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 Town Moor Approved Premises, South Yorkshire Probation Trust, in January 2012

This is the report of an investigation into the death of a resident of Town Moor Approved Premises, Doncaster, run by the South Yorkshire Probation Trust. The man was found dead in his room by another resident on the morning of January 2012. The cause of death was sudden cardiac death related to amphetamine toxicity. I offer my condolences to his family, friends and all those affected by his death.

The investigation was conducted by one of my investigators. The staff at Town Moor cooperated fully with the investigation.

The man had been a resident at Town Moor for two and a half months before his death. Initially, he abstained from illicit drug taking and complied with the rules of the approved premises and the requirements of his licence. However, after a few weeks, he slipped back into drug misuse and died two days after disengaging from the drug interventions programme.

Overall, the man was effectively managed. Probation staff and those from various external agencies maintained regular contact and actively supported him, although communication between them could have been improved. The investigation also identified some gaps in staff awareness of the suicide prevention policies and procedures, but these had no bearing on the man's death which, we conclude, could not reasonably have been foreseen or prevented.

Finally, we express some concerns over liaison with the man's family. Thus, news of the man's death was broken to his family by the police rather than personally by approved premises staff, partly because they lacked the appropriate information. It was also disappointing that it took the intervention of my office to ensure that the Probation Trust contributed to the man's funeral expenses in line with existing policy. Accordingly, I repeat a recommendation to the National Offender Management Service about the need for better guidance to approved premises staff on how to deal with bereaved families.

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

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

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SUMMARY

1. The man was classed as a high risk offender. This was his second period of residence at Town Moor Approved Premises. He had previously stayed there in 2008, but failed to adhere to his licence conditions and was recalled to custody.

2. Appropriate preparation was made for the man's stay at Town Moor, including advance appointments with the local drug support services. He arrived on 4 November 2011, staff inducted him and he settled well. He attended regular meetings with his key worker at the approved premises, offender manager and drug support worker. They all considered him to be motivated. In addition, he attended group sessions at the drug agency and received support from a community psychiatric nurse and job advisor. Periodically, the man had thoughts of self-harm which he was open about and sought help from staff.

3. After negative drug tests in the early weeks of his stay, the man began taking illicit drugs again in December and this continued in January 2012. He admitted his drug use and probation staff encouraged him to continue attending support sessions as well as warning him of the consequences of such behaviour and the links to his offending. In spite of this, he withdrew from the drug interventions programme on 19 January and was found dead in bed two days later. Staff at Town Moor quickly telephoned the emergency services who arrived within four minutes of the call. The cause of death was sudden cardiac death related to amphetamine toxicity.

4. The investigation concluded that those responsible for the man's welfare managed him well and responded appropriately to his relapse into drug-taking. However, information about his drug use in January was not shared with staff at the drug interventions programme and therefore was not considered in the discussions with the man during a meeting at which he was discharged.

5. There was a delay in notifying the man's family of his death and some aspects of family liaison and staff debriefing were not handled in accordance with best practice. In addition, staff at Town Moor were not fully aware of the policies and procedures for supporting residents at risk of self-harm.

6. We make five recommendations to address the areas for improvement identified, including a repeat recommendation to the National Offender Management Service about guidance on family liaison.

THE INVESTIGATION PROCESS

7. This office was notified of the death of the man on 24 January, three days after he died. The Manager of Town Moor had attempted to make contact on 21 and 23 January but owing to out of date contact details, he was unable to do so. One of the Ombudsman's investigators contacted the manager on 25 January, to explain the role of the Prisons and Probation Ombudsman and request preparation of the documents. The following day, another investigator spoke to the manager to introduce herself. Notices were issued to the staff and residents at Town Moor, informing them of the investigation and inviting them to contact the investigator or contribute information. No responses were received.

8. The investigator visited Town Moor on 30 January and viewed the premises including the room in which the man died. During the visit, she met several staff and residents informally. She conducted interviews with staff at Town Moor who were responsible for supervising the man, as well as the resident who had found him and staff from external agencies who were involved in his management. Immediately after the interviews, the investigator had a meeting with the manager to discuss some of the emerging issues. She wrote to the manager on 7 February to confirm the key points.

9. On 31 January, the investigator met the Coroner's officer at Doncaster Magistrates' Court and discussed the investigation and requested copies of the post mortem and toxicology reports. The Coroner's officer advised that they would take at least two months to be completed. In the event, the reports were not received until 9 July.

10. The investigator contacted Rotherham Doncaster and South Humber NHS Foundation Trust to obtain the records of the man's contact with the Doncaster Drug Interventions Programme (DIP) and the Serious Untoward Incident report arising from his death and to request access to the man's key worker at the DIP. A complete set was received on 16 July. The investigator then made further enquiries, by correspondence, with the man's key worker, which concluded on 27 July.

11. One of our family liaison officers, spoke to a member of the man's family, his brother's partner, on 17 February. He explained the remit and role of the Prisons and Probation Ombudsman and invited her to express any concerns. She raised the following points:

    - On the night before his death, the man had told the duty manager that he was feeling unwell and his friend had stayed with him for an hour after the usual curfew. His family wished to know what symptoms the man displayed and what action staff took, if any, other than to allow his friend to stay with him.

    - His family asked that the investigator to speak to the resident who was the last person to see the man alive.

- His family understood that a drugs worker had signed off the man two days before his death. They questioned the decision and wondered whether they had done so too soon given his history of drug misuse.

- What mechanisms were in place to support the man's mental health condition?

- Why were the family not notified of the man's death until 3.30pm?

- The approved premises did not initially offer the family a contribution towards the funeral expenses.

12. The man's family responded to the findings of the investigation and raised a number of concerns, including the management of drug misuse and sharing of information. The issues raised have been addressed in separate correspondence to his family.

13. We regret that this report has been delayed because of the late receipt of key documents, including the post mortem and toxicology reports, without which it was not possible for the investigation to proceed.

TOWN MOOR APPROVED PREMISES

14. Approved premises were formerly known as probation and bail hostels. They are approved by the Secretary of State, under Section 9 of the Criminal Justice Act 2000. The purpose of approved premises is to provide an enhanced level of residential supervision in the community, within a supportive and structured environment, for offenders assessed as presenting a high risk of harm and others charged with offences. While residents have to comply with their individual licence or bail conditions, curfews and the approved premises' rules, they are essentially free to go in and out of the building.

15. Town Moor Approved Premises is one of around 100 in England and Wales. It is a conversion of three terraced houses on three floors, in a residential street in the centre of Doncaster. It has 16 rooms, three of which are shared. Residents share bathroom facilities and all meals are prepared and served by a chef. All the residents are male and are usually high risk offenders.

16. Town Moor is staffed 24 hours a day by probation employees, whose role is to provide support and ensure that residents comply with the rules and their licence conditions. In addition to the manager, there are three probation service workers who work with residents as well as support workers. There is a general curfew between 11.00pm and 7.00am, when all residents are expected to be in the building. There is a final check of residents at midnight and first check in the morning is at 7.30am. Each resident is allocated a dedicated key worker, a trained member of staff who works closely with him to offer support and guidance to achieve compliance with their licence conditions. Residents are responsible for their own health and usually register with a local general practitioner (GP).

Previous deaths

17. Since 2004, when this office began investigating all deaths in approved premises in England and Wales, there has been one previous death at Town Moor in 2007. The circumstances of the deaths are similar as the deceased in the previous investigation was found dead in bed in the morning and the post mortem subsequently established that he had died from an overdose of illicit drugs. However, the findings in this investigation differ.

MAPPA

18. Multi-Agency Public Protection Arrangements (MAPPA) support the assessment and management of the most serious sexual and violent offenders. The aim of MAPPA is to ensure that a risk management plan is drawn up for the most serious offenders and benefits from the information, skills and resources provided by the individual agencies co-ordinated through MAPPA. There are three levels of MAPPA:

    - Level one - An offender on level one MAPPA is normally managed by a single agency. This is the lowest monitoring procedure available under

the MAPPA system.

- Level two - As with level three, anyone who has been identified as falling into the level two heading would be managed by more than one agency, very often limited to probation and the police. However, it is possible to involve more agencies if the circumstances warrant it.

- Level three - Anyone subject to level three is considered as being the highest risk case, where more than one agency will take responsibility for the management of the person concerned.

KEY EVENTS

Background

19. The man was convicted and sentenced to six years' imprisonment plus three years on extended licence, at Sheffield Crown Court, on 13 October 2004. He had a history of substance misuse and described himself as a binge drinker. In May 2008, the man was released on licence from HMP Whatton, to live in Town Moor Approved Premises, in Doncaster. He was recalled to prison a month later, for failing to comply with the curfew imposed as part of his licence.

20. The man had attempted suicide in the past. During his remand in prison in 2004, he tried to hang himself and also cut his arms. In 2009, he took an overdose. He had also cut himself at HMP Acklington in May and August 2010.

21. During his time at Acklington, he was a client of the Counselling, Assessment, Referral, Advice and Throughcare Service (CARATS), the prison's multidisciplinary drug services team. He undertook work on alcohol awareness, overdose harm minimisation and relapse prevention. He had no drug treatment at the prison and the CARATS team considered him unsuitable for methadone. As his release date approached, the CARATS team referred the man to the Doncaster Drug Interventions Progamme (DIP) team and made an appointment for him to attend on 7 November. The DIP deals with Class A drug users who require intensive intervention. The Doncaster DIP had also supported the man when he was released from prison in 2008.

22. On 20 October 2011, two weeks before the man was due to be released from prison, his prospective key worker at the DIP team spoke to a member of the CARATS team. The man had asked to take Naltrexone (which decreases the craving for alcohol and blocks the effects of opioid drugs) which he had used when he was released in 2008. The CARATS worker told the man's prospective key worker that all his drug tests in prison had been negative. The team also said that owing to new guidance, he did not meet the criteria for Naltrexone. (His offender manager later told the prospective key worker that he did not think that the man had a drug problem that required medication.) On 3 November, the day before his release, the CARATS team faxed a release plan outlining the work he had undertaken and his assessments.

Release to Town Moor Approved Premises

23. The man was released on licence from Acklington on 4 November 2011, and was required to reside at Town Moor. He had a number of licence conditions, including a curfew from 8.30am to 9.30am, 12.00pm to 1.30pm and 3.00pm to 4.30pm daily, as well as exclusion from the Sheffield area. He was required to meet his offender manager (probation officer) weekly. (The offender manager is responsible for managing the offender's sentence and any risk.) His licence was due to expire in 2013 and he was expected to stay at the approved premises for a few months until permanent accommodation was arranged.

24. The man's key worker at Town Moor held an induction meeting with him when he arrived on 4 November, in which they went through the conditions of his licence, clarified his curfews and signed various documents. He also registered with a general medical practice. The man was familiar with the rules as he had resided at Town Moor after a previous release in 2008. He said he had a positive outlook and was not going to repeat his mistakes. He reported no physical or mental health problems and said he had no thoughts of self-harm or suicide at that time. Staff allowed him to keep a small amount of painkillers in his room for an injury to his leg.

25. It is recorded in his OASys record (an offender assessment and planning tool) and a record of contact with his key worker that following his release from prison, the man had feelings of anxiety and suicidal thoughts. On Sunday 6 November 2011, he went to see the crisis team at Doncaster Royal Infirmary. The team comprises nurses, doctors, support workers and others who work with substance users to prevent hospital admission for those who experience relapse and those who might be depressed and have suicidal feelings.

26. A member of the crisis team assessed his mental health and emotional well-being and found that he was finding it difficult to come to terms with life outside prison. He said he had become institutionalised and his sleep and appetite had been affected by his anxiety. He had thoughts of cutting himself and had drunk half a bottle of vodka earlier in the day. The team gave the man advice on anxiety management techniques but considered that he had no plans to act on his feelings and found no evidence of acute mental illness.

27. The man attended his pre-arranged appointment with the DIP team on 7 November. He told the DIP key worker that he wished to take Naltrexone as he thought it would be difficult to remain drug-free. He said that he had already been offered drugs in the approved premises and, although he had refused, he was unsure that he would be able to do this consistently. The operations manager at the DIP told the investigator that the man engaged proactively with his key worker and also attended group sessions.

28. The same day, the man discussed his anxieties with a staff member who decided to try to bring forward his appointment with the community psychiatric nurse (CPN), A which was due to take place on 10 November. He also had a meeting with his key worker at Town Moor, in which he handed in a razor for staff to retain. On 9 November, the man reported suicidal thoughts to the staff member. He arranged for him to be seen again by the crisis team and opened an SH1 form, which initiates the suicide and self-harm procedures.

29. The crisis team agreed to pass on the details of the consultation to his CPN with a view to prescribing medication. The man expressed further thoughts of self-harm in the approved premises later in November. SH1 forms were opened and the DIP team agreed to arrange one to one sessions for him to discuss his anxiety and depression. He was also prescribed fluoxetine (an antidepressant) to help stabilise his mood. He continued to see the CPN.

30. The investigator discussed the suicide and self-harm procedures with one of the Town Moor staff who started the process for the man. She was unaware of the procedures once a self-harm form was completed and submitted. The manager of the approved premises was unfamiliar with the documents used and did not know whether there was a suicide and self-harm strategy or policy. He mentioned that if someone was known to have attempted or had thoughts of self-harm, they would be observed informally. Although self-harm notification forms were available, there was no evidence of a policy to provide guidance on formal monitoring.

31. The key worker at the DIP conducted an initial risk assessment of the man on 11 November. The risks identified included self-harm and suicide and she referred him for counselling for anxiety. The management plan was for him to inform his key worker of any changes in his mental health and she noted that he was already working with the mental health team. He would also attend group work sessions as well as one to one meetings. She also recorded that the man admitted to using Subutex in prison, but the CARATs team had said that all his drug tests had been negative. The man requested Naltrexone to "avoid temptation". They went to see the drugs team doctor together, who advised he could start taking it from 14 November, if he tested negative for heroin.

32. That day, the man also had a joint meeting with his offender manager, from the Sheffield area and the staff member (in place of his key worker). They discussed his anxieties and various problems such as outside appointments scheduled during his curfew, his worry about "messing things up" and his wish to go to college and gain employment. They set several objectives, including abiding by the rules, investigating opportunities to study for a forklift truck licence and registering for housing. They agreed to make further plans to help reduce the man's anxiety. It was recorded in the probation case notes that drug tests taken on 11 November, 1 and 13 December were negative.

33. The DIP case notes confirm that the man attended one to one and group sessions regularly in November and December 2011. He enjoyed the sessions and felt supported by the DIP workers and the approved premises staff. He found his sessions with the counsellor and CPN beneficial. He had started Naltrexone in mid-November. He felt it was working and was not tempted to take illicit drugs. He had started a gardening course and had prepared his CV.

34. At his DIP appointment on 21 December, the man was hopeful about the Christmas period as he expected to see his mother and brother. He mentioned that his doctor had prescribed antidepressants the previous week.

35. In an assessment on 23 December 2011, the man's offender manager said that he appeared to be adhering to rules and restrictions. He had achieved his short term goals – such as attending the drug interventions programme, registering with a general practitioner, signing on as a jobseeker, registering for housing and abiding by the hostel rules. However, the assessment concluded that the man's thinking and behaviour about risk situations was still poor. He was also considered a risk of suicide and self-harm.

36. The man had regular, scheduled meetings with his key worker at Town Moor, who praised him for his compliance with the rules and continued good progress. At his first meeting in the new year, on 2 January 2012, he told her he had felt "down and depressed" over the festive season as he had not seen his family. She asked why he had stopped taking all his medication on 21 December and suggested that if he was feeling low, it might not be a good idea to stop taking the medication prescribed to help this. She questioned whether he was taking the painkillers out of habit and told him that his Naltrexone was unlikely to work after such a gap. She and other staff had noticed that he had been spending a lot of time in his room with another resident playing computer games but he appeared in good spirits and positive. She also noted that throughout his stay at Town Moor, he was very open about his feelings of depression and the reasons.

37. During the meeting, the man's key worker at Town Moor and the man also discussed the fact that he had a positive drug test for cannabis the previous week and for amphetamines that day. He did not explain the reason, neither did he dispute the test results and she told him they would test him weekly and more regularly if concerns increased. She also advised him to speak to his DIP worker about the failed tests. They discussed the fact that the man had failed to attend his meeting with his offender manager the previous week for which he had been given a written warning.

38. The man did not attend his DIP appointment on 5 January as he had overslept. Later that day, he said he felt ill and was in pain. As he was in too much pain to walk to the doctor's surgery, Town Moor staff gave him money for a taxi to Doncaster Royal Infirmary, where he was diagnosed with a chest infection and prescribed antibiotics.

39. On 6 January, the man's case was transferred to an offender manager in the Doncaster area. The man's offender manager, the offender manager in the Doncaster area, the man's key work at Town Moor and the man had a handover meeting on that day. They spoke about the man's use of illicit drugs at the approved premises. He still felt he no longer needed to take Naltrexone and he had missed his most recent appointment with his DIP worker. The man's key worker at Town Moor again advised that they might have to carry out drug tests more than once a week. The man regarded his positive test as a minor breach of the rules but they advised him that it was serious. They talked about him spending most of his time in his room on his games console, resulting in little sleep, a lack of concentration during group programmes and poor motivation.

40. At interview, the man's key worker at Town Moor explained that when the man was first released, he had drug tests weekly. In view of his initial negative tests and work with the DIP, they were stopped. However, once he started testing positive, which happened on at least three occasions, tests were carried out every week again from 22 December until his death.

41. The man's key worker at Town Moor also discussed with the man his mental health, activities and family contact. He had stopped taking the fluoxetine for his depression and felt he could cope without it. Apart from their unease about his isolation in his room, she said they had no concerns about his mental health. They discussed how he could fill his time and noted that his mother saw him weekly and that he had met two of his siblings since his release. Plans were made for assessments to enable contact with other family members. The meeting concluded that the man was generally doing well and was mostly complying with the rules and licence conditions. He was expected to continue sessions with his key worker and supervision by his new offender manager.

42. On 7 January, the man tested positive for morphine, cannabis and amphetamine at Town Moor. Two days later, he tested positive for morphine and amphetamines.

43. The offender manager in the Doncaster area told the investigator that the man's offender manager had issued a warning letter to the man about his drug use. He had questioned whether it should stand as the man had disclosed what he had done and the drugs he had used. Her opinion was that it should as it conflicted with his licence condition to address his drug, alcohol and offending behaviour problems and it increased his risk of offending. She thought it important for him to follow it up and obtain relevant support from the local drug services. She believed that as the positive tests were in close succession, they were covered by the warning letter.

The week before the man's death

44. The man's last meeting with his key worker at Town Moor was held on 14 January. They discussed staff concerns about him hiding his drug use rather than talking about it and it was agreed that weekly or more frequent tests would continue. His brother's company had offered him employment, removing asbestos and they made plans for him to find a doctor to carry out the required health examination before he started work. She said that the man was more positive than he had been a few months earlier.

45. On 15 January, the man tested positive for opiates, but he was taking prescribed co-codamol and it was thought that this might have accounted for the result. At a meeting with his offender manager in the Doncaster area, the following day, he was enthusiastic and excited about his prospective job working at the same company as his brother. She had reservations about him working with his brother as he had admitted using drugs when he met him socially. He was adamant that his recent lapse was "stupid" and would not be repeated, whether or not he was in contact with his brother.

46. At his DIP meeting on 16 January, the man admitted that he had used cannabis and 24 ecstasy tablets over the Christmas and New Year period. He said he had stopped taking Naltrexone as he felt he did not need it. The project worker intended to advise him of voluntary services, such as Narcotics Anonymous, at their next meeting. There is no indication that the man revealed

his more recent positive drug tests.

47. The man had a meeting with his offender manager in the Doncaster area later that day, in which he elaborated on the information given to the DIP worker. He said that he had bought drugs that he had then shared with another resident, who he named. They had used 2g of amphetamines, 24 ecstasy tablets and cannabis in a two day “binge”. His reasons were that he was missing his family as he had not spent Christmas with them. He also admitted using the same drugs when he subsequently met his brother socially in Doncaster but said he was back on track. She believed he seemed motivated to change.

48. The man’s offender manager in the Doncaster area reminded the man that as drug use was linked to his offence, his recent use increased the risk he posed. She also warned him that this might be a step towards recall to prison because of both the increased risk and/or further offending, but was keen to ensure that he remained open with her about his drug use and continued to disclose what he was doing. At interview, she said that there was an agreement to test him once or twice a week.

49. The man’s offender manager in the Doncaster area emailed the staff at Town Moor to advise them of the man’s disclosure about his drug taking. The manager of Town Moor told the investigator that Town Moor staff would share such information with the DIP team to be dealt with as part of their support service and the operations manager at DIP confirmed that there was provision for the DIP to liaise directly with the approved premises. There is no evidence that the information about the man’s drug taking was passed to the DIP and it seems he only disclosed to the DIP drug worker the incident at Christmas and not the subsequent episodes.

50. The man telephoned the DIP team on 17 January to say he could not attend his appointment the following day. He confirmed this in another telephone call on the day of the appointment, explaining that he had a job interview that day and would be there on 19 January. Later on 17 January, his prospective employers telephoned to confirm he would be offered a job.

51. On 19 January, a student social worker at the DIP discussed with the man whether he wished to continue with the substance misuse treatment programme as he no longer wanted treatment and had stopped taking the prescribed medication, Naltrexone. He told her that since his ‘blip’ during Christmas, he had not used drugs. They reviewed relapse prevention, overdose advice and the voluntary support available if he needed it. She advised that he could also return to DIP if he needed support again and could see her in the next week or speak to his key worker at DIP, thereafter.

52. The student social worker completed a Treatment Outcomes Profile discharge form. This is used at the beginning, periodically throughout and at the end of substance misuse treatment to assess and monitor its effectiveness. The man does not appear to have been candid about his drug use after Christmas and in January. He said that he was not taking drugs but had a few alcoholic drinks with his brother some weekends. He regarded his psychological health as just

above average and said he felt better in himself since he was drug and treatment free. He also told her about the job he hoped to get with his brother's employer.

53. The man's key worker explained to the investigator that engagement with and attendance at the DIP is voluntary. Some clients disengage before the end of their care package and DIP workers do not always agree with their clients' reasons for requesting discharge from the programme. At the meeting on 19 January, the man decided that he no longer required support from the DIP. The operations manager told the investigator that discharge would have been mutual.

Events on 20/21 January

54. The night care worker on 20/21 January took a handover from day staff between 6.00pm and 6.30pm, she conducted a health and safety check and a variety of other duties such as supervising supper, monitoring the CCTV and letting residents in and out of the building. She also checked that residents were complying with their individual curfews. She explained that a health and safety check is made at midnight and she carries out a final check of residents' welfare at 1.00am before she goes to bed. At this check, residents are required to acknowledge her, even if only by grunting or some form of movement.

55. On 20 January, the man went out three times. On the latter occasion, he left Town Moor at 4.45pm to meet his brother. He returned at 9.40pm and the care night worker signed him in. She recorded that he was heavily under the influence of alcohol. She made a further entry at 11.00pm to confirm that he was in for the curfew. She noted, "the man did return in drunk but has been no problem".

56. The night care worker was aware that the man had been out for a meal and a drink with his brother. She told the investigator that on his return he was staggering but described him as very happy and they had a laugh and a joke. He did not want supper but went for a cigarette with his friend and then they both went up to the man's room to play computer games. The night care worker said she had no concerns about Liversidge. If she had such concerns, she would have shared them with her colleague and between them, they would have conducted additional checks.

57. The casual relief worker and former manager of Town Moor recorded that he carried out a health and safety check at midnight and reported that all was in order. The casual relief worker's recollection was that he agreed that the man's friend could stay until 1.00am. He had seen the man earlier in the evening and described him as unsteady on his feet and staggering drunk. He told the investigator that it was not unusual for residents to return to Town Moor drunk. On that night, he was concerned about two others and had kept them under observation. He had no such concerns about the man at that time and saw him at various points in the evening. By the time he saw him again at midnight, he

thought he had sobered up considerably. Neither of the staff thought that the man looked unwell and they did not mention any bruising or injuries.

58. The man's family believed that he had reported feeling unwell. At interview, staff said that he was intoxicated but had no concerns about his condition.

59. The man's friend was the last person to see the man before his death. He told the investigator that he had been friends with him since the middle of November 2011 and that they played computer games together daily. He considered him to be fit and well in the days before his death. He spoke to him at lunchtime and then saw him when he returned from meeting his brother. He said the man was "a bit tipsy". They had a cigarette and he had to guide him as he was unsteady. They initially played video games together but the man fell asleep on his bed so he played alone for about another hour. They then decided to watch a DVD. During the film, the man went to the toilet a couple of times and the man's friend wondered if he was being sick but noticed that his face was still the same colour. Nevertheless, he was concerned and suspected that he might have taken a drug while he was out.

60. The man's friend added that while watching the film, he observed the man, who:

> "was just laying on his bed with his eyes wide open, just laying there, not moving much, but he was alert. He knew what was going on but he just wasn't really, it's like his body had shut down but his brain was alert".

He asked the man if he had "had anything as well" and he replied no. The man's posture and behaviour led him to believe that he had taken something other than drink but he did not want to create an atmosphere between them by pressing it. Because of his concern, he told him that he would ask the staff if he could stay in his room a bit longer to look after him and see him go to sleep. The man's friend also noticed a bruise and swelling on the man's nose. He thought he might have been involved in a scuffle or slipped after drinking, but when he asked about it, the man told him not to worry and gave no details as to how he had been injured.

61. During the midnight check of residents, the man asked the casual relief worker, who was conducting the checks, if he could stay a bit longer as he was "worse for wear". The man's friend said the casual relief worker agreed to him staying until 12.45. They continued watching the film and he stayed for an extra ten minutes until the end. The man then said he was fine. Just before he left the room, the man's friend opened the window, made the bed, took off the man's jacket and put his phone, water and a bottle of energy drink by the side of the bed.

62. The man's friend and the man agreed that whoever got up first in the morning would wake the other. The man would usually stand up to lock the door as he was leaving but did not do so on this occasion. The man's friend therefore reminded him to lock the door as he left and went to bed.

63. The following morning, the man’s friend knocked at the man’s door at around 7.15am. He heard the television but there was no response. He knocked twice more and then decided to have his breakfast and try again. At 7.30am, he returned and after knocking once, pushed the door open. The curtains were drawn and the room was in darkness. He thought that the man was watching the television as his eyes were open. As he did not respond to his call, he thought he was playing a prank so he spoke again, prodded and shook him. He felt that something was not right but did not immediately think the man was unconscious. He went out of the room and asked the casual relief worker, who was doing the morning health and safety checks, to check on the man. They both went into the room together.

64. When the causal relief worker went into the room, he found the man “lifeless”. He told the investigator that after calling out to him, he tried to lift his arm, but his elbow and shoulder were locked and rigor mortis had set in. In his opinion, the man had been dead for several hours.

Actions after the man’s death

65. The causal relief worker went to the office and telephoned the emergency services. He estimated that the ambulance arrived within four minutes. One of the paramedics checked for signs of life and confirmed that the man had been dead for a long time. The night care worker telephoned the manager of Town Moor who also happened to be the duty manager on call and he arrived just after 8.00am. In the meantime, the night care worker kept the man’s friend in the office with her to support him. The man’s friend confirmed to the investigator that he had been offered staff support as well as bereavement counselling.

66. At about 10.00am, the manager of Town Moor held a residents’ meeting, where he confirmed that the man had died, explained the procedures to be followed and offered support. He told some staff as they arrived for work and other staff members others told their colleagues. He decided not to contact staff at home, as he was unsure whether they would welcome such contact at the weekend. Support and counselling were offered to staff. Although the manager of Town Moor initially scheduled a debrief meeting, this was not held and he spoke to members of staff individually.

67. The man’s mother was his next of kin and the manager of Town Moor passed her contact details to the police. He told the investigator that he was not aware of any requirement for family liaison. He subsequently clarified that he had attempted to telephone the man’s mother, without success. The police officer’s report to the Coroner indicated that the police made a number of unsuccessful attempts to contact the man’s mother. The Coroner’s officer had a similar difficulty when they received the details after the weekend and found an error in the telephone number. The man’s sister-in-law, who has since acted as the representative of his family, telephoned Town Moor two days later to enquire about his possessions and there was subsequently further telephone calls between the family and the manager of Town Moor. She visited the approved

premises with the man's brother on 27 January, where she met staff and viewed the man's room.

68. The Probation Trust initially refused to contribute towards the funeral expenses. However, following correspondence between the investigator, senior managers in South Yorkshire Probation Trust and the National Offender Management Service (NOMS) headquarters, they agreed to do so.

69. The manager of Town Moor attended the man's funeral, together with the man's friend.

70. The post mortem confirmed the cause of the man's death as sudden cardiac death related to amphetamine toxicity.

ISSUES

Management of the man

71. As a high risk offender, the man was supervised under MAPPA. He was excluded from his home area, Sheffield, to avoid contact with his victim, so he had to reside in approved premises elsewhere. He had previously lived at Town Moor when released in 2008, but was recalled to prison shortly afterwards. His offender manager made appropriate arrangements for his arrival and Acklington's drug services agency made an appointment for him to attend the Doncaster Drug Interventions Programme after his release. This was important as drug misuse was linked to his offence.

72. Approved premises staff carried out an induction programme and meetings were held with the man's offender manager and key worker at the agreed and specified intervals. In the main, he was considered to be compliant with his licence conditions, curfew and other approved premises rules, although he later relapsed into taking illicit drugs. This issue is dealt with below. We are satisfied that the arrangements for the man's release to Town Moor were appropriate and that, in general, he was effectively supervised.

Suicide and self-harm prevention

72. During his stay at Town Moor, the man was open about his feelings and expressed thoughts of suicide and self-harm. Although staff completed the appropriate forms when it appeared that he was vulnerable to self-harm, this was not followed up by any formal monitoring or support process. At interview, other than completing a form, staff seemed to be unsure about the process for managing self-harm and the manager was unaware of any formal policy or strategy. The Approved Premises Manual states:

> "All APs must have a strategy for reducing incidents of self-inflicted death…
>
> "As part of their strategies, APs must ensure that their staff are suitably trained and developed. Each strategy must also include a system for monitoring and recording deaths and significant instances of self-harm, and a process for reviewing all such incidents and identifying possible changes to procedure and practice."

73. The cause of the man's death was initially unclear; therefore the investigator explored the instances in which he had reported thoughts of self-harm. Although it was eventually established that his death was not self-inflicted it is of concern that the manager and staff were unfamiliar with the procedures for managing self-harm. The manager subsequently arranged for some of the Town Moor staff to attend training.

74. As a preventative measure to reduce the risk of residents harming themselves, it is essential that managers and staff who have contact with residents have an

understanding of suicide and self-harm prevention measures in approved premises. We therefore make the following recommendation:

The South Yorkshire Probation Trust and the manager of Town Moor should ensure that Town Moor Approved Premises has in place a self-harm and suicide prevention strategy and that staff are familiar with the procedures for managing residents who are vulnerable to self-harm.

The man's drug misuse at Town Moor

75. Arrangements were made for the man to access drug support services in the community before he left prison. He attended both group and one to one meetings regularly and was described as motivated. In the first few weeks after his release, he remained drug-free and tests were negative. In December and January, after failed tests, he admitted to his probation and drug support key workers as well as his offender manager that he had used drugs. He received a warning about his drug use and his offender manager reminded him of the consequences of continued misuse and the link to his offending behaviour. He was encouraged to work with the DIP and share the details of his drug use with his DIP key worker. The approved premises increased the frequency of his drug tests.

76. We are satisfied that staff at the various agencies took action to assist the man to remain drug-free throughout the time that he was resident at Town Moor. Probation staff who supervised him put in place regular testing when it became evident that he had started to use drugs again. They also gave him a warning, which was the first step towards a possible recall to prison if he had continued.

77. The DIP discharged the man on 19 January, two days before his death. At this final meeting, he disclosed his drug use at Christmas but not the incidents in January and the positive drug tests. He chose to withdraw from the DIP and attendance was not mandatory. On the night before his death, staff were aware that he had consumed excessive alcohol, but had no reason to suspect drug use.

78. There is provision for information sharing between probation and DIP staff. The offender manager in Doncaster area passed the information about the man's drug use to Town Moor but this does not appear to have been shared with the DIP worker. Therefore the DIP worker carried out assessments and made judgements without the benefit of accurate information. In spite of the man's assertions that his drug use had been a "blip" and given his recent positive drug tests, it would have been desirable for him to continue being supported so he could try and achieve a period of sustained abstinence. We recognise that it was his choice to leave, nevertheless if the key worker had been in possession of more accurate information she might have advised or guided him differently.

The manager of Town Moor should ensure that information about a resident's drug use is shared appropriately with relevant support agencies.

Contact with the man's family

79. There was a delay of around eight hours before the man's family were told of his death. The manager of Town Moor was not able contact them directly. At interview he told the he was unaware of guidance about liaising with families but later clarified that he had tried, unsuccessfully, to contact the man's mother on the telephone number provided. He therefore passed the details to the police who reportedly encountered similar difficulties.

80. The Approved Premises Manual provides guidance to staff on the procedures to be followed after the death of a resident:

> "All residents must be asked on their arrival to nominate two persons who are willing and able to act as their next of kin…These will be the people whom staff should initially contact in the event of the resident's death."

81. It is implicit in these instructions that the approved premises staff should contact the family after a death. No exceptions are listed. In addition, the South Yorkshire Probation Trust's process management system (PROMS) for the death of an offender in approved premises lists "contact next of kin" as one of the steps to be taken. In this case, the details of one family member were available but incorrect. The possibility of delay in notification would have been reduced if two people had been nominated in accordance with the instructions. We therefore make the following recommendation.

    The manager of Town Moor approved premises should ensure that on arrival, all residents provide the contact details of two people to act as next of kin in the event of an emergency and this should be kept up to date.

82. The guidance manual does not give detailed advice on managing notification to families after the death of a resident. Best practice is that this should be done face to face unless distance or other factors prevent this. In this case, there were valid reasons why the approved premises manager did not fully handle the notification. However, he said that he was unaware of any protocol regarding family liaison. In addition, the Probation Trust initially refused to adhere to their policy to offer a contribution towards the funeral expenses. Following intervention by this office, this was resolved.

83. We have previously made a recommendation to NOMS about insufficient guidance to staff in approved premises on dealing with families. This was rejected on the basis that staff should use their discretion and are already aware of the need to act with sensitivity. Unlike many prisons, approved premises staff rarely have to deal with such deaths. We consider they would benefit from more detailed guidance on actions to be taken and that this case again demonstrates that need. We therefore repeat the previous recommendation, slightly recast:

The National Offender Management Service should provide comprehensive guidance to approved premises managers on notifying and dealing with the family and/or other interested parties following the death of a resident.

Critical incident debrief

84. The manager of Town Moor initially scheduled a debrief meeting. However, this did not take place and he spoke to individual staff ad hoc and in their supervision meetings. Staff interviewed said they felt well supported.

85. In addition to providing support, the debrief is an opportunity for the staff involved in the incident to describe what each of them did and identify any learning points. PROMS lists "conduct critical incident review meeting" as another of the steps to be taken following the death of a resident. We are satisfied that approved premises staff were given appropriate support and advised of access to additional support if they required it. However, we consider it is best practice to hold a meeting where they can discuss the events together. We make the following recommendation:

The manager of Town Moor should hold a critical incident review after a serious incident or the death of a resident.

CONCLUSION

81. The man had been a resident at Town Moor for a short period after a previous release from prison. Before his release in 2011, prison and probation staff prepared well for his arrival, including making pre-arranged appointments with one of the local drug support agencies. The man developed trusting relationships with probation staff and workers from a support network of outside agencies, including DIP, a community psychiatric nurse and job advisors. He initially complied with the approved premises rules and his licence conditions and appeared to those responsible for his management to be well motivated to remain free from drugs and re-build his life.

82. It is clear that after a positive start, the man regressed into misuse of illicit drugs. Probation and DIP staff took appropriate steps to monitor this and assist him to address it. However, he decided to withdraw from his main source of support for drug use and died two days later.

83. The investigation identified scope for better information sharing as well as handling of family contact and debriefing staff after a death. Nevertheless, we are satisfied that the man was suitably managed at Town Moor and that staff could not have foreseen or prevented his death.

RECOMMENDATIONS

1. The South Yorkshire Probation Trust and the manager of Town Moor should ensure that Town Moor Approved Premises has in place a self-harm and suicide prevention strategy and that staff are familiar with the procedures for managing residents who are vulnerable to self-harm.

   The Trust accepted this recommendation.

2. The manager of Town Moor should ensure that information about a resident's drug use is shared appropriately with relevant support agencies.

   The Trust accepted this recommendation

3. The manager of Town Moor approved premises should ensure that on arrival, all residents provide the contact details of two people to act as next of kin in the event of an emergency and this should be kept up to date.

   The Trust accepted this recommendation

4. The National Offender Management Service should provide comprehensive guidance to approved premises managers on notifying and dealing with the family and/or other interested parties following the death of a resident.

   The Trust responded that it fully supports recommendation 4 and would encourage NOMS to consult with Approved Premises managers in the development of such guidance.

5. The manager of Town Moor should hold a critical incident review after a serious incident or the death of a resident.

   The Trust accepted this recommendation