm most evenings.

26. The man began to attend the morning residents' meetings as required. When he met his key worker on 21 June, he told her that he was looking for accommodation close to his family, and that his mother was going with him to complete a housing application. During their meeting, the man told her that he was staying away from his 'old haunts.'

27. For a short time the man complied with the rules and demonstrated a willingness to move forward. However, on 23 June, he returned an hour after his curfew, which almost resulted in revocation of his licence and a recall to prison. He told staff that he had missed a taxi. When staff followed this up with the taxi firm, they confirmed that he had been picked up in an area of Middlesbrough which he had previously claimed he was avoiding. The staff recorded that the deputy manager would make a decision on disciplinary action after the weekend.

28. On 25 June, the deputy manager reviewed the events of the weekend and issued a final warning to the man. He told him that he must start showing commitment to both the rules of Nelson House and the conditions of his licence. The duty manager arranged for the man to be drug tested. Over the next few days, the man attended residents' meetings and returned to Nelson House before his curfew. A sample for a drug test, taken on 27 June, was sent to an independent laboratory.

29. Three days later, on 28 June, the man's offender manager and key worker held a meeting with him. They discussed the final warning as well as his finances, as he had not paid any rent since arriving at Nelson House and claimed to have no money. (All residents are expected to pay weekly rent.) When the man's offender manager challenged him about this, the man said that his cousin had stolen his bank card. They told him they were concerned that he was leaving early each day, returning just before curfew and going to areas that he had intended to avoid. They considered that he had a poor attitude to compliance with his licence conditions and the rules of Nelson House. The results of the drug test carried out on 27 June had not been received, but during the meeting, the man admitted to smoking cannabis occasionally.

30. On 1 July, the man was recorded as going in and out of Nelson House with other residents during the day. Staff thought he appeared to be under the influence of either drugs or alcohol. They received the results of the earlier drug test that confirmed that the man had used cannabis. He was given a verbal warning about this.

Events on the day the man died

31. The man's offender manager spoke to him on the morning of the day the man died, about the concerns raised by staff the previous day. At her request, an Oral Mouth Test was sent for testing. Afterwards the man left Nelson House and returned at 10.30am, covered in mud. He told his offender manager that he had been chased, but gave no further details. He then went to his room.

32. As staff were concerned that the man was using drugs again, which in the past had been the catalyst for his offending, they arranged for a member of the local drug assessment service to visit him later that day.

33. The worker from the drug assessment service arrived at 3.20pm. A member of staff who was on duty checked to see if the man was in the building. He noticed that the man's room key was not in the cabinet and that he had last

signed in at 10.30am, so he called him over the tannoy to report to the office. The man did not go to the office as requested, so the member of staff who was on duty went up to his room at 3.30pm.

34. He knocked at the man's door, but got no response. He went in and saw the man in a kneeling position in the middle of the room with his head resting on a pillow. When he called, he got no response. He moved the man's head to one side and realised that he was not breathing and was very cold. He immediately left the room to get help.

35. The duty manager was in his office having a meeting with the man's key worker and another resident when the member of staff told him that the man had collapsed in his room. He telephoned for an ambulance while the duty manager and the man's key worker went to the man's room. Both of them checked for signs of life but none were present. The duty manager said that it was apparent to both of them that the man had been dead for some time, so they did not attempt to resuscitate him. All staff at Nelson House are trained in first aid.

36. The man's key worker remained with the man while the duty manager went to check whether the ambulance had arrived. A first responder paramedic arrived at approximately 3.45pm. The paramedic attempted to move the man to check him, but realised that rigor mortis was present and pronounced him dead.

Actions after the man's death

37. As is normal practice for emergency calls, the police had been notified and attended Nelson House. Guidance to staff instructs that, when a death occurs, they should inform the resident's family, where possible but the duty manager discussed this with the police who indicated that it was their normal practice to notify families in such circumstances. They decided the police would do so as they had more expertise. (Approved Premises staff are not trained as family liaison officers.)

38. The duty manager said that, after the man's death, both he and the director of Durham Tees Valley Probation Trust, provided support for the Nelson House staff and residents.

39. The next morning, the duty manager attended the residents' meeting and thanked them for their sensitivity during a difficult night. He also made them aware of the support available should they require it. He liaised with the man's key worker and the member of staff who had discovered the man to ensure that they were coping and reminded them of the confidential counselling services provided by Durham Tees Valley Probation Trust.

40. The duty manager spoke to the man's mother and she came to collect her son's personal belongings later that day. He also arranged to visit her, with the Lead Manager for Approved Premises on 3 August, to answer any further questions from the man's family.

41. The investigator spoke to the Lead Manager the day before the meeting with the man's family to find out what financial support had been offered. She said that they were planning to donate to a charity that would be agreed with the family when they met. When asked about contributing towards funeral expenses, she explained that she had been asked by Directors at Durham Tees Valley Probation Trust to try and ascertain the family's financial situation during the visit on 3 August. If they considered that the family were experiencing financial hardship, they would offer to contribute towards the funeral expenses.

42. The investigator explained that the financial position of the next of kin should have no bearing on whether a contribution towards funeral costs is made, and that the current guidelines were to make a reasonable offer of up to £3,000 in all cases. The Lead Manager accepted that this was the case but reiterated that Durham had sought advice from a neighbouring trust and this was what she had been asked to do. Durham Tees Valley Probation Trust later agreed to pay the full funeral costs.

43. Approved Premises guidelines also suggest that consideration be given to creating a memorial to the deceased such as planting a tree in the grounds. Durham Tees Valley felt that they did not wish to accept long-term responsibility for such an undertaking and decided instead to ask the family if they wished to nominate a charity to which a small donation could be made in memory of the deceased. The duty manager raised this at a meeting with the family and a donation was made to the diabetes unit at the local hospital at the request of the man's mother.

44. On 7 July, Nelson House received the results of the sample taken for testing on the morning of 2 July. The results were shared with the investigator and the test was negative for all substances except opiates, but the substance was not heroin. A confirmatory test on the opiate screen was negative which indicated that the trace of the substance was very small.

Post-mortem report

45. A post-mortem carried out on 6 July 2012, indicates that the man's death was due to respiratory failure resulting from the toxic effects of morphine. (The report also mentions that the man told another resident that he had taken '20 blues'. The source of the information is not given and we were not made aware of this during our investigation.)

ISSUES

Response to concerns about the man's drug use

46. The man had a negative drug test just before he left prison. When it became apparent that he was frequenting areas linked with his past offending behaviour and drug use, his offender manager and staff at Nelson House discussed it with him. The man said that he found his return to the area and seeing his family difficult, but he was going to avoid such areas and deal with his past issues. Appropriate measures were put in place for staff to monitor his associations and behaviour that might indicate alcohol or drug use.

47. Nelson House staff identified changes in the man's behaviour and responded appropriately. Drug tests were carried out and arrangements made for a member of the local drug assessment team to see him. The appointment was scheduled for the same day the referral was made. Regrettably, the man was found dead when the drug worker arrived for the appointment. It is not clear when the man took the drugs which led to his death.

48. We are satisfied that staff intervention was appropriate and timely when they discovered that the man had relapsed into using drugs.

Family liaison

49. The Approved Premises Manual 2011 provides guidance to AP staff on the actions to be taken in the event of a resident's death. However, there are two different instructions and only one mentions 'notifying the next of kin.' The first instructions says:

> "… All residents must be asked on their arrival to nominate two persons who are willing and able to act as their next-of-kin. The AP should check that these people fall within the definition above and a record of their names (with addresses and phone numbers) should be kept in each resident's case file. These will be the people whom staff should initially contact in the event of a resident's death ..."

50. While this section indicates that AP staff should make initial contact, it does not give a timeframe for this to be done. Cleveland Police informed the duty manager that they would normally notify the next of kin. Another section entitled 'What to do in the event of an incident of serious self-harm or death' says:

> "…If GP certifies death, police will notify the next of kin and the GP will notify the coroner ..."

It is unclear why there is a different approach when a resident's death is certified by a GP.

51. When the police attended Nelson House on the day of the man's death, the AP deputy manager discussed the need for staff to notify the man's family, and was told that the police were required to do this. The duty manager was aware of the AP guidance that staff should contact the family, but after speaking to the police he decided to allow them to make the initial contact. He considered it unnecessary for both agencies to contact the family, and he felt that the police had more experience in this area.

52. The duty manager spoke to the man's mother the next day and arranged for the family to visit Nelson House later that day. A further pre-arranged visit by both the manager and deputy manager took place at the family home on 3 August. The guidance manual does not give detailed advice on managing notification to families after the death of a resident. While best practice is that this should be done face to face unless distance or other factors prevent this, the duty manager's decision not to notify the man's family of his death in person was made after advice from the police and based on what he believed would be better for the family. We consider that this was appropriate in the circumstances.

53. The Approved Premises Manual 2011 provides clear instructions to probation trusts on the requirements of them to offer families financial support towards funeral costs. The guidance says:

> "… Trusts are required to offer to pay reasonable funeral costs of up to £3,000 with the money being paid direct to the funeral director upon receipt of an invoice. The amount paid should cover the cost of the funeral only and not ancillary items such as clothing for those attending, or go towards the cost of a wake, etc ..."

54. The guidance does not make any reference to, or encourage probation trusts to evaluate the financial position of the family before making the offer. However, the investigation found that this was the initial advice given to the AP manager by senior managers within Durham Tees Valley Probation Trust.

55. We are pleased that after the Nelson House managers' visited the man's family, on 3 August, the full amount was offered by the Trust. The family said that they were very grateful for this as it had been a concern for them.

56. The National Probation Service have said after reviewing the draft report that they will look again at the advise provided for family liaison and if necessary update the Approved Premises Manual if required at the next opportunity.

CONCLUSION

57. The man lived at Nelson House for less than a month before he died. After leaving prison, he said he found moving back to his home area difficult. He received a number of warnings about his behaviour in the early days at Nelson House. He then seemed to begin to settle and spoke of his desire to move on and be closer to his family. However, he started to frequent places linked to his past drug use, and the evidence suggests that he had begun using drugs again.

58. We conclude that the man's death, though sad and coming at a time when he seemed to be re-establishing his links with his family, could not have been predicted or prevented. We consider that staff took reasonable steps to help him address his drug taking and that his overall management at Nelson House was satisfactory.