

**The Death of an  
Approved Premises Resident  
on 2 May 2004**

**Report by the  
Prisons and Probation Ombudsman  
for England and Wales**

**November 2004**

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## **Foreword**

The sad death of an approved premises resident on 2 May 2004 has been investigated under transitional arrangements agreed with the National Probation Service, who appoint a senior investigating officer to work directly to me for the purposes of the investigation. He or she produces a draft report which I then review and amend as necessary.

In this case the senior investigating officer was an Assistant Chief Probation Officer (ACPO) of Humberside Probation Area and I am grateful to him for his comprehensive efforts. The remainder of the report is his, with amendments for reasons of clarity and consistency. The ACPO interviewed staff at the approved premises, where he also examined records. Together with the investigator from my office, he also visited the resident's relatives. I know that both have offered their condolences to his family, but I should also like to offer mine. The family asked a number of questions and the ACPO has done his best to answer them. The final part of the investigation was the commissioning of a clinical review by the Director of Public Health at North East Lincolnshire Primary Care Trust. I am most grateful to him for his contribution.

The report makes a number of recommendations about procedures at the approved premises, although I am satisfied that staff operated in accordance with its policies in existence at the time of the resident's stay there.

Finally I wish to thank the Manager at the approved premises and her staff for the help and cooperation received by the investigators in the course of their work. Facilities were made available and all staff participated fully and readily with the inquiry.

**STEPHEN SHAW CBE**  
**Prisons and Probation Ombudsman**  
**November 2004**

**SUMMARY**

1. The resident was released from HMP Ranby on 23 April 2004. A place had been found for him in approved premises and he arrived there in the late evening of 24 April.
2. He was last seen alive by resident D, his next door neighbour at the approved premises. Resident D estimates he saw him enter his room at approximately 23:30 on the evening of 1 May.
3. At approximately 09:40 on 2 May, approved premises staff went to his room to check on his welfare. He appeared to be dead and drugs equipment was found in the room.
4. There is evidence that the resident had obtained street heroin during his time at the approved premises. A post-mortem examination was conducted after his death and cocaine, heroin and cannabis were found in his body.
5. The investigation report has been written by an ACPO from Humberside. He finds that the approved premises staff acted reasonably in their supervision of the resident, but he makes a number of recommendations designed to improve procedures at the approved premises.

## INTRODUCTION

6. With effect from 1 April 2004 the Prisons and Probation Ombudsman is required to investigate all deaths of approved premises residents in accordance with the terms of Probation Circular 18/2004 which was issued on 30 March 2004. The terms of reference for the investigation are attached in full at Appendix 1. The investigation was established to:
  - investigate the circumstances and events surrounding the resident's death, particularly with regard to his management by the relevant services;
  - provide explanations and insight for the bereaved relatives; and
  - assist the inquest conducted by HM Coroner in achieving fulfilment of the investigative obligation arising under Article 2 of the European Convention on Human Rights, by ensuring as far as possible that the full facts are brought to light and any relevant failing exposed, any commendable action or practice identified, and any lessons from the death are learned.
7. This report was commissioned on 12 May 2004 to report on the circumstances of the death of an approved premises resident which occurred on 2 May 2004. I would like to take this opportunity to offer condolences for their sad loss to the deceased's family and friends. No one can have a greater interest in the outcome of this investigation, and that of the Coroner's inquest, than the members of the family and it is imperative that the close family members are involved in the investigation at an early stage of the process.
8. The investigating officers met with the resident's mother at her home on 7 May 2004. His brother and his partner were also present at the meeting and their views and questions helped to shape this investigation and report. The officers were grateful for their assistance and cooperation at a particularly distressing and difficult time.
9. At an early stage of the investigation interviews were held with relevant members of staff and with two of the approved premises residents. A death in a residential establishment is a traumatic experience for staff, particularly those more directly involved with the discovery, and the investigating officers would like to express their appreciation for the cooperation of those members of staff.

## **THE INVESTIGATION**

10. When the resident's death was discovered it was suspected that the use of illicit drugs was involved. This was evident from the drug related paraphernalia present in his bedroom. A copy of the toxicology report provided for the inquest is attached at Appendix 17, which states that illicit drugs were present in his body at the time of the post-mortem. These were found to be cocaine, morphine (heroin) and cannabis. Whilst the rules of the approved premises prohibit the use of illicit drugs on the premises, residents are free to come and go as they please between the curfew hours and routine drug testing is not a feature for every resident as a matter of course. Similarly, room searches are conducted at regular intervals on a random sample basis each week and these issues are amongst those that the investigation will seek to address to try to prevent similar deaths happening in the future.
11. The initial questions which needed to be answered were to clarify:
  - the time of death
  - the apparent and actual causes of death
  - whether any other person or persons were likely to have been involved
  - whether action could have been taken earlier to prevent the death from occurring
  - the policies and procedures in operation at the approved premises at that time had been followed by staff responsible for the resident's supervision.
12. The events leading up to the resident's death are recorded in the approved premises log-book. The case file containing personal and induction documentation was retained by the investigating officers and arrangements made to interview staff and residents. The CCTV tape was secured for later viewing. Copies of the relevant documents are included within the appendices.
13. Individual interviews were conducted with staff over a number of days immediately following the commencement of the investigation and full copies of each of the interviews are attached at Appendix 5.
14. An invitation was posted on the residents' notice board to provide an opportunity for any resident to speak to the investigating officers on a voluntary basis if they felt that they had anything to say which might aid the investigation. Copies of two residents' interviews are attached at Appendix 6.

### **The resident's time at HMP Ranby**

15. The resident was transferred from HMP Doncaster to HMP Ranby (near Retford in Nottinghamshire) on 13 November 2002. This was his fourth custodial sentence; his first conviction was at age 14 and he had a total of 20 convictions for 36 offences. These were mainly for theft and violence related to his substance misuse.
16. Whilst at HMP Ranby the resident made a written application on 29 April 2003 to attend the drug rehabilitation programme provided at the prison. However on 9 May 2003 it was decided that his name should be removed from the waiting list for the course. He was taking prescribed medication at the time and a member of the Drug Rehabilitation Team stated that it could affect his ability to complete the course. He had also failed three voluntary drug tests whilst at Ranby for cannabis.
17. The Drug Rehabilitation Team response indicated that if in future he was advised to stop taking his medication, then they would be willing to consider a new application from him.
18. The application form required the man to answer questions about his history of substance misuse. He replied that the drugs he had used before were heroin, cocaine, crack, amphetamines, LSD, ecstasy, cannabis, benzodiazepines and solvents. He stated that he took cocaine, crack, LSD and ecstasy in binge sessions and that he used alcohol, heroin, amphetamines and cannabis on a daily basis.
19. In response to questions about his age when he first used particular drugs, he replied that solvents began at age 10 whereas heroin and cocaine were relatively recent (age 30). The man wrote that he used heroin both by smoking and injecting. He also wrote that he had not been using any drugs while he was in jail.
20. At section 6 of the form the man stated that the prescribed medication he was taking at the time (late April/early May 2003) was dothiepin (for acute depression) and Sulpiride (an anti-psychotic tranquilliser).
21. The man's prison Inmate Medical Record and Prescription and Administration Record Chart show that he was being prescribed Sulpiride and Amitriptyline (an anti-depressant) from his arrival at HMP Ranby on 13 November 2002 until the Medical Officer at Ranby stopped the Amitriptyline prescription on 2 May 2003. Dothiepin was prescribed in place of Amitriptyline and the Sulpiride prescription continued. The man continued to receive seven days' supply of Sulpiride and Dothiepin in-possession on a weekly basis until 8 April 2004.
22. On the morning of 18 October 2003 the man informed prison staff at Ranby that he had been experiencing severe abdominal pain since the previous evening. At 10:30 he was taken to hospital where acute

appendicitis was diagnosed. The man had his appendix removed at the hospital before returning to Ranby on 22 October 2003.

### **Lincolnshire Probation Service**

23. The resident was released on licence on 23 April 2004 under supervision by the Lincolnshire Probation Service. A copy of the licence is attached at Appendix 7. The licence period was due to expire on 16 February 2005 unless previously revoked. Prior to his release the requirements of the licence were explained to him and he signed to signify his understanding and acceptance on 16 April 2004.
24. On release, he was instructed to report to the Probation Office in Lincoln which he duly did. On reception to prison the resident was assessed as 'no fixed abode' and his intended address on release was considered unsuitable. Due to his substance misuse he was assessed as high risk of reoffending and had previously found approved premises accommodation beneficial due to the structures and regimes. On Monday 26 April 2004, he contacted the Lincoln Probation Office to enquire if his appointment with NACRO on 28 April 2004 was going ahead. This was confirmed and the approved premises staff member on duty asked that a travel warrant be sent to him to enable him to travel to Lincoln. During her discussion with the approved premises staff member on 26 April 2004, a member of staff from the Lincoln Probation Office was informed of the events since the resident had arrived at the approved premises and she stated that he would only be resident for six weeks. She would be setting up an appointment for him with Addaction for drugs counselling and any mental health requirements in the Lincoln area and would arrange weekly contact with him.
25. Later that afternoon, just after 16:00 she rang back to the approved premises and spoke to a staff member. She confirmed that a travel warrant was being sent to the resident for the NACRO appointment on 28 April 2004, and said that he would be directed to Healthy Living, who would hopefully give him access to a community nurse. He would also be seen by his case manager whilst in Lincoln.

### **The approved premises**

26. A place had been allocated to the resident at approved premises and after reporting to the Lincolnshire Probation Service on release, he arrived at the approved premises just after 21:00 on Friday 23 April 2004. His induction into the approved premises and explanation of the rules and procedures was carried out by a staff member immediately on arrival. A copy of the induction record is attached at Appendix 8.
27. He was allocated room 18 on the first floor, the location of which is indicated on the plan at Appendix 9. A Consent to Medical Records form (Appendix 10) was signed by the resident and faxed off to the

prison on the morning of Monday, 26 April 2004. The standard referral to a doctor at a nearby Medical Centre was signed by the resident on Friday 23 April 2004 and faxed to the Centre on Monday morning 26 April 2004.

28. Although he became a resident at the approved premises (which is sited in the Humberside Probation Area), responsibility for his supervision was retained by the Lincolnshire Probation Service. Arrangements had been made by his supervising officer for him to receive a travel warrant to enable him to get to Lincoln on Wednesday, 28 April 2004 to attend for a supervision session and an appointment with NACRO at 11:30. He was also to be directed to Healthy Living who would arrange access to a community nurse. A record was made on the resident's approved premises notes that he went to Lincoln on 28 April 2004. It is likely from the evidence provided by resident S that the deceased obtained a supply of heroin whilst in Lincoln on that day
29. Staff had no indication of any prescribed medication which he was taking on arrival at the approved hostel, and he failed to disclose that he had in fact had some in his possession. The induction form has been marked n/a against 'check medication'. The log book entry made by a staff member at 18:30 on Sunday 25 April 2004 recorded "I have woken the resident because I was concerned. On awakening he asked me if it was meal time evening, although he attended the evening meal just over an hour ago. I asked him into the office and I asked him if he had taken anything. He told me he had taken 1 x Sulpiride, an antipsychotic drug usually prescribed for schizophrenia. The resident stated that he did not realise that he had it and that he only thought medication had to be declared if you had a lot. He told me Sulpiride had been prescribed to him for a long time along with Dothiepin, an antidepressant. Whilst I have only the resident's word for this, he states that he has been diagnosed schizophrenic for quite some time. This is very troubling. The resident assures me he has no other medication".
30. An appointment was made by the approved premises staff for him to see the doctor at the Medical Centre on Monday 26 April 2004. The clinical review prepared by the Director of Public Health for the North and North East Lincolnshire Primary Care Trusts states that the resident told the doctor that he left prison on Sulpiride 200mg twice daily and Dothiepin 75mg at night.
31. An approved premises log book entry for 27 April 2004 was made to record that "the resident has also received his medication from the chemist". Prescribed medication is retained in a secure cupboard and issued to residents as directed by the General Practitioner. A record of medication issued is maintained for each resident and a copy of the resident's record is attached at Appendix 12.

32. Resident S was already at the approved premises when the deceased arrived and they had established a friendly relationship over the first few days. In his statement (Appendix 6) he relates that they had previously been walking into Scunthorpe but turned back because the deceased couldn't make it. Resident S said that the deceased had told him that he had arrived at the approved premises with some amphetamines with him, but couldn't wait "to have a pop do you know what I mean, have a bit of heroin like". Resident S then said that the deceased had told him himself that he had obtained heroin when he had gone to Lincoln for the day on Thursday, 28 April 2004.
33. In establishing the actual time of death, it was important to determine when the resident had last been seen alive within the approved premises. Due to staff concerns, he had initially been placed on observation on three occasions during the night to check on his condition. This is a routine procedure at the approved premises, and not unusual for a new resident, particularly given the deceased's history of drug abuse going back over a long period of time, and that referral information from both the releasing prison and the supervising probation area had only been given over the telephone up to the time of his admission.
34. The discovery of the resident's death is recorded in the log book as being at 09:45 on Sunday 2 May 2004. That particular weekend had been a Bank Holiday and residents were permitted to sleep in as they wished. It is known from the entries in the log book, and the statements given by the members of staff on duty, that the resident had been present in the approved premises at curfew the previous evening, and had been in his room during the night. However, as all other residents were down to breakfast or out of the approved premises on the Sunday morning, it was decided to check on him to ensure he was well. The members of staff on duty at the time were the Assistant Warden, who had been there during the night on sleeping-in duty, and the Support Worker who had come on duty at 09:00 to start his shift.
35. The night Support Worker on waking night duty had finished her shift and gone off duty at 08:30 on 2 May 2004.
36. The Assistant Warden discovered the death. He had had contact with the resident over the previous few days on returning to work after a week off, and had been made aware of his needs and background. Briefings and entries in relevant notes and C sheets (Resident record of contact forms) had been made in accordance with approved premises policies and procedures. At 09:40 the Assistant Warden went to the resident's room (room 18) to check up on him. In the Assistant Warden's statement he says "Because I hadn't seen him properly since the Friday and I was by the time Sunday came, Sunday morning, I was concerned and I just wanted to go up to his room and make sure everything was alright with him".

37. There was no reply when the Assistant Warden knocked on his door, so he entered the room through use of his pass key. The curtains were closed but the visibility was good. The resident was laid on his bed in the same position as when he had seen him at curfew at 23:00 the previous night. There was a syringe lying on the floor just underneath the bed. The Assistant Warden then went downstairs to get a colleague to go up to the room to check the situation. An ambulance and the police were immediately called.
38. The room adjacent to the deceased's, number 19, was occupied by resident D. The rooms are both shown on the plan referred to above at Appendix 9. Resident D had been at the approved premises since 22 April 2004. He reports having seen the deceased alive at approximately 23:30 on the Saturday night entering his room; he presumes returning "from the toilet or somewhere, I don't know". He also reports hearing the deceased at approximately midnight breathing really hard. He had heard him snoring before, "but nothing like that on Saturday night, nothing at all".
39. On admission to the approved premises, the resident had nominated his mother as his next of kin and had given her home address which was recorded on the file. When the police attended at the approved premises on the morning of 2 May 2004, the resident's mother's name and address were given to them in accordance with Home Office guidance contained within Probation Circular 02/2004 issued on 6 January 2004. One of the police officers radioed through to the Louth Police and an officer from that station then went round to see the resident's mother to inform her that her son had died.

**Whether any other persons were likely to have been involved?**

40. All residents' rooms at the approved premises are single occupancy and each resident has his own key. Rooms were all checked at curfew, and in addition the deceased was subject to three checks during the night at this stage of his stay at the approved premises. Staff undertaking curfew and night security checks used their own pass keys to enter the room which confirms that the door had been locked. Entry could only have been either by a member of staff or by the deceased opening the door to someone. The police secured the room on their arrival at the approved premises and were satisfied that there had been no signs of a forced entry.
41. The approved premises operates a CCTV system for security purposes and the tape for the night of Saturday 1 May 2004 was secured by the investigating officers. However it was subsequently discovered that the video recording machine was faulty and the tape was corrupted. There was insufficient picture quality to enable it to be used to verify any of the evidence from the witness statements.

42. Although the deceased had been resident in the approved premises for one week, he had not been observed making any close friendships with other residents and had spent quite a lot of time alone in his room. There was one resident at the time who could be called upon to help verify the deceased's movements in the hours prior to his death.

**Whether any action could have been taken earlier to prevent the death from occurring?**

43. The resident had been released on licence from HMP Ranby and the terms of his licence had been explained to him on release. The approved premises is not a prison and the only physical restriction on residents is the nightly curfew (normally 23:00) which is strictly enforced. The approved premises operates to set rules which are explained to each resident on arrival as part of the induction process. Each resident signs to signify their agreement to comply with the rules, and they are made aware of the implications of breaking the rules. A copy of the licence conditions and the approved premises rules are attached as Appendices 7 and 14 respectively.
44. The system for regular nightly checks is a local procedure for increased supervision of offenders newly arrived at the approved premises until it is felt that they have settled down. The records show that these checks were carried out; the curfew check at 23:00 is carried out for all residents by the two remaining members of staff on duty. However during the night there is only one waking member of staff on duty and the nightly checks are carried out singly. A recent development announced by the National Probation Directorate is that all approved premises should move towards double waking night cover and consultations are being conducted at national level with the trade unions representing approved premises staff.
45. Routine random room checks are a normal occurrence in the approved premises regime and at some stage during the deceased's stay at the approved premises his room and belongings would have been searched to ensure compliance with its rules. He was aware of this from the induction process and chose to risk detection in the meantime.
46. The approved premises video and surveillance equipment may have provided valuable evidence for this investigation. Instructions have been issued to ensure that its staff carry out a weekly check of the recording machine and the tape quality to ensure that it is operating properly.
47. Some approved premises have introduced random drug testing for residents, but this facility is not currently available at this approved premises (other than for residents who are subject to a Drug Treatment and Testing Order where compliance is monitored away from the approved premises). Arrangements are being made for drug

testing to be carried out in the current financial year in both of the Humberside Probation Service's approved premises.

48. The toxicology report and indeed the resident's history was of a long period where reliance had been made on the use of illicit drugs, in addition to the medication he had been prescribed on release from HMP Ranby. On his admission to the approved premises, full details of his medical history had not been received there and it is imperative that referring officers have full information available to enable a proper assessment to be made either before or on arrival at the premises. Clear expectations to address misuse of illicit substances would be required of the offender, although it appears that in the resident's case he would not have been able to make that commitment.

## **CLINICAL REVIEW**

49. A formal request for a full clinical review was submitted by the Ombudsman's Officer to the Director for Public Health, North East Lincolnshire PCT on 14 June 2004 to assess the resident's medical care whilst in the approved premises.
50. A copy of the review is attached at Appendix 16.

## **Post-mortem report**

51. A post-mortem examination of the resident's body was carried out by the Consultant Pathologist and a copy of his report is attached at Appendix 17.
52. A post-mortem toxicology report was also provided from a professor at the Royal Hallamshire Hospital who concluded that the findings were consistent with the use of illicit heroin and cocaine, with therapeutic range use of Dothiepin. It was the opinion of the professor that the cause of death should be modified to aspiration of gastric contents and drug abuse.

## CONCLUSIONS

53. The resident was known to the Lincolnshire Probation Service as he had been previously supervised by them prior to the offences which led him to a custodial sentence which finished in HMP Ranby. He had been allocated a bed space in the approved premises as his intended address in Lincoln was considered to be unsuitable. The case was retained for supervision by Lincolnshire Probation, but recent Home Office instructions would now dictate that the case be transferred to the Humberside Service for management from a Humberside Probation Office (Probation Circular 52/2004 refers).
54. The resident had started his involvement with drugs and solvent abuse from an early age and seemed unable to cope without them. It is highly probable that he took something prior to arriving at the approved premises and he failed to disclose to staff when asked that he was in fact also taking prescribed medication.
55. It is clear that staff at the approved premises did not know as much about the resident's medical condition as they would have liked to have done on or before his arrival, but their concerns were noted at an early stage. Their actions were in accordance with approved premises policies and procedures and they acted reasonably in their supervision of him.
56. There is no clear indication of the time of death. It is clear however that the resident was present in the approved premises at curfew time (23:00) on the Saturday evening before being discovered on the Sunday morning (09:45). The evidence from resident D places the deceased on the landing outside of his bedroom at approximately 23:30 on the Saturday evening and he also reports hearing him snoring during the night. The nightly room checks also support this but are inconclusive as the deceased was in the same position in bed as when the curfew check was made at 23:00. The fault on the CCTV system cannot be used to verify this information.

## RECOMMENDATIONS

57. It is recommended that the Chief Officer of the Humberside Probation Area:
- (i) arranges for approved premises staff to attend regular information and training sessions regarding mental health issues and medication;
  - (ii) reviews the procedure for additional night-time residents' checks and provides staff with written guidance on conducting such checks until double waking night cover is available;
  - (iii) ensures that the operation of the CCTV system is checked not less than weekly;
  - (iv) considers the introduction of an on-site system for random drug testing of approved premises residents as a matter of urgency;
  - (v) ensures that full information is available to the Approved Premises Manager (allocation officer) when referrals are made to the Approved Premises from both within the Probation Service and external agencies (e.g. Prisons) to include medical history; and
  - (vi) invites the Drug Intervention Programme Manager to consider and comment on this report.

### APPROVED PREMISES

#### Legislative Provision

58. Approved Premises (previously known as approved probation and bail hostels) are an important part of the criminal justice system. They provide an enhanced level of residential supervision in the community as well as a supportive and structured environment. They are intended as a base from which residents can take full advantage of community facilities for work, education, training, treatment and recreation.
59. Statutory provision relating to Approved Premises is made by Section 9 of the Criminal Justice and Court Services Act 2000. Section 9(1) gives the Secretary of State power to approve premises in which accommodation is provided for persons granted bail in criminal proceedings, and for, or in connection with the supervision or rehabilitation of persons convicted of offences. Section 9(3) gives the Secretary of State the power to make Regulations for the regulation, management and inspection of Approved Premises. These Regulations are The Criminal Justice and Court Services Act 2000 (Approved Premises) Regulations 2001, a copy of which is included as Appendix A to this section of the report.
60. The Regulations place a number of duties on managing bodies, in particular about financial control, the conduct of residents and medical care, and the keeping and inspection of records. The Regulations also require the adoption of admissions policies, procedures relating to breach and house rules.

#### National Standards

61. As well as the Approved Premises Regulations 2001, Approved Premises are also governed by a set of National Standards; particularly part F of the standards. National Standards require all probation service areas, and organisations working on their behalf, to operate fairly and consistently with all offenders and residents in Approved Premises, and to avoid inappropriate discrimination on grounds of race, sex, age, disability, religion, sexual orientation or any other improper ground.
62. A copy of part F of the National Standards is included at Appendix B to this section of the report.

#### The approved premises

63. The deceased was a resident at the approved premises. The property is situated approximately one mile north of the town centre within a mixed residential and commercial area. The approved premises accommodates up to 19 male residents in single occupancy bedrooms who are subject to court orders (bailees or probation) or post-custody licensees. It is permanently staffed with a minimum of two members of staff on duty at any time. There is currently one waking and one sleeping staff member on duty during the night between the curfew hours of 23:00 and 07:00 each day, including weekends.
64. The challenge for staff is to not only manage the risk posed by each offender, but to work with them in conjunction with the case manager (a designated probation officer) in a constructive and focussed manner. The National Standards mentioned above sets out clear guidelines on what is expected, and includes:
- as soon as practicable after arrival, every new resident is interviewed by a member of the supervisory staff when the house rules will be explained fully and signed by the resident
  - within seven working days of each resident's arrival, and based on the assessment of the resident, produce a planned programme for the expected duration of stay at the approved premises which addresses behaviour, is congruent with any other orders to which the resident may be subject, addresses the management of identified risks of harm posed by the resident and does not conflict with any reasonable employment requirements or the resident's religious considerations
  - ensure that residents take part in any hostel-run or other programmes on how to avoid reoffending
  - plan for the resident's community reintegration and discharge from the hostel; and
  - contribute to any report to the Court on the resident and include details of any serious or repeated failure to comply with the Court order or the rules of the approved premises, as well as achievements.

### **Staffing Structure – The Approved Premises**

1	Deputy Approved Premises Manager, probation officer
1	Probation Services Officer
3	Assistant Wardens
4	Full-time Support Worker posts worked by 5 people, 2 doing
part-time	
1	Administrative Officer

65. At any one time there is always a minimum of two members of staff on duty. During the night between the curfew hours of 23:00 to 07:00 there is one Assistant Warden on sleeping-in duty and one Support Worker on night waking duty. The task lists for each grade of staff during the day and night is attached.

## SECTION C

### CHRONOLOGY OF EVENTS – THE RESIDENT

Date	Event	Comment
18.10.2002	Sentence	3 years and 3 months imprisonment at HMP Ranby
23.04.2004	Released on licence to 16.02.2005	To report to the Resettlement Team, Lincolnshire Probation Service.
23.04.2004	The approved premises	Arrived at approximately 21.12 and inducted
2.05.2004	Found in bed at the approved premises	At approximately 09:45 his room was checked and police and ambulance were called
2.05.2004	Ambulance crew	Arrived at 10:00 and confirmed death
2.05.2004	Doctor attended	Certified death at 10:55
2.05.2004	Police attended	Arrived at 10:05 and took possession of room 18 Contacted the Lincolnshire Police for notification of next of kin

## SECTION D

### APPENDICES

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