# Investigation into the circumstances surrounding the death of a man at Victoria House Approved Premises, Scunthorpe, in December 2010

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

**October 2011**

This is the report of an investigation into the death of a man at Victoria House Approved Premises, Scunthorpe, on 4 December 2010. The man had told staff the night before that he thought he had taken twice his normal dose of methadone. Despite staff making regular checks on him, he was found dead the following morning. He was 41 years old.

I would like to extend my condolences to the man's family and friends for their loss. I am grateful that the man's family have participated in the investigation during what has been a particularly difficult time. I hope that I have been able to address their concerns and give them a greater understanding of his time in Victoria House.

The investigation was conducted by an Assistant Ombudsman. We are grateful for the assistance from Humberside Probation Trust and in particular to the Director of Probation and the manager of Victoria House.

The man often offended in order to support his drug addiction. His most recent prison sentence was a result of offences he committed while on licence following a previous sentence. However, in the short time following his release from HMP Ashwell, staff had noticed that he was trying hard to engage with his offender manager and not to relapse into illicit drug use.

I make four recommendations as a result of this investigation. These relate to the handling of medication at Victoria House, how overnight checks are conducted and the debriefing of staff after deaths.

**Thea Walton**
**Acting Deputy Ombudsman** **October 2011**

**CONTENTS**

Summary

The investigation process

Victoria House Approved Premises

Key events

Issues

Conclusion

Recommendations

## SUMMARY

1. The man was released from prison on 10 November 2010. As part of his licence conditions, he was required to live at Victoria House Approved Premises in Scunthorpe. He also had to undergo regular drugs tests, and was prescribed methadone (a heroin substitute).

2. On arrival at Victoria House, the man was given a thorough induction. However, it is not clear whether a risk assessment was conducted to assess whether he should be allowed to keep medication in his own possession. This was despite staff being aware that he had previously obtained prescription drugs through deception.

3. The man failed a drugs test on 12 November, and later admitted taking cocaine with a friend. Following that, however, he provided a series of negative tests and gave staff little cause for concern.

4. On 30 November, he attended an interview with the Police about a matter in which he was a potential victim. He was clearly upset following the interviews. The next day, he returned a positive drug test for cocaine. His offender managers did not speak to him about this as they were unable to get to Scunthorpe because of heavy snow.

5. In the evening of 3 December, the man went to the office at Victoria House and told staff that he thought he might have taken too much methadone. He said, however, that he did not want to see a doctor. Staff conducted regular checks throughout the night and did not have any concerns about his welfare. A check at 9.00am on 4 December was, however, missed. At the next check, at 11.00am, staff could not obtain a response from him and thought that he had died. Paramedics attended and confirmed his death shortly afterwards.

6. I make four recommendations as a result of this investigation. These concern the induction check list, handling of medication in possession, the conducting of checks at night and staff debriefs.

## THE INVESTIGATION PROCESS

7. This office was notified of the man's death on 4 December 2010. An Assistant Ombudsman, was appointed to conduct the investigation.

8. The Assistant Ombudsman travelled to Scunthorpe on 10 December to open the investigation. While at Victoria House, he met the Director with responsibility for Approved Premises for the Humberside Probation Trust, and the Senior Probation Officer and Premises manager. The Assistant Ombudsman saw Mr the man's room during a tour of Victoria House and was given a file containing the documentation relating to his time there.

9. While in Scunthorpe, the Assistant Ombudsman also met a policeman at Scunthorpe Police Station. As the man had been interviewed by the Police (as a witness in another matter) less than 72 hours before his death, the policeman had been asked to make further enquiries. However, after making these enquiries, no further action was taken at this time.

10. The Assistant Ombudsman spoke to the Coroner's Officer for the case on 14 December, to explain that the Ombudsman would be investigating the man's death. The Coroner's Officer explained that the Coroner was awaiting the results of a toxicology report before being able to ascertain the cause of death.

11. One of the Ombudsman's Family Liaison Officers spoke to one of the man's sisters on 4 January 2011, and explained the purpose of the investigation and to give the family the opportunity to ask any questions or raise any concerns. The man's sister said that she had three questions that she would like answered:

    - There were no personal letters, photographs or mobile phones in the property that was returned to her by the Probation Trust. The Family Liaison Officer agreed to establish whether the Police or Coroner had any of the man's property.

    - The man's sister also asked about an outstanding court matter in which he was involved as a victim. The Family Liaison Officer suggested that the man's sister speak to his solicitor to take further advice.

    - Finally, the man's sister also asked what consequences the failed drugs test might have had.

12. The Assistant Ombudsman returned to Victoria House on 8 February 2011 to conduct interviews with nine members of staff. He also spoke to an Assistant Director for Humberside Probation Trust, who had carried out an internal investigation into the man's death. The Assistant Director shared the report of his investigation with the Assistant Ombudsman, and I am grateful for his help. The Assistant Ombudsman provided feedback to Humberside Probation Trust following these interviews.

13. On 29 March, the Assistant Ombudsman contacted the Coroner.  By this time, the Coroner had received a toxicology report, which confirmed that the man had died of methadone toxicity.  (This is when the level of methadone in the body exceeds a safe level, potentially affecting the body's ability to function properly.)

**VICTORIA HOUSE APPROVED PREMISES**

14. The purpose of an Approved Premises (AP) is to provide an enhanced level of residential supervision in the community, in a supportive and structured environment. Although residents have to comply with their individual licence or bail conditions, curfews, and the AP's rules, they are otherwise free to come and go from the building.

15. Victoria House AP is one of 101 Approved Premises in England and Wales. It normally accommodates 19 residents and has one additional emergency bed. It is staffed 24 hours a day by probation employees (Assistant Wardens) whose role is to provide support and to ensure that the rules and licence or bail conditions are complied with. A curfew operates from 11.00pm to 6.00am.

16. Information about relevant rules, procedures and expectations is given during induction. All residents are allocated a key worker. Regular key work sessions take place, giving the resident the opportunity to discuss any issues or difficulties in more depth. The day to day routine at the hostel is relaxed, although residents do have to surrender their room keys on weekdays between 9.00am and 11.30am to allow for cleaning. Key work sessions run during the day and some residents have to attend offender management meetings or appointments with other probation staff.

17. Residents are provided with breakfast and an evening meal at the premises. They make their own arrangements for their lunch. A trolley is put out at around 8.30am with cereals and bread for residents to help themselves. The evening meal is provided at around 5.00pm.

18. On arrival, all residents are offered a tour of the AP and the opportunity to register with a local doctor's surgery. Victoria House has an arrangement with the surgery to enable all new residents without a doctor of their own to register during their stay. There is also an arrangement with the surgery and local pharmacy to facilitate the delivery of medication to the premises. All prescription medication must be handed in to the staff at the front office, where each item is logged and stored safely.

19. If staff have any suicide or other health and welfare concerns about a resident, they can be monitored under their suicide and self harm procedures (using forms called SH1s and HC1s – the HC1 form is subtitled "Monitoring for residents who are identified as being a risk of sudden death from serious illness or accidental drug/alcohol overdose). These mean that a resident is checked upon at regular intervals during the day and night.

20. Victoria House keeps basic first aid equipment in the main office, including resuscitation face masks. There are also a number of other first aid kits located around the hostel. All staff are fully trained in first aid and attend a comprehensive four day course, with refreshers every two years. Staff

receive other training including risk assessing, health and safety, and self harm and mental health awareness.

**Prolific and Other Priority Offenders (PPO)**

21. Prolific and other priority offenders (PPOs) are those deemed to be at greatest risk of offending. Once an individual is placed on the scheme, they are closely monitored by the Police and, should they reoffend, they are brought before a court as quickly as possible. Staff on the Prolific and Priority Offender scheme can, however, use a variety of interventions such as support and guidance, employment advice or help with drugs and alcohol issues to help break the cycle of offending. In Humberside, the scheme is a partnership between Humberside Police and the Humberside Probation Trust.

**Methadone**

22. Methadone is a synthetic opiate manufactured for medical purposes. It is used as a substitute for heroin to help treat drug addiction, as it mimics the effects of that drug. However, it also has some of the same side effects, such as drowsiness, apathy, confusion, nausea, vomiting, suppression of breathing reflexes and constricted pupils. If taken in excessive quantities, the use of methadone can lead to coma and eventually to death.

## KEY EVENTS

23. The man committed eight offences of burglary and theft in July 2008, less than a month after being released on licence from HMP Risley where he had served a sentence for similar offences. He was required under the terms of his licence to reside at Queen's Road Approved Premises (AP) in Hull. On 15 July, he had collapsed at Queen's Road after taking an overdose of prescription medication. It was found that he had obtained medication from two different doctors, and had a prescription in a false name from a surgery in Scunthorpe. Probation staff decided to apply for his licence to be revoked but the man left Queen's Road and committed a series of burglaries which led to his subsequent arrest. On 10 November 2008, he was sentenced to four years imprisonment at Great Grimsby Crown Court

24. The man was initially held at HMP Hull. Staff at the Scunthorpe Probation Service kept in regular contact with Hull to monitor his progress. He attended a Thinking Skills Programme (a course designed to help him address his offending behaviour) and was prescribed methadone (a heroin substitute). Staff at Hull reported, however, that he was suspected of secreting other prisoners' prescription drugs in his cell and had been moved to a different wing as a result.

25. By September 2009, the man had been given enhanced status under the Incentives and Earned Privileges scheme (which aims to encourage prisoners to be well behaved and engage with prison activities and offender programmes). He was also addressing his drug use by attending sessions with a Counselling, Assessment, Referral, Advice and Throughcare Services (CARATS) worker (CARATS staff provide non-clinical drug treatment in prisons).

26. On 14 May 2010, the man was placed on the Scunthorpe Prolific and Other Priority Offenders (PPO) list. He was notified of this decision by letter on 17 May. In July 2010, he moved to HMP Moorland. He reported not feeling safe there, however, and was moved again to HMP Ashwell at the start of September. Shortly after he arrived at Ashwell, he was assessed by a member of the CARATs team who informed the Scunthorpe PPO team that he was prescribed 100mg of methadone each day.

27. As he was due for release on 10 November, having served half his sentence, a pre-release sentence plan board was held on 22 September. The board agreed that, as he had no fixed accommodation, a referral should be made for a place at Victoria House AP. It was also agreed that he should be required to undertake regular drug tests as part of his licence conditions.

28. The man's brother died in a road traffic accident on 4 October. The Offender Management Unit at Ashwell confirmed that he had dealt with the news in a mature way. He was allowed to attend his brother's funeral on 26 October.

**Release from Ashwell**

29. The man was released from Ashwell on 10 November. He remained subject to several licence conditions. These included:

  - That he must attend a Prolific and Priority Offender project in Scunthorpe.
  - That he attend for drug tests when required.
  - That he live at Victoria House, unless otherwise agreed with his offender manager, and that he abide by the rules of Victoria House.
  - That he remained at Victoria House between 9.00pm and 7.00am, and sign in there between 12.00pm and 1.00pm.

30. On his release, he was met by his offender manager. He undertook a drug test for opiates, which proved negative even though he had taken an opiate based medication to relieve back pain. (The man had suffered a serious back injury when he was younger.) The offender manager explained the licence conditions to the man who, although he was not happy about the curfew condition, agreed to abide by them.

31. After he arrived at Victoria House at 11.55am, the man was given a full induction by Assistant Warden 1. The man signed the relevant paperwork and agreed to the rules of the AP. This included the Drug and Alcohol Policy.

32. Rule 4 of the Approved Premises concerns medication. It states that "Residents are to hand in to staff ALL prescribed medication. However certain medications may be returned to residents once they have been registered. This is decided by staff once checked against medication classification and suitability of the individual resident to retain medication".

33. The man handed in two boxes of medication, one of which contained an opiate-based medication, which he thought might cause him to fail further drug tests. He was assured that any positive sample would be further tested to analyse its precise contents. The man left the hostel to go into Scunthorpe later that afternoon, and returned before the curfew.

34. The next day, the man attended an appointment with his offender managers. He was unable to provide a sample, and arrangements for him were to have another test later at the AP. In the meantime, the man told hostel staff that he needed to have an increased amount of methadone in order to keep him away from illegal drugs.

35. When the man provided his test, the result was positive for both cocaine and methadone. He was given a verbal warning from his offender manager at the time and was told he would also receive a formal warning letter. The man confirmed that he had visited a friend who had given him a cigarette which he now thought he might have contained drugs, and he said that he would now try and stay away from these people. The man also confirmed that he was receiving 100ml of methadone, which was dispensed by a pharmacist in Scunthorpe. He later gave a negative sample while at his doctors.

36. The following day, the man was involved in an argument with another resident. The incident was seen by staff, who challenged all parties. The man said that he had given some money to two other residents, but they were now refusing to give it back. He said that he didn't want to make a complaint, but would try and keep away from the other residents.

37. On 14 November, the man attended his initial keywork session with Assistant Warden 2 at Victoria House. He engaged well, and Assistant Warden 2 explained the sentence planning process. Later that day, the man asked Assistant Warden 3, for some information about the effects of drugs, including cocaine, heroin and methadone. This was provided for him.

38. The next day, the man saw his second offender manager at the prolific offender unit in Scunthorpe. They discussed his sentence plan, which the man agreed and signed. He still needed to register with a doctor, and talked about going to see his family. He also undertook a drugs test, and tested negative for opiates and cocaine.

39. The man registered with a new GP at the Detyull Street practice, Scunthorpe, on 16 November. This was not the normal practice used by Victoria House residents, but he was rejected by that practice because he had previously used false details there to obtain a prescription. The offender manager recorded that he would be taking 100mg of tramadol (a pain killer) for a short time, and had also been prescribed omeprazole (a drug used to treat excess stomach acid). His methadone prescription had also been increased from 90mg to 100mg.

40. On 17 November, a three way induction meeting was held with the man, the second offender manager and Assistant Warden 2 all attending. They discussed his sentence plan, and the man also confirmed he had received his clothing grant. He had met his sister and other family members the previous day, and had decided he wanted to live in Winterton, away from what he termed "negative influences". He agreed to continue with regular daily appointments with the Prolific and Priority Offender team.

41. Two days later, the man met with a Drugs Intervention Programme (DIP) worker. He said that he wished to be prescribed diazepam (also known as Valium, a drug used to treat anxiety and insomnia), as he had been taking four tablets a day towards the end of his prison sentence. He claimed to have taken them since leaving prison, although he had tested negative for them.

42. The man continued to interact with staff at both Victoria House and the Prolific and Priority Offender team as required. He attended another keywork session on 22 November with Assistant Warden 2, when he said that he had felt tired all weekend, and had spent most of his time at Victoria House. He again said that he wanted to move to Winterton, and that he was going to ask for his methadone prescription to be increased. He told Assistant Warden 2 that he wanted to enjoy his freedom, and that he had found it hard having the

victims of his offences on his conscience. He said that he had previously returned some personal items back to their owners after he had stolen them.

43. Two days later, he spoke to staff at both the Prolific and Priority Offender team and at Victoria House about his problems with the other resident. He was given advice on how to deal with the issue. Later the same day, a telephone call was received at Victoria House from someone wanting to speak to the man. The man declined to speak to the person, who he said had given him cocaine on a previous occasion, which had caused him to fail a drugs test.

44. On 26 November, the man undertook a drugs test with the Prolific and Priority Offender Unit. Although he tested negative for both opiates and cocaine, the cocaine line was faint (a negative test normally produces a strong line). The man denied taking cocaine, and said that he would ask for a retest when he saw the DIP worker later that day. The DIP worker later telephoned Victoria House, telling them that the man's doctor had stopped the prescription of temazepam and was also trying to reduce the level of tramadol. However, the man was prescribed 50mg of diazepam, to be taken supervised daily, and would hand in 100mg at Victoria House each weekend. (He also handed in two doses of methadone every Friday, to be issued by AP staff over the weekend. This was because the pharmacist did not dispense these medications over the weekend.)

45. On 29 November, the man again reported that he did not feel well. He was excused his appointment with the Prolific and Priority Offender. When he saw Assistant Warden 2 later that day, he said that he was building bridges with the other residents. He later confirmed that he had been repaid the money he was owed.

46. The next day, 30 November, the man attended a meeting with the police at The Granary, a police building in Scunthorpe. He was interviewed as a potential victim in relation to an allegation of abuse at a care home where he had stayed when he was younger. The DIP worker accompanied him, and told the offender manager that the man had found the day stressful. In turn, the offender manager let staff at Victoria House know.

47. The winter of 2010 was particularly severe in Scunthorpe, with the heaviest snowfall for many years occurring at the end on November. On 1 December, the man spoke to Assistant Warden 4, and said that, because of a longstanding injury to his neck and back, he would find it difficult to get to the chemist to collect his methadone. Assistant Warden 4, agreed to collect it for him, and the man signed a consent form. Assistant Warden 4 was advised by the chemist to arrive after 10.00am, as the pharmacist was walking in from a neighbouring village. She returned at 10.30am with 100mg of methadone and 5 x 10mg diazepam.

48. Shortly afterwards, Assistant Warden 5 asked the man to provide a sample of saliva for a drugs test. The man initially refused to be tested until he had taken his methadone, but Assistant Warden 5 told him that the offender

manager requested it to be done before he was given his methadone. The man left the office for a short while, before returning and agreeing to the test. The test was positive for cocaine. The offender manager was informed and he said that he would discuss the failed test with the man's second offender manager, and then with the man when the weather allowed. (The offender manager was unable to get to Scunthorpe, and made the notes on the Probation Service computer system, CRAMS, after the man's death as this was the first time he had access.)

49. Later that day, Assistant Wardens 4 and 5 conducted a random search of the man's room while he was out. They found a letter relating to a SIM card in someone else's name (the SIM card was missing) and five pieces of scrunched up tin foil. They called the number on the SIM card, and the man answered. He returned to Victoria House and explained that the SIM was originally that of a friend's daughter, but they had given it to him as he needed one. He said that the foil had come from packets of mints (Assistant Warden 4 confirmed that she had found some unwrapped mints).

50. The man told staff that he was unhappy that his room had been searched. He later returned to the office, bringing some pain killers and the silver foil from a packet of cigarettes, explaining that he didn't want to be accused of anything. He referred to an earlier room search (on 28 November) and the previous day's interviews with the Police and asked Assistant Warden 4 whether "you people care about people's feelings and what they are going through, I thought you were supposed to be looking after people and making sure they are all right". They discussed the matter further before the man left the office.

51. The next day, the man told the manager of Victoria House that he had confessed to the DIP worker that he had taken cocaine. He said that he might need to go to rehab as he wanted to stay away from drugs but would have difficulty given there were many people to tempt him in Scunthorpe.

**Events of 3 and 4 December**

52. The bad weather in Scunthorpe continued. The offender manager was still unable to get into Scunthorpe, and telephoned Victoria House to see how the man was. Assistant Warden 4 told him that the man had gone to collect his methadone, and had also discussed entering a residential rehabilitation facility. Around lunchtime, the man went to see Assistant Warden 4 and apologised for his reaction to the room search. Assistant Warden 4 thanked him for his apology.

53. At 6.19pm, the man returned to Victoria House slurring his words. Assistant Warden 5 noted that he could not smell any alcohol, but he "seems to be repeating himself more than usual". He returned to the office half an hour later, and apologised to Assistant Warden 5 about the drug test of 1 December. He told Assistant Warden 5 that he had felt that he needed to "escape" after his interview with the police. He had met a friend when he went to collect his methadone, had gone back to his house and smoked

some crack cocaine. He also mentioned that he wanted to speak to his doctor about depression.

54. Assistant Warden 3 arrived to start her night duty at 9.00pm. Later in the evening, at 10.50pm, the man returned to the office and told Assistant Warden 3 that he thought that he had taken more than his prescribed dosage of methadone. Assistant Warden 3 noted that he looked “confused, [was] slurring his words and his eyes are very heavy”. The man confirmed that he had brought back an empty methadone bottle, which confused him as this was not something he normally did. Assistant Warden 3 checked the medication tray, and found two bottles of methadone, presuming that they were for the weekend. The man showed her the empty bottle, which, at interview, Assistant Warden 3 confirmed was labelled for Friday, and said that he had not taken anyone else’s methadone.

55. The man confirmed that he did not want to see a doctor, and had not taken any other drugs. Assistant Warden 3 asked him if he wanted her to call am ambulance, and he said that he did not. He also said that he was not going to harm himself. Assistant Warden 3 told him that she was going to put him on an HC1, which meant that he would be checked by staff every two hours during the night.

56. Shortly afterwards, at 11.00pm, Assistant Warden 3 checked on the man in his room. He had taken some sugar which he said had perked him up. Assistant Warden 3 noted that his eyes looked slightly better. The man told Assistant Warden 3 that he was going to put a jumper in the doorway to keep the door ajar so that she wouldn’t need to disturb him when she did her checks. Assistant Warden 3 agreed.

57. Assistant Warden 3 continued to check the man throughout the night with her colleague, a Support Worker, and wrote on the HC1 form that he was in bed asleep. At interview, she recalled that the man was snoring at each check. The support worker completed the check at 7.00am on 4 December, so that Assistant Warden 3 could hand over to Assistant Warden 4. At 9.00am, Assistant Warden 1 relieved the support worker. (During the week, residents are given a “wake up” call at 7.45am. However, this did not take place as 4 December was a Saturday.)

58. During the handover, Assistant Warden 3 told Assistant Warden 4 of the man’s condition. She decided to check the medication tray and found two bottles of methadone (100ml each). Aware that he was also prescribed diazepam, she became concerned that he might have taken an overdose. Assistant Warden 4 decided to telephone the chemist, who confirmed that the man had taken his methadone supervised the day before and had taken 200ml for the weekend. He had also been given 15 x 10mg of diazepam, which the chemist said were no longer supervised. Assistant Warden 4 decided to ask the man about this when he came to the office to collect his methadone. While Assistant Warden 4 conducted these enquiries, the intended 9.00am check was not conducted.

59. At 11.00am, Assistant Warden 4 went to conduct the next check on the man. She looked in his room, and noticed that he looked white around his mouth. Deciding she needed to investigate further, she went to get Assistant Warden 1. The man was lying on his back with a cigarette in his right hand, and his mobile phone on his chest. Assistant Warden 1 immediately thought that he was dead (Assistant Warden 1 explained at interview that he had been the warden who had found residents who had died on previous occasions, and he recognised from the colour of the man's face that he had died). Assistant Warden 4 approached the bed and found that the man was very cold to the touch and had a trail of vomit on his cheeks. She looked for a pulse but could not find one, and was certain that he had died.

60. Assistant Warden 4 returned to the office and, at 11.05am, telephoned for an ambulance and the police. Assistant Warden 1 telephoned the Assistant Chief Officer (ACO) for Humberside, who was on duty, to notify her that the man had died. The paramedic first responder arrived at Victoria House at 11.15am (although the ambulance station is very close to Victoria House, road conditions remained treacherous). He checked for signs of life, but confirmed that the man had died. An ambulance arrived shortly afterwards, and conducted an ECG test (electrocardiogram, a test which measures electrical activity in the heart). This test too confirmed death.

61. Police officers arrived at 11.30am and took details of the man's next of kin so that they could inform them of his death. The Director of Probation for Humberside, went to Victoria House to co-ordinate the response to the man's death and to ensure that staff and other residents were supported. (The ACO would normally have taken this role, as she was on duty, but was unable to travel to Scunthorpe because of the weather.) The police notified the man's sister of his death later that afternoon.

62. The Approved Premises manager spoke to the man's sister on 8 December and offered her the chance to visit Victoria House. The man's sister visited the following Saturday. His possession were returned to her

63. A post mortem examination was conducted at Lincoln County Hospital by a Consultant Histopathologist (a histopathologist is a doctor who examines body tissue after death), on 10 December. The Consultant requested a full toxicological analysis to determine whether any drugs were present in the man's body. This was conducted at the Royal Hallamshire Hospital, Sheffield, on 22 February 2011. This concluded that the level of methadone was at a concentration that "may be fatal even in chronic users". Traces of cocaine were also found, at levels which suggested "misuse in the hours prior to death". Although tramadol and diazepam were found, they were at levels consistent with therapeutic use. The Consultant recorded the cause of death as a methadone overdose, and that the death was due to unnatural causes.

64. In June 2011, the Assistant Ombudsman received a telephone call from the Coroner's Officer. He told the Assistant Ombudsman that the Coroner had asked Humberside Police to make further enquiries into the medication that

the man had been dispensed, as there were inconsistencies in the labelling of the medication. As these enquiries do not fall within the Ombudsman's Terms of Reference, we have not investigated this matter further.

65. On 20 October 2011, an inquest into the man's death was held at Pittwood House, Scunthorpe. The jury returned a verdict that he had died from an accidental overdose of prescription medication [methadone], some of which had been inadvertently supplied. The court heard that the man had received five bottles of methadone on 3 December 2010, each containing 100ml, when he should have received three (one for that day, which he consumed in front of the pharmacist, and two for the weekend). However, another witness confirmed that he had seen the man drink half of each bottle of his weekend supply and the replace the contents with water. He had then returned to the chemist, where he was inadvertently given a further two bottles. He shared one bottle with a friend, and is likely to have taken another bottle on the evening of 3 December. In total, it is likely that he drank 370ml of methadone, when his normal dose was 100ml.

## ISSUES

### Handling of medication

66. The handling of prescribed medication is covered by an instruction known as Probation Instruction (PI) 09/2009 and entitled “Medication in Approved Premises”. This sets out arrangements for how medication should be handled. It aims to ensure that most residents can keep prescribed and “over the counter” medication in their own possession. However, it also states that “some residents will never be allowed [medication in possession] and there will be certain specified drugs/medication excluded from these arrangements.”

67. Annex 5 of PI 09/2009 sets out the types of medication that residents will not be allowed to keep in their possession. These include methadone, tramadol and diazepam.

68. Humberside Probation Trust has a separate policy called “Procedures for Handling of Residents’ Medication”. The latest version of this policy was produced in July 2010, and it is designed to be read in conjunction with PI 09/2009.

69. This policy requires staff at Approved Premises to explain the rules about medication to new residents. Staff should also carry out a ‘medication in possession’ risk assessment, and a new assessment should be completed if the resident’s circumstances change or they are prescribed a different medication.

70. However, it is not clear whether a risk assessment was carried out with regard to the man, despite staff being aware that he had previously obtained prescription medicine using a false name. The induction check list (which was created in September 2009, before the issue of both PI 09/2009 and the Humberside Probation Trust policy) requires that the member of staff “check[s]medication … handed in”, but it does not require that a risk assessment is done. It is also unclear from the local Probation Service contact records whether an assessment is done. In order to ensure that ‘medication in possession’ risk assessments are always completed, I make the following recommendation:

    **Humberside Probation Trust should revise the induction checklists to ensure that ‘medication in possession’ risk assessments are completed. The member of staff completing the assessment should also ensure that they make a note to this effect on the offender’s contact record.**

71. Because the man had previously used a false name to try and obtain prescription medication, it seems that the GP practice normally used by residents at Victoria House refused to register him. At Victoria House, most prescription medication is delivered. However, the man took his methadone supervised each day by a pharmacist, and only brought back methadone to

Victoria House each Friday to be issued by AP staff to him over the weekend. (An audit of the medication records by the Assistant Director for Humberside Probation Trust show that the man returned with the appropriate amount of methadone on each Friday while he was resident.)

72. On 26 November, the DIP worker telephoned Victoria House to inform them that he had now been prescribed diazepam. This should have triggered a review of the man's medication and measures should have been put in place to ensure that he handed in the diazepam so that he would take it under supervision.

73. Indeed, the Assistant Director for Humberside Probation Trust has identified several occasions when staff could have realised that the man had diazepam in his possession. These included when they received the information from the DIP worker, when the information was added to the computer records, when the man told Assistant Warden 2 at a keywork session, when Assistant Warden 4 collected his medication on 1 December, and finally during the room search later that day.

74. The man was also prescribed tramadol after his release from Ashwell. It is not clear whether he also had this in his possession.

75. Given his previous issues with prescription medication, the man should not have had diazepam or tramadol in his possession. Following the results of the toxicology report, it is clear that neither of these drugs contributed to his death. However, it is important for the safety of future residents at Victoria House that staff identify when residents have been prescribed medications that they should not have in their possession, and that residents are challenged and are required to hand them in to be issued under supervision.

**Humberside Probation Trust should ensure that staff identify when a resident is prescribed medication, update records appropriately and challenge them when required to ensure that medication is handed in to be issued by staff**

**Overnight checks**

76. When the man returned to the office at 10.50pm on 3 December, Assistant Warden 3 acted correctly in beginning regular observations after he said that he did not want to see a doctor. The checks were made by two members of staff, and they agreed that he could leave a jumper in his door so that they did not need to use a key.

77. It is reasonable, given that they were not too concerned about the man, that Assistant Warden 3 and the Support Worker agreed to the door being left open. However, this did mean that when they checked on him, they relied on hearing him snore rather than visually observing him. It is unclear whether this would have made a difference, but it is possible that they might have seen something which would have alerted them to how ill the man was. I do not make a specific recommendation on this point, but hope that it will be

considered as part of the recommendation below. (In commenting on the draft, the man's sister said that she thought staff should have gone into his room.)

78. During the week, residents are given a "wake up call" at 7.45am. However, this does not happen at weekends. Following the 7.00am check conducted by the Support Worker, the next scheduled check was due at 9.00am. However, it is clear that this check was not made.

79. When interviewed, Assistant Warden 4 confirmed that 9.00am was also the time the second day worker starts their shift. In this instance, that was Assistant Warden 1. Assistant Warden 4 said that the daily handover between staff made 9.00am an "awkward" time for checks. Assistant Warden 4 confirmed that a check was not made and that, during the handover to Assistant Warden 1, she had thought about the man's medication. By the time she had confirmed with the chemist what medication he should have received, it was 10.35am. The Assistant Wardens discussed whether the man might have taken an overdose, and decided that, as he had apparently been fine throughout the night, they would make the next check at 11.00am when it was due.

80. When they made the check at 11.00am, both members of staff believed that the man had been dead for some time. The first responding paramedic confirmed this shortly afterwards. It is not clear whether a check at 9.00am, would have resulted in a different outcome for the man. However, in other circumstances, the outcome might be different.

81. I note that the internal review has already identified that the check at 9.00am was missed primarily because it coincided with the arrival of a member of staff. A recommendation has been made that the Approved Premises manager ensures that checks are timed so that they do not coincide with other events. I welcome this.

82. However, I also note that even when staff realised that the 9.00am check had not been made, they decided wait until 11.00am to conduct the next check. I believe that, given the concerns surrounding a potential overdose, that they should have made a further check immediately. While accepting that work has already been undertaken in this regard, I make the following recommendation.

**Humberside Probation Trust should ensure that all required checks are conducted appropriately and that the checks are sufficient to ensure the welfare of residents where there are concerns**

**Staff debrief**

83. When my investigator interviewed staff, they were unanimous in being happy with the support offered to them. (Indeed, given the weather conditions, I am pleased that senior managers at Humberside Probation Trust proved flexible in their response and ensured that staff were supported shortly after the man

was found, despite it being a weekend and the Duty Manager being unable to get to Victoria House.)

84. However, while the staff were supported as individuals, they were not given an opportunity to discuss the man's death as a group. Guidance for staff following a death in an AP is given in Annex 12A of the Approved Premises Handbook. In the section entitled "over the next few weeks", managers are advised to "At the appropriate time, seek to arrange a de-briefing for all staff and residents, to try and mark a formal close to the incident." On this occasion, such a debrief did not take place.

85. Although staff were supported, and the Trust undertook a comprehensive review following the man's death, on other occasions some learning might have been missed. Often, when people recollect events in a group, other information emerges that could prove vital to ensure safety in the future. As such, I make the following recommendation:

**Humberside Probation Trust should organise a debrief meeting for staff following any future deaths in Approved Premises**

**The man's property**

86. The man's sister asked the investigator to find out whether all of his property had been returned to her, as she did not receive any photographs, letters or a mobile phone. The Assistant Ombudsman has asked staff at the Approved Premises, the Police and the Coroner's Officer, but has been unable to trace any further property for the man. However, the man's sister has, since the issuing of the draft report, confirmed that the Police have found some further property and will be returning this to her.

**Other family concerns**

87. The man's sister also asked about the outstanding court case with which he was involved, and was interviewed about by the Police on 30 November 2010 at The Granary, Scunthorpe. The Family Liaison Officer suggested that the man's sister spoke to his solicitor about this, and I hope that she has been able to find out how this enquiry has progressed.

88. The man's sister further asked what the consequences of a failed drugs test might be. The man failed a drugs test on 1 December 2010, following the appointment with the Police. The Assistant Ombudsman asked the man's Offender Managers, about this when he interviewed them on 8 February 2011. The offender manager recalled that, because of the snow, he was unable to get to Scunthorpe, and that he told staff at Victoria House that he would speak to the man about the failed drugs test on the following Monday (6 December). The second offender manager thought that the likely outcome of the failed drugs test would be a warning from the local Assistant Chief Officer.

**CONCLUSION**

89. The man had been a long-term user of drugs, and was prescribed methadone, when released from HMP Ashwell on 10 November 2010. As part of the conditions of his release, he was required to reside at Victoria House Approved Premises in Scunthorpe.

90. He was seen daily by staff at Victoria House, and during the week by his offender managers. He appeared to be making progress and, despite a relapse shortly after his release, seemed determined not to take illegal drugs. However, he failed another drugs test on 1 December, the day after attending a long interview with the Police about a matter in which he was a potential victim of abuse.

91. On 3 December, staff at Victoria House noticed that the man was slurring his words. He returned to the office, and said that he thought he might have taken two doses of methadone. Staff asked if he wanted to see a doctor, but he declined. Nonetheless, one of the night duty staff arranged for checks to be made on him every two hours.

92. However, the check at 9.00am was not made, as staff were conducting a handover. When the next check was made, at 11.00am, the man was found dead. A post mortem and toxicology report found that he had died from a methadone overdose.

93. I conclude that staff at Victoria House acted appropriately on 3 and 4 December. Although a check was missed at 9.00am on 4 December, I think it is unlikely that this would have made a difference to the outcome. However, I have made a recommendation to ensure that checks are always made at the required time. I have also made recommendations regarding how medication is dealt with at Victoria House, and that staff should be debriefed fully after a death.

## RECOMMENDATIONS

1. Humberside Probation Trust should revise the induction checklists to ensure that 'medication in possession' risk assessments are completed. The member of staff completing the assessment should also ensure that they make a note to this effect on the offender's contact record.

   In response to the recommendation, Humberside Probation Trust replied: HPT has reviewed the Approved Premises Induction Process and in accordance with PI 09/2009 staff have been instructed to undertake a risk assessment and ensure the outcome of this assessment is recorded. In respect of the deceased, the Approved Premises manager confirmed that given his substance misuse history, and the nature of his prescribed medication, the 'medication in possession' process was implemented albeit not recorded on Crams. The subsequent internal investigation conducted by the Assistant Director, identified a number of improvements to the 'medication in possession' process including amendments to the MED 1 and MED 2 forms to ensure more accurate recording of information and staff sign off, which have all been implemented.

2. Humberside Probation Trust should ensure that staff identify when a resident is prescribed medication, update records appropriately and challenge them when required to ensure that medication is handed in to be issued by staff

   In response to the recommendation, Humberside Probation Trust replied:

   In addition to the review of the induction and amendments to the 'medication in possession' process in accordance with PI 09/2009, HPT has implemented a new protocol with the Drugs Intervention Programme in North Lincolnshire to ensure timely and accurate information exchange is undertaken in a robust and auditable manner, where the Approved Premises has responsibility for the management and safe-keeping of a controlled drug.

   A new process has been introduced to ensure any changes to prescribing are accurately recorded and shared with staff during handover sessions.

3. Humberside Probation Trust should ensure that all required checks are conducted appropriately and that the checks are sufficient to ensure the welfare of residents where there are concerns

   In response to the recommendation, Humberside Probation Trust replied:

   HPT has reviewed arrangements for conducting health checks on residents and issued an instruction that required checks are scheduled to avoid coinciding with handover arrangements. Staff have also been instructed to ensure they enter rooms and check residents during required checks.

4. Humberside Probation Trust should organise a debrief meeting for staff following any future deaths in Approved Premises

In response to the recommendation, Humberside Probation Trust replied:

A de-brief meeting was in fact held. HPT, as stated in the Prison and Probation Ombudsman's report, ensured that support was provided to staff both on the day of the man's death and subsequently. A detailed internal investigation was expedited and reported in February 2011. The terms of reference of this investigation also included consideration regarding possible capability or disciplinary issues. Because of this a group de-brief was not undertaken until the outcome of the investigation, which concluded that no disciplinary action was warranted. A de-brief meeting was held after that. However, staff have said that they would have welcomed an earlier de-brief, so HPT will ensure that one is held immediately following any future deaths of AP residents.

Humberside Probation Trust also offered some general comments on the report:

HPT expedited a rigorous internal investigation into the tragic death of the man which was completed in February 2011. A copy of this report is attached and clearly identified a number of the issues raised in the Prison and Probation Ombudsman's report. An Action Plan to address the learning points identified has already been implemented, and is currently under review and subject to audit.

HPT welcomes the Prison and Probation Ombudsman's report conclusion that staff at Victoria House acted appropriately on 3 and 4 December and that although a check was missed at 9.00am on 4 December it is considered unlikely that this would have made a difference to the outcome.

The man received an enhanced level of contact with the Prolific and Priority Unit in Scunthorpe well in excess of national standards given his prolific and priority status. In addition he was very closely monitored by the Drug Intervention Programme specialist staff on release from custody.

The Prison and Probation Ombudsman's report also refers to the man's sister requesting information regarding the investigation into allegations of abuse experienced by him as a child whilst in residential care. The Director of Probation has recently received an update from the Humberside Police Investigating Officer in respect of this matter and confirmed that they will update the man's sister.