PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man at Ozanam House Approved Premises, Newcastle upon Tyne, on 13 January 2014

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 investigation report into the death of a resident at Ozanam House Approved Premises, Newcastle upon Tyne, who died from a heroin overdose on 13 January 2014. He was 37 years old. I offer my condolences to the man's family and friends.

Staff at Ozanam House cooperated with our enquiries.

The man had been a resident at Ozanam House since 2 December 2013, after his release on licence from prison. On the day of the man's arrival and throughout his stay, he tested positive for opiates and benzodiazepines and admitted to staff that he took heroin. A few days before his death, the man's had agreed to be referred to a local drug support agency.

Although the man engaged with his offender manager, he did not comply with the requirement to attend supervision sessions with probation staff at Ozanam House. As a result of this and his breach of other rules at the approved premises, the manager withdrew his place. The man's offender manager planned to transfer him to another approved premises on 14 January, but the man was unaware of this. On the afternoon of 13 January, staff conducting room checks at 2.00pm did not see the man in the building and assumed he had gone out. At a later check that afternoon he was found dead from an overdose of heroin.

The investigation found that Ozanam House staff did not carry out room checks at random intervals, as should happen and, on the afternoon of the man's death, the checks did not follow the local procedures which stipulate they should be conducted in pairs. This meant that the 2.00pm check missed out a bathroom, which each member of staff thought the other had checked. It was not till a later check that the man was discovered. The man had taken a significant amount of heroin and we cannot know whether it would have been possible to save him if he had been found earlier. It seems surprising that steps to recall the man to prison were not initiated when he persisted to use illegal drugs and did not turn up for appointments to help him address his problems. However, I recognise that many residents of approved premises have ongoing drug problems and probation staff managed him within the parameters of Northumbria Probation Trust's substance misuse strategy. After his death, I am concerned that no one from the approved premises contacted the man's family until the next day and not in person, as national guidance requires.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **November 2014**

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SUMMARY

1. The man was released on licence from HMP Northumberland on 2 December 2013, to live at Ozanam House Approved Premises in Newcastle upon Tyne. His licence conditions included a requirement for him to address his drug and alcohol problems. The man had a long history of substance misuse and offending and had previously failed to adhere to a licence condition to live at St Christopher's House, another approved premises in Newcastle, after an earlier release from prison in October 2013.

2. After his release from prison, the man did not report to Ozanam House at the prescribed time. When he arrived at 8.40pm, he appeared to be under the influence of drugs. He admitted that he had used cannabis but tests were positive for opiates and benzodiazepines. Staff gave the man a full induction, including advice on the risks of overdose and how to minimise them.

3. On several occasions, after being out during the day, the man returned to the approved premises apparently under the influence of drugs. The staff conducted frequent drug tests, which were all positive. They requested additional monitoring to ensure he was safe during the night.

4. The man missed several meetings arranged with his key worker at Ozanam House but attended meetings with his offender manager (probation officer). This meant that his key worker was initially unable to discuss his needs and arrange for appropriate community drug support. She had referred him to a local agency a few days before he died and was waiting for an appointment. The man breached approved premises rules several times by going into another resident's room and allowing the resident in his room. His key worker gave him a warning for not complying with this rule and for missing key work meetings. After he missed a further meeting on 9 January 2014, the manager of Ozanam House gave notice to the man's offender manager that he was withdrawing his place. His offender manager arranged for him to transfer to St Christopher's House on 14 January but did not tell him about this in case his behaviour got worse or he absconded.

5. On 13 January, during a room and building check, probation staff found the man unresponsive in a toilet. They called the police, who removed the door and found the man with a syringe. (During a further check, they found an older syringe hidden near the ceiling.) An ambulance crew arrived and pronounced him dead.

6. The investigation found that Ozanam House's room and building checks were not compliant with national instructions and that staff did not adhere to the local policy and procedures on how they should be conducted. The police notified the man's family of his death. Probation staff telephoned them the next day, but the national policy stipulates that initial contact with a family after the death of a resident should be in person.

THE INVESTIGATION PROCESS

7. Notices announcing the investigation were issued to staff and residents at Ozanam House, inviting anyone who might have information relating to the man's death to contact the investigator. No one responded.

8. The investigator visited Ozanam House on 24 January. She met the deputy manager and interviewed two members of staff. An Assistant Ombudsman conducted additional interviews on 21 February.

9. We informed HM Coroner for Newcastle of our investigation, who provided the toxicology report. We have sent a copy of this report to the Coroner.

10. One of the Ombudsman's family liaison officers spoke to the man's parents to explain the investigation process and invite them to identify any relevant issues they wanted the investigation to consider. They raised the following:

    - What were the man's licence conditions?

    - How did he test positive for drugs three times under supervision and what happened after each positive test?

    - They understood it was approximately three hours before the man was found in the toilets. Why did it take so long to find him?

    - The police had told them that a syringe without a needle had been found close to the man and wanted to know whether the needle had been found.

11. The man's family received a copy of the draft report. They raised a number of questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence. We have made one change to the report following factual accuracy feedback from NOMS.

OZANAM HOUSE APPROVED PREMISES

12. Approved premises (formerly known as probation and bail hostels) accommodate offenders released from prison on licence and those directed to live there by the courts as a condition of bail. Their purpose is to provide an enhanced level of residential supervision in the community, as well as a supportive and structured environment.

13. Ozanam House is an Approved Premises near the centre of Newcastle upon Tyne. It helps to resettle prolific lower risk offenders as well as those who have committed more serious offences. Ozanam House has a manager, offender supervisors and support staff.

14. Each resident is allocated a key worker who acts as their primary point of contact and assists with practical issues. Regular key work sessions give residents the opportunity to discuss any difficulties and issues such as benefits, health and future accommodation are routinely discussed. Residents at Ozanam House are all asked to register with a local GP. Approved Premises do not provide healthcare and a resident's medical treatment is a confidential matter between the resident and their doctor.

15. Residents are required to abide by the rules and regulations of Ozanam House, including an overnight curfew. During the day, they are permitted to go out unaccompanied and there is no requirement to tell staff where they are going. Breakfast, an evening meal and supper is provided to all residents.

16. Ozanam House has an established routine for inducting all new residents. The induction is carried out by a member of staff on duty at the time the resident arrives. During the process, residents are told about the local house rules and their expected behaviour. Alcohol and illicit drug use is forbidden at Ozanam House.

Previous deaths at Ozanam House

17. The man's death is the sixth at Ozanam House since 2007. One of the previous deaths was due to a drug overdose.

KEY EVENTS

18. The man was convicted of robbery and sentenced to three and a half years imprisonment on 29 February 2012. He had a history of drug and alcohol misuse and numerous previous convictions. The man was released from prison on licence on 3 October 2013, to live at St Christopher's House Approved Premises in Newcastle. While living there, several of his drug tests were positive. The man breached his licence conditions by failing to return to St Christopher's House and he was recalled to prison on 28 October 2013.

19. The man was released again from HMP Northumberland on licence, on 2 December 2013. His licence listed several conditions, including a requirement to reside at Ozanam House Approved Premises; a curfew between 9.00pm and 7.00am; to be well behaved, not commit any offence and not do anything to undermine the purposes of his supervision; and working with his offender manager to address his drug, alcohol and anger offending behaviour issues. His risk management plan noted his misuse of opiates and diazepam (a sedative used to treat anxiety) and that approved premises staff should monitor his presentation and alert the medical services if necessary.

20. After the man left prison, he was expected to report to his offender manager (probation officer) at 1.00pm, at Ozanam House. He arrived at Ozanam House at 8.40pm and said he was unaware of the appointment with his offender manager. (His licence had stated that he should report to the duty officer.) The member of staff who met him at Ozanam House noticed that he appeared to be under the influence of drugs and the man said that he had used cannabis. The man took a test which proved positive for opiates and benzodiazepines.

21. A project worker completed an induction with the man, in which they had a discussion about the risk of overdose and watched a DVD about how to minimise the risks. He signed various documents, including a drug treatment contract. This advised that on release from prison, tolerance to drugs is low and even a minor dose of non-prescribed substances could result in overdose or death. The man did not register with a GP as the surgery's policy at the time was that residents should not register unless they needed immediate treatment. (Since the man's death, the policy has been revised so that residents register routinely when they arrive at Ozanam House.)

22. Residents at approved premises are allocated to a specific offender supervisor, often referred to as a key worker. The man's key worker told the investigator that the objectives were to support the man to have a more stable lifestyle, facilitate his rehabilitation after a long history of offending and reduce his drug and alcohol issues. At her first meeting with the man on 4 December, they had discussed his positive drug test. The man said he had used heroin on his last night in prison but he did not think he had a problem and had suffered no withdrawal symptoms. He told her that he felt in the right frame of mind to stay drug free.

23. The man's key worker emailed the details of their discussion to the man's offender manager, for his meeting with the man that afternoon. The man failed to attend his next key work meeting on 11 December.

24. On Friday 13 December, the man's key worker and offender supervisor had a meeting with the man who had tested positive, earlier that day, for opiates and benzodiazepines. The man denied that he had used the drugs revealed in the test but said he had taken heroin the night before. They agreed to repeat the drug test and send it for laboratory testing, but no other immediate action was proposed. During the meeting, the man asked for his curfew times to be relaxed. The offender supervisor explained to him that as he had used heroin, tested positive for drugs and had failed to attend his key work session, all within a few days of his arrival, he could not agree to a relaxation of his curfew. He said that he would review it when the man started to produce clean drug tests. The man was unhappy with the response and abruptly walked out of the meeting.

25. The man was reported to be under the influence of drugs or alcohol when he returned to Ozanam House at 8.45pm on 15 December. No action was taken at the time.

26. The man's key worker and offender supervisor had arranged another key work meeting to be held on Monday 16 December, the first weekday after their last meeting on 13 December. The man failed to attend. His key worker told the investigator that she had informed the offender supervisor that the man had missed the meeting but left it to her to decide what action to take. She said that it was still early days for the man after his release and they liked to give residents a chance to settle down and accept their licence conditions.

27. The key worker recorded that a key work meeting on 24 December had been productive. She thought the man had probably made the effort to attend as he had asked for home leave over Christmas and wanted to ensure that it was approved. They discussed a number of issues, including his historic and current drug use, several breaches of Ozanam House rules, the key work meetings he had missed and the importance of such meetings. The man admitted that he sometimes felt tempted to use drugs and said that he might consider engaging with a drug worker in the near future. His key worker said that at that stage, she had been unable to arrange a community drug worker as the man had not attended his previous key work meetings.

28. During the meeting, his key worker gave the man a first written warning for inappropriate behaviour, specifically, failing to attend key work meetings and allowing other residents in his room (which was prohibited at Ozanam House). She explained to the investigator that three warnings would lead to withdrawal of a resident's place at the approved premises.

29. On 2 January 2014, after going out during the day, the man returned to Ozanam House, seemingly under the influence of drugs or alcohol. He did not attend a planned key work meeting the next day, with another key worker. The second key worker had intended to issue the man with a warning for

going into the room of another resident and having the resident in his room, in spite of previous verbal warnings. (This warning was not issued as the man did not attend key work meetings scheduled for 3 and 9 January.)

30. When the man returned to Ozanam House with the resident at 4.00pm on 5 January, staff believed they were under the influence of drugs. The next day, the man tested positive for methadone and benzodiazepines.

31. The offender supervisor's last meeting with the man was on 7 January. He told the investigator that the man had complained of boredom and had said that he was struggling with some of the approved premises rules as he considered them to be petty. The offender supervisor agreed to refer him to the education and training department. They also discussed his substance misuse, which had been linked to his offending. The man was adamant that the drug tests had been incorrect and he had not taken the drugs identified by the tests, but he did not deny taking other substances. He agreed to be referred to a drug support agency. The key worker noted, in a form completed on 16 January, after the man's death, that she had made a telephone referral to the Turning Point drug support agency on 8 January.

32. The manager of Ozanam House holds weekly resident review meetings. At the meeting on 7 January, he and the other staff discussed the man's refusal to engage and his non-compliance with the rules. After he failed to attend the next key work meeting on 9 January, the manager decided to withdraw his place. Both he and the key worker considered that the man should be recalled to prison. However, the decision had to be taken by his offender manager. They gave a week's notice of the termination of the man's residency to enable the offender supervisor either to find alternative accommodation or arrange for the man to be recalled to prison. The key worker advised the offender supervisor to discuss the situation and possible options with the deputy manager, who was managing the premises at the time. The offender supervisor and key worker did not tell the man about the decision as they were concerned that if he knew, his behaviour might deteriorate or that he might abscond.

33. The key worker noted in the man's record on 9 January, that he had only attended one key work session since his arrival and all his drug tests had been positive. She indicated that if he presented any further unmanageable behaviour or was late for his curfew, approved premises staff should request that he should be recalled to prison. When the man returned to Ozanam House that evening, his demeanour suggested that he was again under the influence of drugs. He was aggressive and abusive to the project support worker on duty and told her he did not like it there and preferred St Christopher's House. The project support worker told the investigator that, for safety reasons, she did not conduct an immediate drug test as there was limited staffing at the time. She explained that if drug use is suspected in the evening, a drug test can be suspended until the next day when there are more staff on duty.

34. On 10 January at 6.15pm, the man went out with his friend. They returned at 7.40pm and the man appeared to have taken drugs. An entry in the man's record that day, noted the decision to move him to St Christopher's House on 14 January and that his offender supervisor would take him there. The offender supervisor told the investigator that as a result of the man's repeated failure to attend key work sessions, he had drafted a formal warning letter to be issued on 13 January 2014, stating that if the man did not comply with the requirement to attend key meetings in future, he would either be issued with a final warning or recalled to prison. The man died before this was issued.

35. At Ozanam House, routine room and building checks are carried out at 8.00am, 10.00am, 2.00pm, 4.30pm, and 11.00pm. The manager and the staff interviewed explained to the investigator that room checks must be carried out in pairs. They check if the resident is in their room and what they are doing as well as checking for damage to the building, drugs or other illegal substances. During the early morning check, staff are required to get a response from the resident to ensure that they are well. The manager gave the investigator a note issued on 11 April 2013, reminding staff about security issues, including ensuring that room checks are carried out in pairs. Ozanam House's staff induction agenda also includes sessions on safe practice in room checks and working in pairs and knowing where your colleagues are at all times.

36. On 13 January, another project support worker was working a 12.00pm to 12.00am shift at Ozanam House. She told the investigator that as she was walking to work, she saw the man and his friend. When she spoke to them, neither appeared to be under the influence of drugs. Around half way through her handover with the morning staff, the project support worker noticed that the man and his friend had returned. CCTV footage shows that at 12.36pm, they went to the friend's room, where the man stood at the door for a few minutes and then went into the bathroom alone.

37. A third project support worker said that at 2.00pm, she and the second project worker carried out the building checks. Although they worked as a pairs along the landing, they inspected each room on their own. The third project worker checked some of the rooms, including the man's, but he was not in. The second project worker checked the others and they met along the corridor. The third project worker asked the second where she was up to and she replied that they had finished. The third project worker took this to mean that she had checked the bathroom as well as the residents' rooms. However, the second project worker had assumed that the other project worker had checked the bathroom. The third worker saw nothing in the man's room to suggest he had been taking drugs and marked him as being out as neither of them had seen him elsewhere in the building during their checks.

38. Another worker and the second project worker conducted the next building check just after 4.30pm. When they reached the middle floor, they shouted into the bathroom, to alert any occupant and then went in to check as there was no reply. Within the bathroom, there was a private cubicle and the door was shut. They tried to push it open but realised that someone was behind the door. As they could not get a response from the person, they decided that

the quickest way to get help was to use their personal alarm which is connected to the police station.

39. The police arrived within three minutes. Staff then went to check the rest of the building to try and work out who was missing. While the police were trying to get into the cubicle, the other worker managed to squeeze her head round the door and identified the man by his clothes. The police then removed the door. They found the man with a syringe. (The needle was missing and never found. The police surmised that it could have been flushed away or placed in the sharps box provided to dispose of sharp objects.) An ambulance arrived and the crew pronounced the man dead.

40. The key worker telephoned her line manager and the duty manager who supported the project support workers. They informed the residents of the man's death. The manager was not working that day.

41. The police notified the man's mother of his death that night. The duty manager telephoned her the next morning and offered his condolences. He informed her that, in line with national guidelines, the Probation Trust would contribute towards the funeral costs.

42. The toxicology report concluded that the cause of the man's death was heroin toxicity and that he had died between one to two hours after taking the drug. The pathologist added that the level of concentration of the drug could have posed a serious risk, even to a tolerant user.

ISSUES

Management of the man

43. Before the man's release from prison, his offender manager had made arrangements for him to reside at Ozanam House. When he arrived, approved premises staff inducted him, including advice and discussion on the risks of drug misuse and they conducted a drug test which was positive. Meetings were scheduled with his key worker and his offender manager.

44. Generally, the man attended meetings with his offender manager. However, he missed several key work meetings and did not adhere to some of the approved premises' rules, particularly those relating to being in another residents' room. The man's key worker and offender manager fixed additional appointments to encourage him to attend key work meetings and warned him formally about his behaviour. After two warnings, the manager of Ozanam House gave notice that his bed would be withdrawn and his offender manager arranged for him to transfer to St Christopher's House.

45. We consider that the arrangements for the man's release and subsequent supervision were adequate and staff made appropriate efforts to engage with him. Staff addressed his failure to comply with the rules by issuing warnings of the consequences of repeated contravention and withdrawing his place. Ultimately, the possibility of revoking his licence and recalling him to prison was being considered.

The man's drug misuse at Ozanam House

46. Northumbria Approved Premises Substance Misuse Strategy acknowledges that a substantial proportion of residents are involved in substance misuse but that approved premises are not drug/alcohol rehabilitation projects and are not the ideal environment for detoxification. They work on the principle of harm reduction and minimisation. Among the expectations set out in the strategy are that residents with a substance misuse problem should engage with the plans and provisions for managing their addiction and, if they are unwilling to do so, their residency will be reviewed and they might be asked to leave. Approved premises staff are expected to refer residents with such problems to appropriate agencies such as a GP or drug support agency.

47. The guidance recognises that relapse is an integral part of the recovery process and sets out an expectation that staff will liaise with the resident's offender manager and other relevant agencies. It also states that:

> "A positive drug test or admission of drug misuse should not, in itself, form grounds for breach action. However, prolonged misuse may result in the enforcement process being pursued and the withdrawal of their bed … Similarly, if an individual has a condition of abstinence from alcohol as a condition of bail or licence, staff have a clear obligation to notify … the offender manager …"

48. A drug test taken on the day that the man arrived at Ozanam House was positive and he admitted that he had used heroin. Subsequent tests were also positive and on several occasions when he returned to the approved premises in the evening, he appeared to be under the influence of drugs. The man challenged the accuracy of the drugs detected in the tests and, on at least one occasion, staff agreed to send the test away for further analysis.

49. The man's key worker had not referred him to a drug treatment agency as he had missed most of his key work meetings so they had not been able to discuss it. Just before he died, he had agreed to a referral and his offender supervisor and key worker had taken the first steps to action this.

50. Although his licence stipulated that he should comply with any requirements by his supervising officer to ensure that he addressed his alcohol, drug and anger offending behaviour problems and that he should not commit any offence, there was no specific condition for the man to abstain from drugs and alcohol as we have seen explicitly recorded on licences in other investigations. The man's records show that staff recorded their suspicions of drug use and carried out several drug tests. They also made notes to alert other staff to the need to carry out additional monitoring and welfare checks on the man and refer him to the medical services if they were concerned. It was not always possible to conduct tests immediately when staff noticed signs of drug misuse.

51. In spite of the man's repeated failed drug tests and his disclosure that he had used heroin, he denied that he had a problem. Understandably, his persistent non-attendance at appointments with his key worker delayed a referral him to a drug support agency. Engagement with a drug support agency requires some acceptance from the individual that there is a problem and a willingness to address it. It was not until 7 January, that the man agreed to be referred. His key worker made a telephone referral on 8 January, but the man died before receiving an appointment.

52. We are satisfied that the man's offender manager and staff at Ozanam house acted in line with the substance misuse strategy to assist the man to address his drug misuse. When it became clear that he continued to use drugs, they took reasonable precautions to ensure his welfare, including tests and additional monitoring at night. It is unfortunate that the man died before he was able to engage with a drug support agency.

Drug testing at Ozanam House

53. The manager of Ozanam House wrote to staff on 18 April 2012, to advise them about writing entries in records about suspected drug use. He explained that as well as indicating that a resident appeared under the influence of substances, they should qualify their observations and explicitly state the signs of misuse. They should also conduct a drug test. On 3 January 2014 and 6 January 2014, the manager sent further notes to staff, repeating the instruction that they should perform drug tests if they suspect a resident is under the influence of drugs or alcohol. The expectation was that the test

should be done at the time, subject to a risk assessment, or the next morning if it was not possible in the evening. In the note of 6 January, the manager drew attention to the Ombudsman's finding in a previous investigation that staff had not completed such tests.

54. On several occasions, staff suspected that the man was under the influence of drugs and/or alcohol when he returned to Ozanam House in the evening. On 15 December and 2, 6, 8 and 10 January, they noted that the man appeared to be under the influence but they did not always record the signs and did not take drug tests. We make the following recommendation:

The Manager of Ozanam House should ensure that staff promptly test residents suspected of substance misuse and record the signs if an immediate test is not possible.

Building and room checks

55. The staff who checked the building and rooms at 2.00pm said that although they had completed the checks together, they separated along the landing and checked each resident's room individually. When they had finished, there was a misunderstanding between them as to whether the other had checked the bathroom where the man was found. He was discovered unconscious at the next check, just after 4.30pm.

56. The Approved Premises Manual states that staff should carry out regular tours of the building during the day and night, including checks of residents' rooms. We assume by 'regular' it means frequent, as the manual goes on to say that checks should be random, rather than on a fixed schedule, to avoid residents thinking that they are closely observed only at certain times. Checks at Ozanam House were conducted at regular fixed times every day and were not random.

57. Northumbria Probation Trust's guidance on room checks states that, "staff should, in pairs, check residents' bedrooms on a regular basis … " The manager of Ozanam House told the investigator that the strict expectation is that staff conducting the room checks should remain together in the same location and that all areas, including the bathroom should be checked. He said that since the man's death, he had reiterated this to staff.

58. The requirement for staff to conduct checks together is for their own safety. It is perhaps understandable that the staff who were working in a pair on the same landing did not feel the need to check each individual room together. However, it is unfortunate that this led to a misunderstanding about which rooms had been checked. It appears that the man went into the bathroom at 12.36pm, when he returned to the premises. The toxicology report suggests that he would have died between one or two hours of taking the heroin so it we cannot know whether, if he had been found at the 2.00pm check, it would have been possible to save him. We make the following recommendation:

The Manager of Ozanam House should ensure that building and room checks are managed in line with national guidelines and that staff conduct them in pairs, as stipulated in the local policy.

Family liaison

59. The Approved Premises Manual sets out the expected procedures and standards for notifying a resident's family of their death. It says that a representative of the approved premises should contact the resident's family immediately, usually face to face, except where a GP has certified death in which case it is done by the police. There should be ongoing contact, with timely information about the circumstances of the death, both verbally and in writing.

60. The police contacted the man's family several hours after his death and a representative of Ozanam House telephoned them the next day. We consider that someone from the approved premises should have contacted the man's family the day he died and gone to see then in person. We therefore make the following recommendation:

The Manager of Ozanam House should ensure that national guidance about contacting families after a death is followed.

RECOMMENDATIONS

1. The Manager of Ozanam House should ensure that staff promptly test residents suspected of substance misuse and record the signs if an immediate test is not possible.

2. The Manager of Ozanam House should ensure that building and room checks are managed in line with national guidelines and that staff conduct them in pairs, as stipulated in the local policy.

3. The Manager of Ozanam House should ensure that national guidance about contacting families after a death is followed.

No	Recommendation	Accepted/ Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	The Manager of Ozanam House should ensure that staff promptly test residents suspected of substance misuse and record the signs if an immediate test is not possible.	Accepted	The manager to re-issue instructions on testing, recording and qualifying signs of substance misuse	By end August	Monitoring of records and review and discussion with team at 6-month point
2	The Manager of Ozanam House should ensure that building and room checks are managed in line with national guidelines and that staff conduct them in pairs, as stipulated in the local policy.	Accepted	Room checks practice will be changed to build in a random characteristic to our procedures. The manger to raise this at the divisional managers meeting in August. Immediately after the death instruction was issued to all staff to work as dictated in pairs.	Random checks to be implemented in September. Working in pairs: detailed re-instruction will be issued on publication of the final report.	Ongoing monitoring of the room check procedure
3	The Manager of Ozanam House should ensure that national guidance about contacting families after a death is followed.	Accepted	The national guidance on contacting next of kin is, as the report points out, that the AP should make contact immediately unless the police take on the responsibility. That is what happened in this case. The fact that the police then took several hours to make contact was beyond Ozanam House's control and was not something that the AP could reasonably be expected to know had happened.	In the event of another resident death at Ozanam House	n/a

			Face-to-face contact is the preferred method but the national guidelines allow for alternatives. This is because the choice of method should be driven by what the bereaved themselves prefer. Requiring contact in person in all cases would risk acting against bereaved families' wishes. We should also point out that the standards at Annex 23-F of the AP Manual apply equally to other custodial settings on the recommendation of the Inter-Ministerial Advisory Panel. They cannot be changed unilaterally for one setting.		