

A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man at Trent House
Approved Premises, Nottingham in November 2012**

Our Vision

*'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision'*

This is the report of an investigation into the death of a man at Trent House Approved Premises in Nottingham, in November 2012, four days after his release from prison. He was 41 years old. The post-mortem report indicated that his death was caused by respiratory failure resulting from a pulmonary thromboembolism (a blood clot travelling to the lungs). I offer my condolences to his family and friends.

An investigator was appointed to the case. A clinical reviewer was commissioned by this office to undertake a clinical review of the medication issued to the man when he left HMP Ranby. Staff at Trent House cooperated fully.

The man was released from HMP Ranby on 29 October and arrived at Trent House the same day. One evening in November, staff helped him change his bedding as he was suffering from back problems. Night supervisors checked him at about 11.15pm and again not long after midnight, after other residents said they were concerned about him. He appeared sound asleep. At a routine check at 6.00am the next morning, staff found him unresponsive. They called the emergency services and performed chest compressions, but a paramedic who attended shortly after pronounced him dead. It appears that he had died in his sleep during the early hours.

The coroner was satisfied that the man died from natural causes not related to his medication. However, the investigation found that procedures in the national Approved Premises Manual for handling medication were not followed and signs of possible drug intoxication on the evening before his death were not investigated. Although it would not have affected the outcome in his case, the investigation also discovered that not all supervisory staff at Trent House had up to date first aid training, as their national guidance requires.

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
Prisons and Probation Ombudsman

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SUMMARY

1. The man was released on licence from HMP Ranby on 29 October 2012. He was given some medication before he left – a painkiller and an antidepressant. He arrived at Trent House Approved Premises in Nottingham that afternoon. He told staff about the two medications he had been given at Ranby. He was allowed to keep these medications in his room, but there was no risk assessment to determine if this was appropriate. He handed in three other medications, which he appears to have collected on his way to Trent House. These were locked away.
2. One morning in November, staff asked the man to hand in the two medications he had been given at Ranby, which he did. Over the course of the day, he was issued with more than the stated dose of three of his medications. The approved premises staff were unaware that he appears to have visited his GP surgery again in the afternoon to collect more medication. Another resident said he also saw him snorting crushed subutex (a heroin substitute) later that day.
3. During the evening of the same day, a night supervisor changed the man's bedding for him as he was suffering from back pain which made it difficult for him to move. Staff gave him his medication at 8.25pm. During a routine check at about 11.15pm, staff saw him apparently sound asleep and snoring on his bed. Shortly before midnight two residents said they were concerned about him, so staff checked him again. He was still snoring and fast asleep. The two night supervisors said they heard his snores from the floor below in the middle of the night.
4. The next morning, during a routine 6.00am check, the night supervisors opened the man's door and found that he was unresponsive and not breathing. They called the emergency services, moved him to the floor and tried to resuscitate him. A paramedic arrived but pronounced him dead a short while later. The post-mortem report indicated that the cause of death was respiratory failure resulting from a pulmonary thromboembolism (a blood clot had travelled to his lungs and stopped him breathing).
5. The investigation found that staff at Trent House could not have predicted or prevented the man's death. While not related to the cause of death, we found that procedures outlined in the national Approved Premises Manual for issuing medication were not followed and that not all of the staff were first aid trained as they were supposed to be. We make three recommendations about these matters.

THE INVESTIGATION PROCESS

6. The Ombudsman's office was notified of the man's death on 8 November 2012. On 16 November, the investigator visited Trent House. He interviewed the manager and the night supervisors. He visited HMP Nottingham later that day to speak to two men who had spent time with the man at Trent House the day before his death, but one had since returned to custody and one chose not to be interviewed.
7. The clinical reviewer completed a clinical review of the medication issued to the man when he was released from Ranby.
8. A copy of this report has been sent to the local coroner.
9. One of our family liaison officers contacted the man's relatives. They asked whether his time in prison had contributed to his subsequent death in the approved premises. The clinical review has looked at the medication he was prescribed at prison before he left Ranby. He died from natural causes and there is no indication from the post-mortem toxicology report that drug levels were such as to be life-threatening. His relatives also asked about monitoring in the approved premises. Approved premises residents are subject to enhanced hostel checks twice a day. Their room can be searched, there is CCTV and they have to comply with a curfew. The report describes the checks that were made.
10. The man's family received a copy of the draft report as part of the consultation process. They family have not made any comments ahead of the report being made final.

TRENT HOUSE APPROVED PREMISES

11. Trent House is an approved premises run by Nottinghamshire Probation Trust. Approved premises were previously known as probation hostels. They mostly accommodate offenders released from prison on licence who initially require a supervised environment.
12. Every resident attends an induction session and signs to say that he understands the rules. They are not allowed in each other's rooms and are not supposed to socialise outside the approved premises. Each resident undertakes not to bring illicit drugs into Trent House, to undergo random drug tests and allow intelligence-led room searches. Residents who test positive for drugs are offered help and advice. Each resident is allocated a keyworker.
13. Residents are initially asked to hand in any medication to staff. This relies on residents' honesty because they are not searched. The medication is labelled and stored in a locked cabinet in the duty office. The resident has to ask a member of staff to issue medication and must take it in front of them and sign for it. Provided there is a risk assessment some residents are allowed to keep their prescribed drugs in their rooms.
14. We have investigated one previous death at Trent House, in January 2005. In that case, staff were informed by a resident that the man was unwell and that it was likely that he had taken heroin. The man was sleeping heavily and staff checked him frequently during the next hour until it became apparent that his condition had deteriorated. The emergency services were called but the man was found to have died on arrival at hospital. We did not identify any changes in procedures that might have helped prevent the death.

KEY EVENTS

HMP Ranby - 24 September – 29 October 2012

15. Shortly before his release from prison on licence, the man transferred to HMP Ranby on 24 September 2012. He suffered from chronic long term pain and arrived at Ranby with prescriptions for gabapentin (to treat nerve pain) and mirtazapine (an antidepressant). A doctor reviewed him on 28 September and reduced his gabapentin prescription from 3600mg to 2400mg per day. The doctor prescribed trazodone instead of mirtazapine as an antidepressant, with one daily 150mg dose. He was released on licence from Ranby on 29 October when he was given a two-week supply of gabapentin and trazodone.

Trent House Approved Premises

29 October

16. The conditions of the man's licence required him to:
 - reside at Trent House Approved Premises in Nottingham
 - attend supervision sessions with his offender manager at his local probation office
 - address his drug and alcohol use
17. The man was also subject to a curfew which obliged him to stay inside the approved premises from midday until 2.00pm each day and overnight from 8.00pm until 9.00am. He had to sign a curfew register at the start and end of each curfew period.
18. The man arrived at Trent House at 1.30pm on 29 October. During an induction health screen he told staff that he was prescribed trazodone and gabapentin. He was asked if he used drugs and the answer recorded on the form is 'prescribed subutex'. (Subutex is a heroin substitute). He had a history of substance misuse but he had not been given this medication at Ranby). He said that he did not drink alcohol (although previous risk assessments indicated that alcohol had contributed to his offending behaviour). He said that he was already registered with a GP, which was nearby.
19. The man handed in three medications which staff noted on his medication record and stored in the duty office cabinet. He had not mentioned them during his health screen. These were:
 - 30mg dihydrocodeine (a pain killer) – the dosage was one or two tablets, four times daily.
 - 300mg pregabalin (similar to gabapentin, used to treat nerve pain) – the dosage was two each day.
 - 500mg ciprofloxacin (an antibiotic) – the dosage was one tablet twice a day.
20. None of the medicines had been supplied to the man by HMP Ranby on his release. It is possible that he had visited his community GP on his journey from the prison to the approved premises, but we have not had access to his

GP records to confirm this. He did not hand in his gabapentin or trazodone and staff did not request them, even though he had mentioned them during the health screen. There was no risk assessment to check if it was appropriate for him to have these drugs in his possession.

30 October

21. On 30 October, the man met his offender manager at the probation office. He talked about his recent problems with heroin in prison. He said that he no longer drank alcohol. That day, Trent House records indicate that he was issued with three dihydrocodeine and one ciprofloxacin from the cabinet.

31 October

22. On 31 October, the man was issued one dihydrocodeine from the duty office cabinet. There is no record of any other medication being issued.

Day of the incident

23. The man signed in late for his curfew at the duty office at 9.50am. The manager gave him a verbal caution. He said that his medication made him sleepy. The manager realised that he was referring to drugs which he had not handed over to staff for safe-keeping and he asked him for them. He brought his supplies of gabapentin and trazodone from his room and the manager put the medications in the duty office cabinet. He entered them both on the medication record underneath the first three drugs:
 - 150mg trazodone – the dosage was one each night, but he did not ask for any to be issued that day.
 - 400mg gabapentin – the dosage was two to be taken three times a day.
24. After the man's death, Resident A told the investigating police officer that he had spent most of the day of 1 November, with him. He said that they had visited the GP surgery at 5.00pm and afterwards the man collected some medication from the pharmacy. Later, back in the man's room at Trent House, the resident said that he saw him snorting crushed subutex. He said that the man struggled to walk because of back pain. He did not inform approved premises staff of his concerns at the time.
25. There are always two night supervisors on duty at Trent House during the evening and overnight, based in the duty office at the entrance to the building. On the evening of the incident, Supervisor A began work at 7.00pm. His colleague finished at 10.30pm and Supervisor B joined him for the rest of the night.
26. Day staff did not record any concerns about the man on the handover sheet which the night staff checked when they started their shift. He came to the duty office seven minutes early to sign for his curfew and Supervisor A asked him to come back at 8.00pm. When he did not return, the supervisor took the curfew register up to his room for him to sign at 8.07pm. .

27. The man said that he was suffering from back pain and the supervisor noticed that he was finding it difficult to move. He needed his bed sheets changing and the supervisor brought a fresh set and made the bed for him because of the difficulty he was having moving.
28. The supervisor offered to bring the man's medication to his room, but he went to the duty office to collect it. The supervisor issued his medication at about 8.25pm. In total, he had asked for medication from the duty office cabinet on five separate occasions that day between 9.55am and 8.25pm. He was given seven dihydrocodeines, six pregablin, four ciprofloxacin and eight gabapentin. The last three medications were all issued in excess of the stated daily dose. The man's signature on the medication record deteriorated throughout the day, and was barely legible by 8.25pm.
29. The supervisor noticed that the man was hobbling and hunched over, when another resident came into the office and commented that he did not look well and offered to help him because of his poor mobility. Before he left the office, the man said that he was having trouble waking up in the mornings, so the supervisor offered to wake him at 6.45am the next morning before he finished his night shift. He also checked that the man had the duty office telephone number in case his back problem worsened and he could not get out of bed.
30. Although the man was struggling physically, the supervisor told the investigator that he spoke clearly and lucidly when he visited the duty office. He did not consider that he was under the influence of drugs or alcohol. He thought that his main concern at the time was his bad back.
31. CCTV footage shows the man leaving his room at 8.41pm, returning at 8.45pm and leaving again at 8.55pm. He was unsteady on his feet and struggling for breath as he reached the top of the stairs. The resident told the investigator that the man spent some time in the downstairs lounge. He helped him upstairs to his room at 9.19pm, when again he was unsteady on his feet.
32. After the resident had walked him to his room, the man slumped onto his bed. The resident recalled that his movement was uncoordinated and his speech unclear. He knocked over his toiletries and he was worried about him. Resident B joined them. The two men went in and out of his room a couple of times and eventually Resident A was alone with him. He put some food by his bed and left him to sleep at about 10.12pm.
33. Supervisor B came on duty at 10.30pm. At 11.00pm, both supervisors locked the gates and set the alarm at the start of the nightly curfew. Between 11.00pm and 11.30pm, both supervisors completed the nightly roll check. They knocked on each bedroom door, opened the door, checked the identity of each resident and made sure they obtained a response. At 11.22pm, they knocked on the man's door but got no reply. They opened the door and saw that he was lying on his back, snoring very loudly on his bed on top of his duvet. His chest was rising and falling and they did not wake him because he seemed to be in a deep sleep.
34. Resident B, who had been in the man's room earlier with the other resident, checked him again at 11.28pm and 11.46pm. At 11.49pm, they went to the

duty office to say they were concerned about the man. Resident A asked Supervisor A to check him.

35. Both supervisors checked the man again at 12.07am. He was still lying on his bed snoring loudly and did not appear to have moved. Supervisor A again noticed his chest was rising and falling. They attempted to get a verbal response but he appeared to be in a deep sleep so they did not wake him and shut the door again. Supervisor B told the investigator that they had no reason to suspect that he was under the influence of either drugs or alcohol. He said that his room did not smell of either.
36. In the early hours of the morning, both night supervisors said they could hear the man snoring loudly while they sat in the downstairs lounge below his room. Resident A also said that he heard him snoring. Both supervisors spent the night either in the office or watching television in the lounge.
37. At 6.00am, both supervisors began the routine morning roll check. They had checked about two thirds of the residents when they knocked on the man's door at 6.12am. They did not obtain a response so they opened the door and found him lying on his back on the bed, but he was not breathing and had vomit around his mouth. Supervisor A shook his shoulders and called his name repeatedly, but got no response. He turned him onto his right side to help clear the vomit.
38. Supervisor B called the emergency services. A paramedic was dispatched immediately, but in the meantime the person on the telephone advised the two members of staff what to do. Both supervisors lifted the man from the bed to the floor. Supervisor A started chest compressions and then the other supervisor took over. Supervisor A tried to check his mouth for any blockages, but this proved difficult because his jaw was stiff. He thought that rigor mortis might have set in.
39. The night supervisors asked a resident who had come out of his room to open the front door to let the paramedic in. A paramedic arrived at 6.22am and, while Supervisor B continued chest compressions, performed an electrocardiogram test (ECG) (a test which measures the electrical activity of the heart). This showed no signs of life. After a few minutes, the paramedic told him to stop performing chest compressions and pronounced the man dead.
40. When the police attended they found the following in the man's room:
 - Paracetamol – a pack of eight x 500mg tablets of which three were missing
 - Gabapentin – a pack of six x 400mg tablets, of which four were missing
 - Pregablin – a pack of 14 x 300mg tablets, all of which were missing
 - Oxytetracycline – an antibiotic – a pack of 15 x 250mg tablets, of which eight were missing
 - A packet of an unidentified white powder, possibly some of the crushed subutex a resident told the police that the man had snorted the previous evening

41. The man's relatives visited Trent House on Thursday 15 November. His belongings were packed and returned to his family when they returned on 22 November. In line with national guidance, Trent House contributed appropriately towards the cost of his funeral, which was held on 28 December.
42. The post-mortem report indicated that the man's death was caused by respiratory failure resulting from a pulmonary thromboembolism. This means that a blood clot formed in the vessels in his legs, travelled up to his lungs and stopped him breathing. A urine test completed during the post mortem examination gave positive results for dihydrocodeine, tramadol (a pain killer) and paracetamol but was negative for trazodone. No tests were ordered to determine levels of subutex, gabapentin and pregabalin. The pathologist wrote:

'The level of dihydrocodeine is higher than generally seen in therapeutic dosing, but has not reached the level usually associated with acute fatal toxicity, especially in an individual taking this drug regularly who is likely to be tolerant to its toxic effects. The levels of tramadol and paracetamol are sub-therapeutic. Recent alcohol consumption has been excluded.'
43. As the man's death was the result of natural causes, there will be no further investigation by the Coroner.

ISSUES

Medication

44. The clinical reviewer completed a clinical review of the medication issued to the man when he left Ranby. The remit of his review was very narrow. We do not normally commission a clinical review for deaths at approved premises, but at around the same time there were two deaths of residents at approved premises in the East Midlands. Both had recently been released from Ranby with medication. The clinical reviewer examined whether it was appropriate for healthcare staff at Ranby to issue the man with a two week supply of trazodone and gabapentin when he was released. He was satisfied that appropriate medication was provided.
45. During the man's health screening on 29 October, he told approved premises staff that he had been prescribed trazodone and gabapentin. However, staff did not ask him to hand in the medication to be stored in the duty office cabinet. The health screen and the subsequently completed medication record did not match. Instead, he handed in three other medications which were entered on his medication record. It is not clear where he obtained these, as we do not have access to his community clinical record. He kept his gabapentin and trazodone in his room for three days before this oversight was spotted.
46. The local medication management policy for Nottinghamshire approved premises had not been updated since March 2008 and did not reflect the national guidance in the Approved Premises Manual, which should be followed by all Probation Trusts. The manual stresses that residents' prescribed medication should either be delivered to approved premises staff by the local pharmacy under an existing arrangement or collected by a member of staff from the pharmacy. This procedure allows oversight of the medication a resident is taking. Residents should not be allowed to collect medication or retain it without a medication in possession risk assessment. It appears that the man was able to do both.
47. The man seemingly made visits to his GP surgery in nearby St Ann's (where he was a registered patient) on 29 October and 1 November. There was no communication or coordination between the approved premises and the surgery or associated pharmacy to establish what medication he was taking. Trent House had previously had an agreement with The Arboretum Practice, but this arrangement had ended by November 2012, because the surgery was closing. An agreement with another GP surgery had not been reached when he lived at the approved premises. (There is one now.) There was no protocol with his surgery to help ensure that the guidance in the manual was followed.
48. The Approved Premises Manual stresses that it is important to record the issuing of medication clearly to establish that residents have taken the correct dose of medication at the required interval. However, it also states that it the resident's responsibility to take their medication at the right time. The manual emphasises that staff are not obliged to keep reminding a resident to take his medication, unless the failure to do so would result in an increase in risk.

49. On 1 November, the man was given more than the stated dose of gabapentin, pregablin and ciprofloxacin across the five visits he made to the duty office. Different staff issued the medications. The layout of the medication record is confusing and does not easily assist staff to see at a glance how much of a particular drug has been issued. The Approved Premises Manual recommends the use of a Medicine Administration Record (MAR) chart, which is the formal tool used to issue medication in a care setting. This would ensure more rigorous control of medications.
50. It is clear from the medication record that the man's signature deteriorated through the day on 1 November. It is barely legible on the last occasion. Resident A thought that he was incoherent and uncoordinated during the evening. Supervisor A was under the impression that he had a bad back and poor mobility but said he recalled him speaking clearly when he collected his final dose at 8.25pm. The CCTV shows him very unsteady on his feet when he was helped back to his room at 9.19pm. It is possible that this was the result of his back problems but the Approved Premises Manual reminds staff that they can refuse to issue medication if they are concerned that a resident is already under the influence of drugs or alcohol. They should then seek medical advice before issuing any more medication.
51. In addition to the medication the man was issued from the duty office, the police found a number of partially empty packets of medication in his room after he died, including pregablin and gabapentin. Another resident also told the police that the man had used subutex in his room on 1 November and had picked up more medication from his GP surgery that afternoon. The post-mortem report shows traces of tramadol, which he never mentioned to staff and was not prescribed in Ranby. This drug is not supposed to be kept in possession at an approved premises.
52. Although it does not appear that the man's death was related to the medication he took, it is important for safety that approved premises follow the national guidance about medication. We make the following recommendation:

Nottinghamshire Probation Trust should ensure that the governance of prescribed medication in approved premises follows the guidance in the Approved Premises Manual.

Identifying possible signs of drug intoxication

53. Although the cause of the man's death was a pulmonary embolism, it is a concern that some signs of possible drug intoxication appear not to have been identified and acted on. Typically people who die from the effects of opiates are deeply unconscious, not rousable and are often heard to be snoring heavily before their breathing stops. These warning signs have been evident in a number of deaths investigated by this office. When the staff had seen him earlier in the evening they did not consider he was under the influence of drugs or alcohol, but one of the residents who spent some time with him said his movements were uncoordinated and his speech was unclear. During the night of the incident, two residents expressed their concern about him and the night supervisors went to check him again. They could not get a response from him and he was snoring loudly.

54. While it might well have been the case that the man was in a deep sleep as the night supervisors supposed, we consider, because of his known drug problems, it would have been prudent for the staff to have tried more actively to gain a conscious and lucid response in case medical help was needed at that stage. We accept that this is a difficult judgement for staff to make, and fully acknowledge that drug toxicity was not found to have been the reason for the man's death, but think it would be helpful to raise awareness of the symptoms of drug-induced unconsciousness among approved premises staff. We make the following recommendation:

Nottingham Probation Trust should ensure that staff supervising residents in approved premises are made aware of the common symptoms of drug-induced unconsciousness and drug intoxication and know how to respond.

First aid training

55. The Approved Premises Manual states that all supervisory staff should be first aid trained. Supervisor B told the investigator that, although he knew how to perform chest compressions from past experience, he had not received any such training from Nottinghamshire Probation Trust. We make the following recommendation:

Nottinghamshire Probation Trust should ensure that all supervisory staff in approved premises have up-to-date first aid training.

RECOMMENDATIONS

1. Nottinghamshire Probation Trust should ensure that the governance of prescribed medication in approved premises follows the guidance in the Approved Premises Manual.
2. Nottingham Probation Trust should ensure that staff supervising residents in approved premises are made aware of the common symptoms of drug-induced unconsciousness and drug intoxication and know how to respond.
3. Nottinghamshire Probation Trust should ensure that all supervisory staff in approved premises have up-to-date first aid training.

We received the following response from Nottinghamshire Probation Trust:

‘Since the man’s death, the following actions have been implemented across all three Approved Premises in Nottinghamshire in order to ensure compliance with the national Approved Premises Manual in relation to healthcare and medication in possession:

‘Review of the Approved Premises Manual 2012

- ‘All staff have been issued with a copy of section 21 of the national Approved Premises Manual and asked to sign a receipt to confirm they have read it and are encouraged to raise any queries with Approved Premises managers and discuss in morning meetings.
- ‘Approved Premises managers are required to identify gaps in non-compliance with the Manual

‘Actions to update procedures to ensure compliance with the Approved Premises Manual

- ‘An Information Sharing Protocol for GPs has been produced following liaison with designated GP surgeries (this has been agreed with the designated GP surgeries and we are awaiting the return of signed copies). Other GP surgeries will be provided with the protocol as required. (The national NOMS lead for Approved Premises has been supportive in this process and has provided positive feedback in relation to the protocol.)
- ‘All current residents have been reviewed to check current GP registration and medication in possession status.
- ‘A local healthcare and medication in possession manual has been produced in accordance with the Approved Premises Manual and there is a hard copy in each duty office and appropriate paperwork has been included in induction packs and in keywork sessions.
- ‘New non-medication in possession forms introduced to provide clear recording of all individual drugs which are supervised.

- 'New medication in possession forms have been introduced to capture any new prescribed or purchased over the counter medication during the period of residence.
- 'Approved Premises Managers are conducting medication in possession assessments on offenders' arrival at Approved Premises as a contingency until staff are trained.
- 'Approved Premises Night Supervisors have been tasked to incorporate new forms into induction packs at each site.
- 'Staff have been instructed to review medication in possession on a weekly basis during keywork sessions

'A Trust Director has completed a brief review of the management of the case and has proposed the following recommendations:

- 'All induction and medication in possession forms to be completed electronically and signed and dated.
- 'All Approved Premises records to be maintained using the Trust's recording and administration system to ensure that all staff are working to the same record.
- 'Review of storage of individual medication (eg potentially instruct night supervisors to prepare daily packs of medication for the following day).
- 'Approved Premises staff should undertake further training in relation to substance misuse and potential risks.
- 'Further training in relation to induction work should be enhanced with direct observation following the Social and Emotional Early Development Strategy (SEEDS) framework.

'Training

- 'All Approved Premises staff, including out of hours managers, have been trained in emergency first aid at work.
- 'Training arranged for all Approved Premises staff in relation to medication in possession.
- 'A further one day training course is to be delivered in May to ensure staff can recognise the common symptoms of drug-induced unconsciousness and intoxication and know how to respond. This will also include input from the designated GP surgeries.
- 'The induction checklist has been re-written (to be launched at the training events).

'Audit/Management checks

- 'Daily audit of all supervised medication to be completed and recorded. Approved Premises managers to be alerted immediately of any discrepancies.
- 'All Induction/medication in possession assessments to be passed immediately to managers to countersign.
- 'Managers are providing additional checks for medication in possession until the new forms are embedded and staff are clear and confident.

'Strategic Management

- 'Nottinghamshire Probation Trust Board have agreed to the re-establishment of the Approved Premises Task and Finish group, (which includes Trust Board membership) to review work completed during 2012 and also to review the implementation of the Approved Premises Manual, initially focusing on healthcare and medication in possession.
- 'The senior Approved Premises Manager is to join the Trust's Health and Safety Committee (which includes Board membership).
- 'The Chief Executive has recently visited all three Approved Premises and specifically focused on medication in possession in her discussions with staff.

Outstanding tasks to be completed by end May 2013

- '2008 medication in possession policy to be updated in early April 2013.
- 'Further guidance to be added to the local healthcare and medication in possession manual.
- 'Information sharing agreements with releasing prisons re healthcare.
- 'Linking community psychiatric nurse services and GP services for Approved Premises residents.
- 'Closer working with the high risk teams and offender managers pre-release to ensure accurate information re healthcare and vulnerability.
- 'Further management and quality assurance checks to be developed.
- 'GPs to sign the information sharing protocol.
- 'Medicine Administration Records to be implemented.
- 'Induction packs to be reviewed to incorporate all the changes relating to induction.

Disciplinary Procedures

- Two members of staff are subject to a disciplinary investigation in relation to their role in improvement plan actions (although not in relation to the incident itself).