Investigation into the circumstances surrounding the death of a man, a resident at an Approved Premises in the Wales Probation Trust, in January 2010

Report by the Prisons and Probation Ombudsman for England and Wales

December 2010

This is the report of an investigation into the death of a man, a resident of an approved premises in the Wales Probation Trust. The man died in his room in January 2010, just five days after arriving from HMP Guys Marsh. He was 33 years old. A post mortem established the cause of death as respiratory depression due to a combination of illicit drugs. I offer my sincere sympathy and condolences to the man's family for their loss, as I do to all those who have been affected by his passing.

The investigation was carried out by one of my colleagues. I would like to thank the staff at the approved premises for their full and ready co-operation with the investigation.

The man had a long history of drug misuse, for which I am surprised that he received no treatment during his last period in prison. Following his release from Guys Marsh to the approved premises, staff suspected that he was misusing drugs again. However, he was engaging with the local drug agency and had been honest with staff regarding the prescription medication he had obtained. Staff described him as polite and determined to stop offending.

When the man returned to the approved premises on 9 January, he appeared dazed and confused and staff therefore conducted a drug test, which showed that he had taken opiates. He had already tested positive for cannabis and benzodiazepines that morning. Following these positive tests, staff should have told the manager. I make a recommendation in this regard and in ensuring that earlier drug tests take place as directed by local policy, since the man should first have been drug tested when he arrived at the approved premises.

When staff checked the man in his room at 11.00pm that evening, they discovered he had vomited on his bed and was lying fully clothed on top of the covers. They placed him in the recovery position and monitored him throughout the night. At 8.00am, staff discovered he had again vomited in his sleep, cleared his airway and placed him in the recovery position. When they checked the man two hours later he had stopped breathing and attempts to resuscitate him were unsuccessful.

Staff had clearly considered the man's condition, as evidenced by their monitoring of him throughout the night. However, it is my conclusion, that they did not understand the seriousness of his condition. He was dazed, confused, had tested positive for opiates and vomited twice in his sleep. I believe that an ambulance should have been called when they discovered he had vomited on the first occasion. While it is impossible to know if this would have led to a different outcome, it does, at the very least, represent a serious lapse in the quality of care the man received at the approved premises.

I will copy my report to the Governors of HMP Swansea and HMP Guys Marsh in relation to my comments about information sharing on drug treatment.

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.

Jane Webb
Acting Prisons and Probation Ombudsman **December 2010**

CONTENTS

Summary

The investigation process

The Approved Premises

Key findings

Issues

Conclusion

Recommendations

SUMMARY

On 1 October 2004, the man was sentenced to six years and six months imprisonment at Crown Court. He was released from HMP Erlestoke to an approved premises on 20 March 2009. Just over a month later, he transferred to a further approved premises, to be nearer his partner. Following concerns regarding the man's breathing, he was taken to hospital on 23 May and was subsequently diagnosed with pneumonia. He discharged himself four days later and did not return to the approved premises. He was therefore recalled to prison, arrested by police and taken to HMP Swansea the following day.

The man transferred to HMP Guys Marsh on 29 July. He remained there until he was released back to the approved premises on 5 January 2010. During the period of his recall, he was not regarded as a priority for drug treatment and therefore did not receive any input until just before his release. I find this surprising, given the man's long history of drug misuse and consider this issue further in the report. However, I am pleased to note that prior to being released he was given appropriate information regarding harm minimisation and the risk of overdose and an appointment was made with the local community drug service.

On his arrival at the approved premises, the man was given a one-to-one induction by his keyworker. However, he was familiar with most of the rules, due to his previous stay at the approved premises and a number of staff also knew him. All the staff who spoke to my investigator, described the man as a polite and courteous resident who seemed to have matured and wanted to change his lifestyle. The man disclosed that he had last misused drugs in prison on 25 December. The keyworker therefore took the decision not to drug test him on his arrival, since she thought the drugs he had taken in prison would lead to a positive result.

The following day, the man attended his appointment with a support worker at the local community drug service and with his offender manager at the local probation office. He told them both that he wanted to obtain a diazepam prescription. On 7 January, he registered with a local general practitioner (GP) surgery and was prescribed diazepam. He had not told approved premises staff where he was going and had not registered with the agreed surgery, as required by the approved premises rules. Nevertheless, on his return to the approved premises, the man gave his medication to staff as required.

The man was out of the approved premises for most of the following day. When he returned, staff observed that he was unsteady on his feet and sleepy, but the man said he was still getting used to his newly-prescribed medication. On 9 January, he was drug tested for the first time. The result was positive for cannabis and benzodiazepines. No action was taken as staff attributed the result to his prescribed medication and the cannabis he had disclosed that he had recently taken in prison. When he returned to the approved premises that evening, he appeared dazed and confused. Staff were concerned that he had misused drugs and so more tests were carried out. The result was positive for opiates.

Staff emailed the man's offender manager and the approved premises' deputy manager but immediate enforcement action was not considered necessary. Since it

was a Saturday, these two members of staff would not have received these emails until Monday morning. An on call manager should have been telephoned and I make a recommendation in this regard.

When staff checked the man in his bedroom at 11.00pm, they found that he had vomited in his sleep and was lying fully clothed on top of the bed covers. They cleaned him, checked his airway, placed him in the recovery position and decided that he should be monitored hourly. This continued hourly until 6.00am, when the observations were decreased to every two hours. When he was checked at 8.00am, the man had vomited in his sleep. Again staff cleaned him, cleared his airways and put him in the recovery position. When he was checked two hours later he had stopped breathing. An ambulance was called while one member of staff and a resident attempted to resuscitate him. Whilst this member of staff responded quickly and professionally, they were not aware of the current guidelines from the Resuscitation Council and I make a recommendation in this regard. Soon after the paramedics arrived, the man was pronounced dead.

According to local policy and national advice available from NHS Direct, an ambulance should have been called much earlier, either when the man returned to the approved premises dazed and tested positive for opiates, or when staff subsequently discovered he had vomited in his sleep. All the staff involved were first aid trained and had clearly considered the situation, as evidenced by their decision to monitor him throughout the night. Seemingly, they did not comprehend its seriousness. I make two recommendations in this regard, with the aim of ensuring staff are fully equipped with the knowledge and confidence to act appropriately in such emergency situations in the future.

THE INVESTIGATION PROCESS

1. The investigation was opened on 13 January 2010, when the investigator visited the approved premises and issued notices announcing the investigation to staff and residents. The notices included an invitation to those who wished to submit information related to the man's death to make themselves known to the investigator. No one came forward as a result. During the visit, the investigator was taken around the approved premises, including the room the man had lived in, and met several members of staff.

2. My investigator was given access to the man's files, from both the approved premises and HMP Guys Marsh. She later returned to the approved premises on 16 and 17 February and conducted interviews with ten members of staff and one resident. The investigator also conducted a telephone interview with a member of staff at Guys Marsh.

3. The investigator met the Assistant Chief Officer (ACO) on 17 February to provide him with an update on her investigation. A summary of the issues discussed was provided to the Assistant Chief Officer who responded to the investigator in writing. I am grateful to the Assistant Chief Officer for his consideration of the issues presented at this early stage of the investigation.

4. One of the Ombudsman's family liaison officers wrote to the man's mother on 20 January, to inform her of the investigation and invite her to raise any issues she wished the investigation to address. My investigator and the family liaison officer visited the man's mother on 9 March. She was concerned that the man had not been deemed in breach of his licence straight away and returned to prison when he provided a positive drug test. She also asked why medical assistance had not been called on discovering the man had vomited at 11.00pm on the eve of the man's death or at 8.00am on the morning of the man's death. I hope that this report helps the man's family to better understand what happened in the time leading to his death.

THE APPROVED PREMISES

5. The purpose of an approved premise is to provide an enhanced level of residential supervision in the community for offenders assessed as presenting a high risk of harm, within a supportive and structured environment. Whilst residents have to comply with their individual licence or bail conditions, curfews, and the approved premises' house rules, they are essentially free to come and go from the building. All residents at the approved premises are subject to curfew at night.

6. The approved premises in which the man died is one of around 100 approved premises in England and Wales. At the time of the man's death, it was one of two in the South Wales Probation Area. The four Probation Areas in Wales merged on 1 April 2010 to form the Wales Probation Trust.

7. The approved premises in which the man died accommodates up to 25 residents in single rooms. It is staffed 24 hours a day by probation

employees, whose role is to provide support and ensure that residents comply with the rules and licence or bail conditions. The two approved premises in the South Wales Probation Area share a manager, who divides their time between the premises which are 40 miles apart. Each approved premises has a deputy manager who is based there permanently.

8. There are several members of staff on duty during normal office hours. After 5.30pm and at weekends, this is reduced to two members of staff. During these hours there is also a deputy manager or manager and assistant chief officer who are on call and contactable in case of an emergency or if a decision needs to be made regarding a resident.

9. Each resident is responsible for their own health. If they require a consultation with a doctor or visit to hospital then, unless it is an emergency, the onus is on the resident to arrange the appointment. During their stay, residents are required to register with a doctor at a surgery. At the time of the man's death, all medication was held by the approved premises' staff and locked in the office. Residents had to request their medication, sign for it and consume it in front of staff. Following the implementation of new national guidance (Approved Premises: Probation Instruction 09/2009) this system has now slightly changed. Following an individual risk assessment, some residents can now keep some medication in their own possession.

10. This is the first death to occur at this particular approved premises since April 2004, when the Ombudsman's office began investigating all deaths in approved premises in England and Wales. There was a second death at this particular approved premises two months after that of the man who is the subject of this report. This was due to a heart attack. There are few similarities between the circumstances of the two deaths.

11. My office previously investigated a death at another approved premises, the other AP in the former South Wales Probation Area, in September 2008. The report made two recommendations. Firstly, that all staff be trained in basic first aid, with consideration given to training all staff in cardio-pulmonary resuscitation (CPR). Secondly, the Ombudsman recommended that the Chief Officer should review arrangements for supporting staff following the death of a resident. I am pleased to report that this investigation found that all the staff at the approved premises are trained in first aid and CPR and that staff felt fully supported following the death of the man. However, despite this training, there were issues with the decision-making by staff which will be discussed further in the report.

KEY FINDINGS

12. At the age of 16, the man left school without any qualifications. He had never worked. The man's mother said that he was a happy and outgoing person, who was always willing to help others. He had two children, aged eight and nine years. He was trying to re-establish contact with his children following his release from prison.

13. The man had a long history of offending, dating back to 1990, when he was 14 years old. He misused drugs from an early age and much of his offending was related to his substance misuse, either committed to fund his habit or whilst under the influence. He had been in prison on several occasions prior to his most recent sentence.

1 October 2004 – 4 January 2010

14. The man was sentenced to six years and six months imprisonment at Crown Court on 1 October 2004. Having served his period in custody, the man was released, on licence, from HMP Erlestoke to an approved premises on 20 March 2009.

15. As an offender on licence, the man had to meet with his offender manager each week to address issues assessed as relevant to his offending. These sessions mainly focussed on the man's drug misuse, lack of suitable housing, his relationship with his partner and access to his children. The Approved Premises Service Officer (APSO), told my investigator that he remembered the man from previously working at another approved premises. He said that staff had concerns that he was misusing diazepam, an anti-anxiety drug, at that time.

16. The man was transferred to his current approved premises to be nearer his partner on 27 April. Around a week later, he was assessed by a Criminal Justice Mental Health Liaison Nurse. She is based at the approved premises one afternoon per week and completes mental health assessments on new residents. On the basis of this assessment, she wrote to a doctor at the surgery to inform him that the man had been released from prison with a pregabalin prescription for anxiety. She said that he had no mental health issues or history of self-harm or suicide.

17. On 14 May, the man had to be carried to his room by two other residents. When the night supervisor checked on him he was 'out cold'. The night supervisor therefore stood him up and spoke to him to ensure that he did not require any medical attention. The man denied misusing drugs. Nevertheless, staff monitored him throughout the night to ensure his condition did not deteriorate.

18. Staff subsequently became concerned about the man's breathing and he was admitted to hospital around two weeks later with suspected pneumonia. He remained in hospital for four days until he discharged himself on 27 May. Since he did not return to the approved premises or attend his supervision

appointment, his offender manager completed the paperwork later that day for the man to be recalled to prison. This was approved by the Parole Board. Police arrested the man and he was taken to HMP Swansea the following day.

19. Prison records note that the man asked for an appointment with the Counselling, Assessment, Referral and Throughcare service (CARATs), the prison drug misuse service, on 10 June. The CARATs team completed an assessment and decided the man needed low level intervention, gave him some worksheets to do in his cell regarding his cannabis misuse and put him on a waiting list for the Integrated Drug Treatment System (IDTS). (IDTS provides offenders with a range of treatments, including clinical and psychosocial support such as symptomatic relief, detoxification, one to one sessions and peer led group work.) The CARATs worker gave advice about reducing the risk of an overdose.

20. The man did not receive any further support from the CARATs team at Swansea. He transferred on 29 July to HMP Guys Marsh. There is an entry in his CARAT record on 28 August from the CARATs team manager at Guys Marsh to indicate that she had completed a file review and the man was on the waiting list to be seen. She told my investigator that at the time the CARATs team was understaffed and there was a waiting list of around 70 people. (I am pleased to learn that this has since improved.) However, she said that if prisoners had urgent concerns they could be prioritised and seen earlier. The man was not regarded as a priority since the notes from the previous prison said he only needed low level intervention for cannabis misuse.

21. Around this time, the man’s case was reallocated to a new offender manager who has been a qualified probation officer since 2004. On 28 October, the new offender manager completed a referral to approved premises in preparation for the man’s eventual release. He did this at the request of the Public Protection Casework Section (PPCS) since they had indicated that once the man was offered a place at an approved premises, he would be released.

22. The man’s new offender manager also completed a report for the review of re-release by the PPCS and Parole Board (also known as an annex H) which outlined the sentence and risk management plans, along with his assessment of the man’s suitability for release. The offender manager based this on a review of the man’s file, a telephone conversation with him and with his offender supervisor at Guys Marsh.

23. The man’s new offender manager did not support the man’s release on licence and placement at an approved premises, as he assessed his risk of offending or harm could not be appropriately managed in the community, particularly given his continued drug misuse when released earlier in the year. This assessment was agreed both by his line manager and the responsible ACO. However, the Parole Board made the decision to release the man and, at the beginning of December, set his release date as 5 January 2010.

24. An entry in the CARATs record on 9 December by a support worker indicates that a release plan was opened and overdose information was discussed with the man. In addition, he said that he needed a Subutex (used for the treatment of opiate addiction) prescription for his release. The support worker told him that this would not be possible since Dorset Primary Care Trust (PCT) did not prescribe Subutex. He said he was not interested in alternative medications as he had been prescribed Subutex before and felt it was the most successful to stop him misusing opiates. The support worker faxed the Criminal Justice Integrated Team (CJIT), the community drug service, a referral form for an appointment for the man after his release.

25. The support worker received a telephone call from CJIT on 14 December 2009. They said that the man would have to go through the normal prescribing process and it could take up to two weeks from his first appointment for his prescription to be issued. The support worker discussed this with the man who said that he thought he would be able to wait, but was worried that if he gave positive drug tests he would be recalled to prison.

26. The following day, the man's appointment with CJIT was confirmed for 6 January 2010 at 11.30am. Details of this appointment were given to him and he was told that CJIT would disclose the results of drug tests to the approved premises.

27. On 17 December, CJIT called the CARATs support worker at Guys Marsh to ask whether the man's prescription could be started in the prison. They were told that this could not be done. The CJIT worker said that they would call the CARATs support worker at Guys Marsh back after speaking to the doctor to check whether prison drug tests would be enough to satisfy him that a prescription was needed. There is no record as to whether this happened and the last entry in the CARATs file notes that the man was released and a release plan was completed.

28. This plan noted that the man was currently misusing unprescribed Subutex, he should engage with CJIT on release, attend all appointments and address his substance misuse. Recently released prisoners often have a reduced tolerance for drugs and are more prone to overdose. The CARATs team manager at Guys Marsh said that prior to his release, the man was spoken to and given a booklet about minimising the risk of overdose. Having reviewed the paperwork, she told my investigator that the man had received a good pre-release service from CARATs staff, enabling him to engage with CJIT services as soon as he was released.

29. The man's offender manager was informed of his release date around 20 December. He therefore contacted the approved premises manager who confirmed that a place would be available on 5 January. The man's offender manager also faxed a form to the Parole Board requesting extra licence conditions for the man in order to manage his risk of harm and re-offending. The man's offender supervisor at Guys Marsh informed the man's offender manager of the arrangements regarding CJIT following his release.

Tuesday 5 January

30. On 5 January 2010, the offender manager completed the man's Offender Assessment System (OASys) documentation. This assesses the man's risk of harm and re-offending, as well as outlining a plan for the rest of his sentence. The offender manager was responsible for managing the man's sentence plan, involving weekly appointments with him and liaison with approved premises' staff. He held around 60 other cases at the time.

31. The offender manager noted that the man would need to engage with CJIT on release with regards to his drug misuse. It was also noted that he had overdosed previously and been "close to death". The offender manager sent an email to the Social Services Department with regards to trying to set up access for the man with his children. (In response to the draft report, the man's family said that he had been in hospital for accidental overdoses on two occasions.)

32. At midday, the approved premises received the man's licence from the prison, indicating that he was due there by 3.00pm and would be on licence until 6 March 2011. The man had signed the licence on 18 December 2009. Extra conditions suggested by the offender manager and deputy approved premises manager were included along with the standard conditions. The man's conditions were:

    - To be well behaved and not re-offend.
    - To keep in touch with his supervising officer and receive visits from them as required.
    - To permanently reside at the approved premises and to abide by their rules.
    - To only undertake work approved by his offender manager.
    - Not to travel outside the United Kingdom.
    - Not to consume alcohol or illicit substances on or off the premises.
    - To report to staff at the approved premises every two hours.
    - To abide by the curfew at the approved premises between 8.00pm and 10.00am
    - To be excluded from an area of Swansea relating to the victim of his offence.
    - To address his substance misuse and offending behaviour.

33. The man had not arrived at the approved premises by 3.00pm and the Approved Premises Security Officer (APSO) therefore telephoned the man's offender manager who agreed to extend the time limit to 4.00pm, otherwise he would be recalled to prison. They had already checked that there had been no known delays on the trains the man would use during his journey. (Following receipt of the draft report, his family explained that he had telephoned them to say that he had gone to the wrong platform and had consequently missed his train. A family member made several attempts to telephone the probation office to let them know, but there was no reply.)

34. At 3.50pm, the man attended a probation office and was told to go straight to the approved premises, where he arrived five minutes later. As is standard for all new residents to an approved premises, the man had an induction with an Approved Premises Officer (APO). She had also been assigned as the man's keyworker. She would have been the man's first point of contact and responsible for completing individual offence-focussed work with him every week. She is normally keyworker to around six residents.

35. The man's keyworker had some knowledge of him from the last time he had stayed at the approved premises, although she had not been his keyworker then. She said that he seemed more positive on this occasion and had matured somewhat. He spoke of his determination not to go back to prison for the sake of his children. His keyworker described the man as "pleasant, polite and always respectful of staff".

36. The keyworker explained the approved premises rules to the man, showed him around the approved premises and issued him with keys to his room. She also completed a suicide and self-harm assessment during which the man did not disclose any previous or current thoughts of self-harm or suicide. After their interview, the keyworker verified this information against the man's file. She referred him to the approved premises mental health nurse for an assessment which is standard procedure.

37. As part of the induction, the keyworker also completed a general health assessment. The man said he had "general aches and pains but was fit". He told the APSO he had been prescribed pregabalin for anxiety. He handed her this medication as per approved premises policy. He also disclosed that the last time he drank alcohol was on 26 December 2009. He considered drugs to be his main issue since he was 11 years old and had misused heroin, benzodiazepines, LSD and amphetamines.

38. The man told his keyworker that he last misused heroin and Rivatril (a sedative) on 25 December when he was in prison. He also signed an agreement that he would give all his prescribed and unprescribed medication to approved premises staff and that he would register with the local GP identified by the approved premises. The agreement outlined that taking his prescribed mediation at the right time was his responsibility. It must always be taken in front of staff and signed for in their presence.

39. After the induction, the keyworker asked the Approved Premises Security Officer (APSO) to drug test the man four days later on 9 January. Since the man had admitted misusing drugs in prison, she believed the test would currently be pointless and calculated that the drugs would have left his system by then. At 5.00pm, the keyworker made the following handover entry in the log book:

> "[The man] - new resident to be seen by his probation officer tomorrow. To be drugs tested over the weekend and regular monitoring

thereafter. He has a huge, longstanding drugs problem. On two hourly signings and 8.00pm – 10.00am curfew."

Wednesday 6 January

40. The following day, the man's offender manager telephoned the approved premises to find out how he was settling into the approved premises and remind him of his appointment later that day.

41. The man went to CJIT and spoke to a support worker regarding obtaining a diazepam prescription. She explained that all information he discussed with her would be passed on to the approved premises and suggested he talk to a GP about the diazepam prescription. This appointment with CJIT was not noted in the approved premises diary and the man had therefore attended the agency without notifying staff of his intentions. The staff considered that this was unhelpful in the context of trying to assist him stop offending. However, this appointment was known to both the man's offender manager and Guys Marsh, who could also have passed this information on.

42. Later that day, the man's keyworker helped him apply for a crisis loan from the Department for Work and Pensions (DWP). She also noted that he had attended CJIT and was waiting for his medication, which he was hoping to receive the following day.

43. At 3.00pm, the man attended his appointment with the offender manager at the local probation office. They discussed his licence conditions, drug misuse, access to his children and health issues. He told the offender manager that he was trying to obtain a diazepam prescription and the offender manager advised him to be honest with staff at the approved premises. The offender manager was concerned that the man was so eager to obtain a prescription straight after being released from prison. At that stage, the offender manager was unaware whether he had been prescribed diazepam in prison. However, he knew that when the man had been released earlier in the year, he had not been honest with the approved premises' staff about the amount of diazepam he had been prescribed. They also discussed the man's housing needs and the possibility of him visiting his grandmother.

44. During their interview, the offender manager thought that the man had seemed anxious about complying with all of his licence conditions and wanted to succeed. However, he also seemed happy and motivated and the offender manager's main focus was to try to set realistic targets with the man, rather than attempt to address all of his issues at once.

Thursday 7 January

45. On 7 January, the offender manager telephoned the Criminal Justice Mental Health Liaison Nurse. She was due to complete a standard mental health assessment with the man the following week, since he was a new resident. However, she told my investigator that if staff at the approved premises had more urgent concerns, she would have completed this assessment earlier.

46. The offender manager told the nurse that he was concerned that the man was intending to try and obtain a diazepam prescription. The nurse said she would talk to the man about this issue at their appointment. In the meantime, she telephoned the prison who confirmed that he had not been prescribed diazepam and should not need it, as he had been prescribed pregabalin to treat his anxiety. Prison staff also informed the nurse that on a number of occasions the man had been unable to provide a urine sample for drug testing, but that there was no medical reason for this. (After reading the draft report, the man's family said that he had told them he was having difficulty urinating.)

47. The nurse gave the offender manager this information and he became more concerned about the man's desire to obtain a diazepam prescription. He intended to discuss this issue with him at their appointment the following week and obtained his consent to speak to any GP he registered with. The offender manager also emailed Social Services to arrange supervised contact for the man with his children.

48. Later that day, the man attended a GP surgery (not the usual surgery for AP residents). Staff only became aware of where he had been when he returned to the approved premises and gave his prescription of diazepam to staff to lock in the medication cabinet. Staff were unclear whether the GP knew of his past history and the medication he had already been prescribed.

49. The deputy manager challenged the man when he returned to the approved premises about why he had not made an appointment with the surgery with whom the approved premises has a contract. All the residents are expected to attend this surgery. The deputy manager's belief was that the man did not attend the surgery as he knew they would not prescribe diazepam. He had experienced problems monitoring his diazepam prescription during his previous stay at the approved premises. The man denied this and said the reason he did not attend that surgery was that he did not have a good relationship with the GPs there. He began taking the diazepam as prescribed that evening.

50. The deputy manager believed the man was intentionally not keeping the approved premises' staff informed of his movements. In addition, by attending a different surgery the GP would have less of an understanding of the approved premises' policies or a working relationship with staff there. The deputy manager discussed his concerns with the Criminal Justice Mental Health Liaison Nurse as he had been concerned the man had possibly been advised to attend that surgery by CJIT.

51. As a result of this conversation, the nurse telephoned CJIT who confirmed that the man had tried to get a diazepam prescription from them but was told that he needed to attend a GP. The nurse therefore telephoned the surgery and spoke to the locum GP who prescribed the diazepam that morning. The locum GP said that the man had requested this prescription and since he had tested positive for benzodiazepines (of which diazepam is a type), she had

given him a week's prescription of the drug. The doctor had agreed with the man that the following week he would see the permanent doctor and start on a reducing dose of diazepam. The nurse also told the locum GP that the man was currently being prescribed pregabalin, of which the doctor had been unaware.

52. That evening all the residents were breathalysed for alcohol as is standard procedure. The man's test was negative.

Friday 8 January

53. A relief APSO works at the approved premises on his days off from being a prison officer. As a relief worker his responsibilities are the same as an APSO, except that he is not a keyworker for any residents. He had known the man for a number of years both in his capacity as a prison officer and when the man was resident at the approved premises in 2009.

54. The relief APSO helped the man to apply for state benefits. He also tried to complete a basic skills assessment with him but postponed this as he said he was struggling because he had not yet adjusted to his new medication. The APSO said that he believed the man was more positive than when he had met him previously. He tried to encourage the man by telling him that there were lots of people willing to support him. However, the relief APSO said he was still slightly unsteady on his feet and slurred his words, which was his similar to his previous experience of him.

55. The man was out of approved premises for most of the rest of day, although he returned every two hours to sign in as required. At 7.50pm, he returned to the approved premises and complained of losing £33 when visiting his partner in a nearby hostel. The approved premises' staff checked with staff at the other hostel, who were unaware of any money being found.

56. A member of staff saw the man shortly after his return and observed he was "a little unsteady on his feet". Therefore he asked the man to sit in the television room where he could observe him easily. The man fell asleep immediately. He was woken up by approved premises staff who were concerned he had taken more than his prescribed medication and assisted him to his bedroom. They put him on his bed and left the light on. The member of staff said the man apologised for his behaviour and believed it was due to the new medication. The member of staff did not have serious concerns about him and had seen him in a similar state several times when he was previously resident at the approved premises.

57. The member of staff made an entry in the log that the man might need to be checked throughout the night and he would discuss this with night staff. It is not clear whether this conversation occurred but he was checked at 11.00pm, 1.00am and 1.46am and was found to be asleep on each occasion.

The eve of the man's death

58. Due to staff concerns the previous day regarding the man's demeanour and his keyworker's instructions, the Approved Premises Security Officer (APSO) drug tested him at 11.45am. The man tested positive for benzodiazepines and cannabis. The APSO believed the positive test could be explained by the diazepam he had been prescribed and his self-reported cannabis use in prison. For these reasons the APSO did not consider enforcement action was necessary. Such action would not necessarily have meant an application for the man's recall to prison but could also have included a verbal warning or a more formal written warning endorsed by the assistant chief officer.

59. However, the APSO told my investigator that in such situations residents are given the benefit of the doubt and re-tested in two days. He emailed the test results to the man's offender manager. The APSO said that if he had had urgent concerns about the man he would have called the on call manager, who would have instigated an out of hours recall, if they believed the situation to be serious enough. However, the APSO believed the man was more able to communicate than normal. The log then notes that he went out with his partner, whom he first introduced to the APSO. The APSO did not have any more significant conversations with the man before he finished his shift that evening at 7.55pm.

60. The man's mother told my investigator during her visit that she saw her son briefly at 12.15pm when he came to her house. However, she told him to leave the area as it was part of his exclusion zone, which he did immediately. Later that afternoon, her other son, the man's brother, picked her up and they met the man outside the approved premises at 2.15pm. They all went shopping for clothes for the man and drove him back to the approved premises within two hours so he could sign in again. The man's mother said he seemed happy and positive and said nothing which gave her cause for concern. He was looking forward to meeting his offender manager in two days' time, to try and arrange access to see his children.

61. When the man returned to the approved premises at 8.00pm that evening, staff noted that he seemed "dazed and confused" and was falling asleep as soon as he sat down. The night supervisor had just begun his shift and asked the man whether he had misused drugs. The man denied this but said he was still getting used to his new medication which made him drowsy. The night supervisor asked him to provide a urine sample in case he later had to call a paramedic, so that he was aware of any drugs the man had taken. He had known the man from his previous stay at the approved premises and had needed to call an ambulance for him on that occasion. The man was unable to provide a sample and the night supervisor therefore allowed him to have his dinner and some more fluid before trying again. He said that during this time the man was walking round the approved premises talking to other residents.

62. At 8.30pm, a woman who staff believed was his ex-partner, came to visit the man but visitors are not allowed in the approved premises. She was allowed to speak to the man briefly in the reception area before being asked to leave.

63. Fifteen minutes later, the man was again unable to provide a urine sample. The night supervisor therefore tested his saliva which was positive for opiates and negative for all other drugs. The man denied taking any drugs other than his prescribed medication. The night supervisor told the relief ASPO, who was the other member of staff on duty at the time, about the results of the test. He also emailed the man's offender manager and the deputy approved premises' manager. The night supervisor said this was standard procedure and his only concern was for the man's safety. He therefore asked other residents to "keep an eye" on him.

64. Since it was a Saturday and the offender manager only works weekdays, he did not receive the Approved Premises Security Officer (APSO's) email until the following Monday. He said that in normal circumstances, on receipt of such an email, he would have immediately have completed a recall report for consideration by his line manager.

65. The night supervisor said that his impression of the man was that he was always "under the influence of something" but would never admit to taking anything other than his prescribed medication. He remembered him well from his previous stay at the approved premises, when he had the habit of falling asleep in front of the television. On one occasion the night supervisor had checked on him throughout the night when he believed he may have misused drugs.

66. At 11.00pm, the approved premises staff check that all the residents are in the building. When the night supervisor and the relief APSO checked the man's room, they saw that he was sleeping fully clothed on top of his bed and had vomited. Having got a response from the man, they cleaned him, made sure his airways were clear and put him in the recovery position. They left the room with the light on in case he became disoriented during the night.

67. Both members of staff discussed the man's condition and decided that, as he did not appear to be in any immediate danger, they would monitor his condition throughout the night. They agreed to call an ambulance if his condition deteriorated at all, for example further vomiting, if his breathing altered or he tried to get up. The night supervisor said he was aware of the dangers given the man's history and because he had called an ambulance for him the last time he stayed at the approved premises.

68. The relief APSO began his shift around 11.45pm that night. When he arrived at the approved premises, the night supervisor and the relief APSO he was taking over from explained what had happened with the man. From this handover, the relief APSO understood that there were no serious concerns about the man but that he should be checked throughout the night to make sure his condition did not deteriorate. The relief APSO who gave the

handover to the current APSO left the approved premises at the end of his shift, at around midnight.

The day of the man's death

69. Both the night supervisor and the relief APSO checked the man at hourly intervals between 12.10am and 6.00am. On each occasion they went into his room, returned him to the recovery position and checked that he was breathing. The relief APSO said he did not believe the man's breathing was laboured or that he showed any other symptoms of difficulty. The night supervisor emailed the man's offender manager to update him on the situation (although again he would not have received this email until Monday morning) and, with the relief APSO, decided that the checks could be reduced to every two hours.

70. The Approved Premises Security Officer (APSO) started work at around 7.30am and the relief APSO began around five minutes later. They received a verbal handover from the night supervisor and the relief APSO, who also asked that they test the man's urine since this would provide a more accurate indication of any drug misuse and could be passed on to CJIT and the man's offender manager. The night supervisor then left the approved premises.

71. The APSO checked the man at 8.00am and found that he had vomited again which had slightly impaired his breathing. However, he noted in the log that the man was "fine" and cleared his airways. The relief APSO told the investigator that he was not concerned that the man had been sick again. He felt that enough time had passed since he returned to the approved premises and the APSO did not seem worried about his condition. The relief APSO finished his shift and left the approved premises shortly afterwards.

72. Two hours later, at 10.00am, the APSO checked the man and found that he had vomited again and was not breathing. He said the man was pale but still warm to the touch. He therefore moved him to the floor to make cardio pulmonary resuscitation (CPR) more effective and did 15 chest compressions. Since he noticed blood and vomit around the man's mouth, he then ran downstairs to the office to get a mouthpiece before he administered any breaths. While downstairs, he told the relief APSO what had happened and asked him to call an ambulance as the man had stopped breathing. The APSO immediately went back to the man, attached the mouthpiece and administered two breaths and then continued with the CPR cycle.

73. Meanwhile, the relief APSO called for an ambulance and remained in the office to oversee the management and security of the building. The telephone operator asked if he could get the telephone to the APSO and the relief APSO gave the handsfree monitor to a resident to take to him. This resident asked another resident which was the man's room as he had the emergency services on the telephone. The other resident then went to that room and threw the telephone into the room. Having seen what had happened, the resident went into the room and picked up the telephone but the emergency services had been cut off in the process.

74. Having had some basic first aid training in his previous employment, the resident offered to assist the APSO with CPR, which he knew could be tiring. The APSO confirmed that the resident had some first aid training and then accepted his offer, asking him to provide the breaths while he completed the chest compressions. The resident blew one breath and mucus came out of the man's nose which he wiped away. As he was about to give another breath, the paramedics arrived and took over, attaching their defibrillator to the man. (A defibrillator is a portable electronic device which measures electrical activity in the body and advises on action to be taken.)

75. At 10.30am, the APSO telephoned the covering on call duty manager and told him that he believed that the man had died but the paramedics were currently with him. Having checked on the welfare of his staff, the deputy manager contacted the ACO on call as well as the ACO responsible for approved premises. Both said they would go to the approved premises as soon as possible.

76. The on call duty manager arrived at the approved premises at 10.53am, passing the paramedics on the way out who confirmed that the man had died. He checked his staff's welfare and offered them the chance to go home. The APSO accepted this offer. The police also arrived, along with both ACOs, a short time later. All the staff said they felt well supported following the man's death. Residents were gathered in the lounge a short while later and the ACO responsible for approved premises told them about the man's death. Staff were available to any resident who required support.

77. The police told the man's next of kin, his mother, of his death by going to her house that morning. She subsequently visited the approved premises, along with her partner, and spoke to staff about her son.

Post mortem and toxicological findings

78. A doctor completing a toxicological analysis found the following present in the man: tramadol (a painkiller), O-desmethyltramadol (made by the body following consumption of tramadol, morphine (a painkiller), codeine (a painkiller), diazepam, nordiazepam (a sedative), cocaine, beta hydroxybutyrate (made by the body) and cannabis. The doctor concluded that:

> "There has been previous illicit heroin misuse. The tramadol and diazepam concentrations likely represent previous therapeutic range use. It is unlikely that any of the drugs detected would have caused death independently at the concentrations detected, but the combination may have had a detrimental effect on conscious levels and respiratory drive."

79. The post mortem established the cause of death as "respiratory depression due to (or as a consequence of) a combination of illicit drugs". Respiratory

depression, also known as hypoventilation, occurs when breathing is insufficient to perform the necessary gas exchange. It therefore leads to an increased concentration of carbon dioxide. It can occur after drug misuse and can be particularly common in cases of drug misuse when opiates are taken with benzodiazepines.

ISSUES

The man's drug treatment whilst in prison

80. Following a breach of his licence, the man was recalled to HMP Swansea on 28 May 2009. On 10 June, he asked to see the CARATs team in relation to his drug misuse. They assessed the man as suitable for low level drug intervention for cannabis misuse and he was put on a waiting list for IDTS. He did not receive any further input in relation to his drug misuse at Swansea and was transferred to Guys Marsh on 28 July. A month later, Guys Marsh CARATs team completed a file review on the man. Since his notes from Swansea indicated that he needed low level intervention, his case was not given high priority. The man did not approach the CARATs team himself.

81. Given the man's well documented serious drug misuse, I am surprised that he was not regarded as a priority by the CARATs teams in either prison. His drug misuse was related to his offending, risk of harm to others and had influenced the offender manager's decision not to recommend re-release to the PPCS and Parole Board. It is possible that the man was not honest regarding his substance misuse to CARATs staff but they could have liaised with his offender supervisor in the prison or offender manager in the community. In addition, both members of staff could have liaised with the CARATs team to ensure the man was receiving the appropriate treatment.

82. Although I do not make a formal recommendation in this regard, the Governors of Swansea and Guys Marsh will wish to ensure that there is sufficient information sharing between these different teams, to ensure a prisoner receives drug treatment appropriate to his risk, history and need.

83. Once his release date had been set in December, CARATs staff met the man who disclosed that he had been misusing unprescribed Subutex in prison and would like a prescription for the drug once released. The CARATs team liaised with the local drug service in the community to try and set this up but were unable to do so. However, they discussed this with the man and gave him an appointment with CJIT for the day after his release which he attended. I am satisfied that he received a good handover from the prison to the community drug service. I am also pleased to note that the man was given the appropriate information regarding harm minimisation and the increased risk of overdose following his release from prison.

The man's registration with a GP surgery

84. During his induction at the approved premises, the man signed an agreement that he would register with the approved premises' recommended GP with whom they had a contract to provide services. Despite this, two days later the man registered with another surgery. He did not tell anyone that this was his intention but on his return told approved premises staff that he had been prescribed diazepam. In line with local policy at the time, he handed over the medication immediately for staff to dispense to him as prescribed.

85. When challenged as to why he had not gone to the surgery he was told to go to and with whom the assisted premises has a contract with, the man claimed it was because he did not get on with the staff there. However, some approved premises staff said they believed it to be because the contracted surgery staff knew of his past diazepam misuse and, as a result, it would have been difficult for him to obtain a diazepam prescription there. Staff at the contracted surgery were also more aware of approved premises rules and procedures. They would have been likely to contact the approved premises before prescribing such medication, or check with the prison as to whether it had been prescribed there.

86. During interview, the duty manager questioned whether the approved premises had any right to force a resident to register with a specific surgery or whether such a restriction would represent a violation of an individual's right to choose. Given the nature of approved premises and residents' freedom to leave during the day, it would be difficult to enforce a resident to attend a particular GP. It was made clear to the man which GP he should attend, but he chose to ignore this requirement. Furthermore, he was honest on his return about where he had been and handed in his medication. There was proactive sharing of information between approved premises' staff, the man's offender manager, the criminal justice liaison nurse, the contracted surgery and Guys Marsh in clarifying the man's prescription.

87. The man was provided with the appropriate information, but made a personal choice as to which GP to register with. In these circumstances, I am satisfied that there was little else staff could have reasonably done to monitor the man's treatment and prescriptions.

Drug testing and follow-up action

88. The local policy for the management of drug misuse within approved premises states that the man should have been drug tested when he arrived at the approved premises. The man's keyworker says that she did not conduct a drug test at that time since the man had admitted to misusing heroin and Rivatril on 25 December. She therefore requested a drug test be done on 9 January to give these drugs a chance to leave his system. However, 11 days had already passed since his last disclosure of drug misuse, which should be sufficient for him to provide a negative drug test. Regardless of this, the drug test should have been conducted as a means of corroborating the man's disclosure and so staff were aware of any drugs in his system.

89. In the evening of 8 January, the man had to be taken to bed by staff. He was drowsy but they believed this to be due to the new prescription medication he was taking. The APSO, who has 17 years' experience working in probation hostels, said that the man's behaviour did not seem overly concerning. However, he felt that because the man was polite and easygoing he was perhaps given more chances than other, more difficult residents.

90. Following concerns that the man was misusing drugs and as per the keyworker's instructions, the man was drug tested for the first time on the

morning of the eve of the man's death. He tested positive for cannabis and benzodiazepines. It is unclear from records whether this test was based on a urine or saliva sample. At 8.00pm that night the man was again drug tested as staff were concerned about his demeanour, recording that he appeared "dazed and confused" on his return to the approved premises. This test was positive for opiates. Since the man had been unable to provide a urine sample, it was based on a saliva test.

91. The discrepancy between these two tests on the same day is unhelpful. It could reasonably be expected that since cannabis can stay in the system for a number of weeks and the man was being prescribed diazepam (a type of benzodiazepine), the latter test would also have been positive for these two drugs. A number of staff had concerns about the accuracy of using saliva drug tests and preferred to use those based on urine wherever possible. The APSO said that saliva tests can be disputed whereas urine tests are over 99 per cent accurate.

92. The local policy for the management of drug misuse within approved premises states that if a resident disputes the results of a drug test, a second sample should be taken and the resident should be informed that this will be forwarded to a laboratory for analysis. Following the positive test, the man denied misusing any opiates but a second sample was not taken. However, it is also clear that the man often tried to hide his drug misuse. It is likely that staff balanced their prior experience against the need to conduct a second test.

93. Following the man's positive drug test for opiates, the night supervisor emailed the man's offender manager and the deputy manager, although neither would have received them until Monday morning. The night supervisor said he regarded this second test as the first unexplained positive one. He said that emailing the offender manager was standard procedure in such an instance. He also took into account that the man had only been released from prison a few days previously and was engaging with CJIT. He added that he would only consider recalling someone to prison after a single positive test if he was instructed to do so by the offender manager.

94. The duty manager said that as a result of the first test being positive to cannabis and benzodiazepines, he would expect staff to notify the offender manager by email and make a record in the drug test book. He said that if the member of staff was less experienced they might also call the duty manager for an opinion. In relation to the second test, the deputy manager would expect the same procedure to apply. Since the night supervisor was a more experienced member of staff he would have been satisfied with him making the decision, especially since the man was in the approved premises at the time. Staff therefore acted in accordance with the deputy manager's expectations.

95. The approved premises' manager said that following a first positive drugs test, she would expect staff to refer the resident to a community drug agency. She said this is in line with national guidelines. Following the man's second

positive drug test, she said the process would have been no different unless staff had concerns regarding any increased risk the man presented to others. If they were concerned about this risk, a duty manager should be called who could sanction his immediate recall. The manager would then contact NOMS and if they agreed with the reasons for recall, they would in turn contact the police who would issue a warrant and the resident would be arrested. This would all happen within the space of around two hours.

96. According to the OASys documentation, the man's risk to others was related to his substance misuse and therefore a positive test could have resulted in an increase in his risk to others. The approved premises' manager said this was one of the factors which would need to be discussed with the on call officer. Indeed, the man's offender manager said that he would have immediately applied for the man's recall to prison on the basis of such information, although he had not communicated this to the approved premises' staff.

97. Probation Circular 05/2006 on drug testing of residents in approved premises says that:

> "Testing positive for drugs should not automatically lead to eviction from the hostel where the resident is motivated to accept treatment. Management of those who test positive will depend on:
>
> - The risk status of the resident
> - The perceived effectiveness of treatment
> - The number of positive tests
> - The extent to which repeated breaches undermine respect for the rules and/or encourage drug use in others
> - The order or licence to which the resident is subject.
>
> "Balancing these issues is a matter best determined on a case-by-case basis and NPD is not proposing a detailed national enforcement regime."

98. South Wales Probation Trust's policy for managing illegal drugs in approved premises instructs that:

> "The outcome of all drug and alcohol tests must be forwarded to the offender manager without delay via e-mail and entered on CRAMS. Where a positive test occurs out of hours then the on call officer to be contacted immediately, with an e-mail also sent to the offender manager to inform them of your actions and an entry made on CRAMS."

99. CRAMS stands for Case Recording and Management System and is used by South Wales Probation Trust as their database of contact and decision making with offenders. In this man's case, it is clear that this guidance was not followed, since the on call officer was not contacted following either positive drug test on 9 January.

100. In a letter to my investigator, the ACO with overall responsibility for approved premises in the area, made it clear that he would expect a consultation with the on call officer to take place following a positive drug test. He wrote that:

> “Had it taken place as required, a discussion about recall would also have followed. The fact that [the man] was not considered for recall is not inappropriate in itself however and guidance was not breached. Further, any discussion that *may* have taken place would not necessarily have resulted in recall.
>
> The policy referred to above was issued to all staff in April 2009. Copies were sent electronically to all and a hard copy remains in the approved premises’ General Office in the ‘Procedures File’.”

101. I therefore make the following recommendation:

The ACO should remind all staff of the guidelines regarding drug testing, ensuring that these tests are carried out as required and the necessary action is taken following a positive test.

First aid training

102. All staff at the approved premises have attended a three day first aid course, with only one member needing a one day refresher. Despite this, the APSO’s understanding of the cardio pulmonary resuscitation guidance was out of date. He believed that the current ratio of chest compressions to breaths to be 15 to two. The resident also believed this to be the case (although he had not had first aid training for around ten years). The ratio was revised by the Resuscitation Council in 2005 which now recommends 30 chest compressions to two breaths. I therefore make the following recommendation:

The ACO should ensure staff are aware of the most recent Resuscitation Council guidelines and have attended the relevant refresher first aid courses.

103. Notwithstanding this, the APSO responded quickly and professionally to the situation, continuing CPR until paramedics took over. The resident’s willingness to assist the APSO should also be noted and commended.

Calling an ambulance

104. When the man returned to the approved premises at 8.00pm on 9 January, staff noted that he appeared ”dazed and confused” and fell asleep as soon as he sat down. He then provided a saliva sample which was positive for opiates, although he denied misusing drugs. He had provided a positive test for cannabis and benzodiazepines earlier that day. Staff checked on the man in his room at 11.00pm and found that he had vomited while asleep. They cleared his airway and put him in the recovery position and decided to check

on him hourly until 6.00am. Staff checked him again at 8.00am when he had once again vomited. Once more, they put the man in the recovery position and cleared his airway, also noting in the log book that his breathing had been impaired due to vomit up his nose. When they checked the man again at 10.00am he was not breathing.

105. The night supervisor had agreed with the relief APSO that after the first time the man had been sick if his condition deteriorated at all, including vomiting again, they would call an ambulance. When they did a handover with the day staff, they explained what had happened with the man but were not specific in terms of what action they believed should be taken if he vomited again. They had left the approved premises before the man vomited a second time.

106. When asked how staff would decide to call an ambulance the relief APSO said:

> "I assume it does rely on the first aid training. Experience comes into it, commonsense comes into it. I've asked myself this question dozens of times, so don't think it's the first time I've thought about this. And in hindsight we all wish we'd called an ambulance but part of me thinks if we had called an ambulance, because somebody's vomited, would they have turned up? Had they turned up, had they seen what we had seen, would they have taken any further action? Would they have said no, he's not vomiting, he's stable, he's breathing, he's got a pulse."

107. When the relief APSO was questioned further about whether the man had all his vital signs (that is pulse, breathing and blood pressure) when he was checked and whether there was a reason to call an ambulance, he said, "I don't know". He said that the longer that the night went on, and the more time passed, the greater the staff felt that he was "safe". When asked if the fact that the man vomited for a second time would be a risk factor, the relief APSO said he did not think it would be as long as he was in the recovery position. On reflection, he said he did not think that he should have done anything differently.

108. The APSO said he believed calling an ambulance to be a "judgement call" and when he checked on the man at 8.00am there was no indication that an ambulance should be called. Staff were aware of the man's substance misuse history and some had direct experience of dealing with him when he had been under the influence of drugs at the approved premises before. I believe that this may have clouded their judgement in the belief that the more time passed, the 'safer' he became.

109. The approved premises' manager said:

> "I think there were always concerns with [the man] about his potential to use drugs. And so staff were all aware of that and did keep an eye on him. And sometimes his demeanour would lead you to believe that he may have been under the influence of something, even though he may have been drug tested and it was negative. There was the way

that he perhaps looked which made you think gosh, I wonder if he's taking something because he was a bit slow of speech sometimes, but I think that was just his personality, that was just his way."

110. The ACO responsible for approved premises expressed his concern that staff did not call an ambulance when they discovered the man had vomited the first time at 11.00pm. He said:

> "This concern was echoed by [the approved premises' manager] and the police investigating the incident asked about this also. All of our staff in our Approved Premises have received three-day, certificated first aid training and I was surprised that, recognising that the man was sufficiently sick to need to be placed in the 'recovery position', the emergency services were not then called.

He went on to say that had a consultation with the on call manager occurred as required, following the positive drug test at 9.00pm, he believes that the emergency services would have been called quicker. He accepts that this is speculation made with the benefit of hindsight.

111. Staff said there was no guidance that they knew of regarding when to call an ambulance in such a situation, but that this relied on their personal judgment. In response to this, the ACO responsible for approved premises referred to the local policy on the management of drugs within approved premises. He said:

> "Section 5 refers to the administration of controlled drugs and states at paragraph (iii) : 'if the resident, after taking his medication, becomes overly drowsy, lethargic or starts to slip into unconsciousness then the emergency services should be called immediately.'
>
> "[The man] exhibited all of these symptoms and was also taking prescribed medication – benzodiazepines. Paragraph (iv) of the same also states, 'if the duty officer has any concerns [with any of the above], then they should contact the on call officer without delay.'
>
> "I accept that this does not refer more explicitly to changes in behaviour or health following the misuse of illegal or non-prescribed drugs, and the policy is being amended to make this clearer. Policy guidance does exist however, it was made available to all staff and it would have been appropriate in the case of the man."

112. As the ACO responsible for approved premises comments, the above policy could be clearer with regard to staff concerns if a resident has taken non-prescribed or illegal drugs. I am pleased that the policy is being amended to reflect this. Regardless of this, the ACO himself says staff should have called an ambulance when the man first returned to the approved premises and was dazed and confused and tested positive for opiates, especially as he had also taken diazepam.

113. The NHS Direct website advises that if someone has vomited and is confused or sleepy an ambulance should be called immediately. This is regardless of any potential drug misuse. Furthermore, when the man vomited a second time, I believe this should have been another trigger to calling an ambulance. None of the staff in contact with the man believed the situation serious enough to call an ambulance. I believe that this was not the case and an ambulance should have been called. However, it was clear from talking to staff that they considered the man's condition carefully and made, what they thought were, suitable arrangements to monitor his wellbeing. I conclude that this was not a negligent decision (not to call an ambulance), but an error of judgement made from failing to recognise the seriousness of the situation. I therefore make the following recommendation:

The ACO should ensure that all staff are familiar with the local policy for the management of illegal drugs and alcohol within approved premises, particularly in relation to when an ambulance or on call officer should be contacted.

114. However, my concern is also that, despite first aid training, staff were unable to recognise the symptoms the man was exhibiting as an emergency. Resources are available to staff, as they are to the general public who have medical concerns, such as NHS Direct. The ACO may wish to consider publicising such resources within the approved premises.

115. Furthermore, I am unaware of any quick reference resource in approved premises in England and Wales to provide advice to staff on action which needs to be taken in particular medical emergencies. My investigator contacted the head of the approved premises team at the National Offender Management Service (NOMS), who was also unaware of a national resource. Such information could take the form of laminate card to be displayed as a reminder in all areas of approved premises, so that staff have the knowledge and confidence to act as appropriate when a medical emergency or issue occurs. For example, this could include information such as if a resident is suspected of taking an overdose or is vomiting in their sleep, as in this man's case. I therefore make the following recommendation:

NOMS considers issuing all approved premises in England and Wales with quick reference cards to be displayed throughout the approved premises, giving information on appropriate action in a medical emergency or if certain symptoms are exhibited by a resident.

CONCLUSION

116. The man had a long history of drug misuse. When he was released to approved premises in January 2010, he told staff that he was determined to move away from offending and drug misuse for the sake of his children. Unfortunately, it seems he was unable to desist from this lifestyle and five days later died as a result of respiratory problems caused by the drugs he had taken.

117. Staff at the approved premises clearly tried to motivate the man and invested time in trying to assist him in leading a law-abiding lifestyle. All those who encountered him described him as polite and happy. He received an appropriate induction at the approved premises, although he was not drug tested immediately on his arrival. Four days later, he was tested twice with a positive result for cannabis and benzodiazepines on the first occasion and opiates on the second. He denied any drug misuse.

118. Following this second drug test, the man appeared confused and when he went to bed, vomited twice in his sleep. No advice was sought from the on call manager. Staff monitored him throughout the night and put him in the recovery position on several occasions, but did not call an ambulance. When they checked on him at 10.00am, he had stopped breathing and staff were unable to resuscitate him. Staff should have called an ambulance, at the latest, at 8.00pm when he vomited for the first time. Their assessment that the man’s condition was not serious was an error of judgement and as I have said, at the very least represented a considerable lapse in the care the man received at the approved premises.

RECOMMENDATIONS

1. The ACO should remind all staff of the guidelines regarding drug testing, ensuring that these tests are carried out as required and the necessary action is taken following a positive test.

   The Trust accepts this recommendation. Whilst Probation Circular 05/2006 does not require the automatic eviction [and thus the recall] of a resident following a positive drug test, local policy does require that an on-call officer is contacted for advice following such a test result. This did not happen immediately [and for some time].

   All staff in both Approved Premises have already been instructed to follow local policy.

   A draft practice direction dealing with the management of a range of health and drug misuse issues has also been issued to all staff in both Approved Premises. All staff members have been required to sign to acknowledge receipt of this draft paper and comments are being sought. It will be launched formally by the ACO and the Approved Premises' Manager at two all-staff events later in August. Relevant recommendations from Ombudsman's reports will be referenced at those meetings.

2. The ACO should ensure staff are aware of the most recent Resuscitation Council guidelines and have attended the relevant refresher first aid courses.

   The Trust accepts this recommendation with the following hopefully-helpful qualification. The 2005 guidelines advise 30 chest compressions to every two breaths. Prior to their revision, the ratio was 15: 2. All staff in the South Wales area Approved Premises have received certificated first aid training since that time and would have been advised of the guidance during that training. The member of staff identified in the draft report received his training last year.

   The Trust routinely provides two-day certificate-renewal ['refresher'] training for all staff when their first aid certificates are close to expiry. This rolling programme is already in place and staff from both Approved Premises in South Wales are booked for training during August and September, and later as their certificates come up for renewal.

   Notwithstanding this, because of the misunderstanding over compression to breath ratios quoted in the draft report, I have asked the Trust's Health and Safety Manager to prepare a short, written resuscitation guide for all Approved Premises' staff. This will be issued in parallel to certificate-renewal training and will not replace it. This should be available and circulated within a month [mid-September 2010].

3. The ACO should ensure that all staff are familiar with the local policy for the management of illegal drugs and alcohol within approved premises,

particularly in relation to when an ambulance or on call officer should be contacted.
The Trust accepts this recommendation. Existing local policy covers these matters but requires clarification to make expectations with regard to practice more explicit. The draft practice direction attends to this [and may be clarified further when staff responses are collated] and the staff meetings planned for its launch will reinforce these expectations.

4. NOMS considers issuing all approved premises in England and Wales with quick reference laminate cards to be displayed throughout the approved premises, giving information on appropriate action in a medical emergency or if certain symptoms are exhibited by a resident.

   NOMS accepts this recommendation. It is understood that work to develop such a card is being taken forward by the Independent Advisory Panel on Deaths in Custody, Offender Health and the NPSA and once that is complete NOMS will arrange to issue the card to all Approved Premises.

   NOMS also undertakes to remind all staff working in Approved Premises of the need to undergo refresher first aid training regularly and take appropriate action when residents fall ill, ie to contact medical advice, such as from NHS Direct, whenever there is any doubt about what medical action may be required.