

**Investigation into the circumstances surrounding the death
of a man on 22 April 2005
at an Approved Premises under the
management of the Greater Manchester Probation Area**

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

July 2005

This is the report of an investigation into the circumstances of the death on 22 April 2005 of a man whose probable cause of death was a drug overdose. It was well known that he had a long term history of misusing drugs.

The man was released from HMP Holme House to the Approved Premises. The prison and Greater Manchester Probation Service had worked together with him to make plans for his return to the community. His arrival at the approved premises went smoothly, and he was welcomed by one of the Assistant Managers who gave him a comprehensive induction. He went out of the hostel soon afterwards but sadly died later that evening.

Since 1 April 2004, my office has been responsible for investigating all deaths of approved premises residents, including those due to natural causes. The Assistant Ombudsman conducted this investigation with the assistance of an investigator from my department.

A clinical review into the man's healthcare needs was conducted on behalf of Central Manchester Primary Care Trust. I am grateful for the clinical reviewer's assistance, especially as it is not customary for such reviews to be undertaken following deaths in approved premises.

I would like to extend my condolences to the man's family and friends for their loss. They have expressed disappointment with the services offered to him on release, which they consider were not adequate for him to overcome his heroin addiction within the community. However, along with the investigation team and the clinical reviewer, I have been struck by the extent of the multi-disciplinary resources and planning that went into his release. I do not believe that there were any deficiencies. My sympathies are therefore also with those responsible for his resettlement planning. They too are disappointed that he did not achieve all that they had hoped.

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Summary

- 1 Between the age of 18 and his death, the man had been convicted of many offences and been sentenced on 23 occasions, including nine periods in custody. He also received financial and community penalties, on some occasions breaching their conditions and being sentenced again. By the definition of the police, courts and probation service of Greater Manchester, he was identified as a prolific offender and thus the intensive multi-disciplinary resources of the Operation Rhodes prolific offender project were made available to him. Operation Rhodes is the project which works in the borough where his home town is situated. Its members include probation, police and nursing staff who work together to try to help offenders deal with their drug use and so reduce their offending. Offenders who have served sentences longer than 12 months are eligible. They have four appointments with their supervisors each week, including a weekend home visit and fast tracked medical appointments.
- 2 On 27 May 2004, the man was convicted of robbery from a shop and sentenced in September to 15 months imprisonment which he served at HMP Manchester. He was referred to the prison's Counselling, Assessment, Referral, Advice and Throughcare (CARATS) team and plans were made for his release on licence on 19 November to another Approved Premises. He breached the conditions of the licence which was revoked seven days later and he was recalled to prison.
- 3 The man's recall to prison took place on 26 November. He was located initially in Manchester, but was transferred to HMP Holme House on 2 March 2005. The prison records include a number of adjudications and one positive drug test. Again the CARATS team worked with him, and again the probation area arranged accommodation in one of their hostels and supervision by Operation Rhodes.
- 4 He was released from Holme House on 22 April, with a condition of residence at an approved premises. He made his own way from the prison to the probation office in Oldham, from where he was taken by probation staff to the approved premises, arriving at about 4:00pm. He was welcomed by the Assistant Manager on duty, and made himself a drink before the induction interview was carried out. He then left the building, saying that he was going to see his children. Later that evening, the police contacted Chorlton Hostel to enquire about residents as a body had been found nearby. It was later identified as that of the resident of the approved premises. His death was the result of using excessive amounts of heroin.

Background

The man

- 5 He was born 5 April 1974 in Oldham and was 32 years old when he died. He had had a long term relationship, but regrettably the relationship failed though he did keep in contact with his twin sons. His next of kin was recorded as his elderly grandmother, and his sister has also been attending to his affairs.
- 6 His criminal record dates back to April 1992 and, by the time of his death, he had 23 convictions mostly for acquisitive crimes committed to finance his drug misuse. He served many custodial sentences and had also had an earlier admission to another hostel in Greater Manchester.

The approved premises

- 7 Approved Premises, formerly known as Probation and Bail Hostels, are approved by the Secretary of State within Section 9 of the Criminal Justice and Court Services Act 2000. They provide accommodation for people granted bail in criminal proceedings and also supervision and rehabilitation for people convicted of offences. Hostels can provide a supportive, structured environment in the community for high risk and difficult to manage offenders. The purpose of the period of residence is to ensure that the individuals concerned are subject to close oversight in the community. Their supervision within the approved premises is governed by the National Probation Service's Standards for the Supervision of Offenders.
- 8 Referrals to the approved premises are evaluated by a Central Admissions unit and the senior probation officer there decides whether or not a place can be offered. There is no contact between the staff at the hostel and a prospective resident until the day that they arrive, and all contact is by their home probation officer who retains responsibility for supervision during the period of residence.
- 9 The approved premises is one of seven in Greater Manchester. The probation area has a specialist senior manager over all the approved premises, with managers and other staff for each hostel. At the time of the man's death, the manager of this approved premises was also the manager of another located on the other side of the area. That arrangement changed shortly after the death but was not related to it. There is a deputy manager, and four assistant managers, one of whom was on duty on the day that the man arrived and later died.
- 10 The approved premises is situated in a pair of large houses, and in a large, well maintained garden. It provides accommodation for 27 male residents. The houses have been adapted in order to meet the requirements of residents and staff, and were about to be extensively refurbished. Some residents have single rooms, and others who have

just arrived share double rooms. In the domestic areas of the house there are several lounges, television, dining area, laundry and tea and coffee making facilities. Breakfast and dinner are provided each day. A doctor is available locally. The hostel has links with a number of community organisations including a local college that provides a computer-training course and a basic skills assessment programme. At night time a night supervisor is on duty and awake all night, with an assistant manager who goes to bed.

- 11 Unless subject to specific curfew arrangements imposed by a Court, all residents must be on the premises between the hours of 11:00pm and 7:00am. No alcohol or non-prescribed drugs are allowed on the premises and the possession and taking of prescribed medicines must be carried out in accordance with premises' policy.
- 12 The approved premises has a well established routine for inducting new residents which is carried out by whichever assistant manager is on duty at the time. It is good practice that a guidance document has been developed for staff to use which ensures that they provide a consistent induction for all residents. The document reminds staff to inform new residents about the rules regarding the use of drugs, but it does not give any advice about the risks, especially to residents who have just been released from prison who may have reduced tolerance levels. The induction follows a script and usually consists of two interviews, which are completed by signing the resident's contract which is comprehensive and written in Plain English. The contract includes the requirement that residents:
 - Don't use alcohol and/ or other substances to a level that stops you taking part in hostel routines and has a bad effect on you, other residents and staff.
 - Alcohol, illegal drugs, gases, solvents and drug using items are not allowed in the hostel or its grounds.

Conduct of the Investigation

- 13 The investigation was opened by one investigator and then handed over to two investigators from the PPO department. They studied all the records from Holme House, including those for the healthcare and drug advice teams. They also studied the records from the Probation Area, including those from the approved premises. Interviews were conducted with hostel staff, the Operation Rhodes team and the Burglary and Drug Reduction Co-ordinator from the Crime and Disorder Partnership.

- 14 It is not usual practice for clinical reviews to be requested following deaths in Approved Premises. However, in this case the investigators identified questions about the medical aspects of the man's resettlement plan and so commissioned a review which was carried out by the North West Regional Prison Health Development team.

Key findings

Prior to 22 April

- 15 The sentence which the man was serving at the time of his death was imposed on 9 September 2004. On 18 December 2003, he had committed a robbery from a shop and had been convicted of the offence on 27 May 2004. A report was prepared by a Probation Officer, which described his long standing history of drug use which resulted in the breakdown of his relationship and long term offending to fund his habit. He did not have a fixed address and, although he was in contact with his sister and grandmother, neither could offer him anywhere to live. The report recommended a Community Rehabilitation Order with conditions of residence at an approved premises and supervision by Operation Rhodes. He was remanded for assessment for the recommendation but breached the conditions.
- 16 The man was sentenced to 15 months imprisonment and was located at Manchester prison. The First Reception health screen referred him to the prison's detoxification wing. On 4 November he tested positive in a Mandatory Drug Test for opiates. He was released on licence two weeks later on 19 November with the condition that he live at another Approved Premises.
- 17 The man did not conform to the conditions of the licence and it was revoked on 22 November because:
 - (i) he failed to wait at the prison for collection by probation staff
 - (ii) he refused an opiate blocker because he said he had taken illegal drugs
 - (iii) he failed to notify the address for a weekend home visit
 - (iv) he failed to attend the Drugs Service on 22 November.
- 18 He was recalled to prison the same day and again located in Manchester. On 8 December, he agreed to transfer to HMP Risley but, when he arrived there, he refused to get off the bus and was returned to Manchester. On 19 December, the man was placed on Stage 1 of the prison's anti bullying procedure as he had assaulted another prisoner, and this remained open until 15 January 2005.
- 19 The following month on 5 January 2005, the man was escorted between two places. The Prisoner Escort Report (PER) for the journey refers to the prison's suicide and self harm monitoring procedure, the F2052SH form, having been open during an earlier sentence between 19 and 22 December 2003. This in turn refers to an earlier F2052SH in 1998, which was closed after the man stated at a review meeting that it had been opened by the escort company following what he described as a silly comment he had made to the police. Another F2052SH was opened between 30 June and 5 July 2004 when he was at HMP Forest Bank and complained about threats from other prisoners. There were

no other references to risks of suicide or self harm. This history was confirmed at the request of the Central Admissions unit, before his place at the approved premises was approved.

- 20 On 19 January, the man was found in possession of opiates and a mandatory drug test on 26 January gave a positive result for opiates. He was placed on a prison disciplinary charge which was proved, and 18 days were added to his sentence. Another drug test on 29 January was negative.
- 21 On 8 February, the man was placed on another disciplinary report for using threatening, abusive or insulting words or behaviour. He was sentenced to five days confined in his cell, which was suspended for three months. He was placed on the prison's basic regime from 20 February, which meant that he had fewer privileges and less time to associate with other prisoners. He was transferred to Holme House on 2 March; having been found fit for transfer by healthcare staff, and his involvement with their CARATS team began soon after his arrival.
- 22 A Probation Service Officer (PSO) from Operation Rhodes was allocated to provide day to day support for the man and liaise with other team members. She visited him at Holme House on 7 April and, because he was to receive the support offered by Operation Rhodes, she was accompanied by another team member who was a police officer. They were joined by a member of the CARATS team. In interview with the investigation team, the PSO described the meeting with the man as very productive, and said that she thought he was determined to make a success of his release. At the meeting, the man was informed of the rules of the approved premises and the implications of breaching them. It was agreed that he would be prescribed naltrexone prior to and after his release. This is a legal drug which is prescribed to someone who is drug free and has the effect of blocking any effect from taking opiates. The prescription would usually begin about ten days prior to release.
- 23 Holme House ran Job Weeks and the man attended on weeks beginning 11 and 18 April. He prepared a curriculum vitae in which he said that he had completed basic training in the Army in 1995.
- 24 He was due to attend the prison's healthcare on 15 April to give a urine sample, but failed to attend and it was reported that he had used subutex on the wing the previous day. On 21 April, the day before he was due to be released, the CARATS worker informed the PSO that naltrexone was not administered as he had used subutex whilst in the prison. The man was refused permission to return to visit Holme House following release because there was evidence from security intelligence that he had been involved with illicit drugs or that he might have smuggled drugs or other articles into the prison. This condition was imposed as a result of security reports in January concerning drug

use, abuse of telephone calls, concealed items in letters, using other prisoner's telephone PIN numbers and having drugs in his property.

22 April 2005 and afterwards

- 25 The man left Holme House on 22 April and his licence included the conditions that he had to:
- (i) report to the Probation Office
 - (ii) participate in Operation Rhodes
 - (iii) live at the approved premises.
- He was given a two day supply of amitriptyline, which is an anti-depressant. He was also given a travel warrant to Manchester, and discharge grant of £46 plus a cheque for £50 for the weekly rent.
- 26 At about 2:00pm, the man arrived at Hyde Probation Office as requested and met the PSO and a different policeman who was also a member of the Operation Rhodes team. They told him the times for his supervision appointments, gave him a diary to record the appointments, and a bus pass. They then drove him across Manchester to the approved premises.
- 27 The man arrived at the hostel between 3:30pm and 4:00pm, and was greeted by the assistant manager (AM) on duty at the time. The assistant manager invited the man to make himself a drink and left him for about half an hour, checking on him once in that time. Because the man had been in another approved premises previously, the assistant manager realised that he would be familiar with the rules and so suggested that both induction interviews were combined. The man agreed to this suggestion. The AM read the rules and contract to him, and said that he gave additional explanations to make sure that he understood. The man told him that he had not used drugs prior to being released, had come out clean and intended to stay clean. The AM told the investigation team that, although it was not part of the standard induction, he was aware of notices to residents which referred to impure heroin in the neighbourhood. He decided to draw them to the man's attention. This was good practice on the AM's behalf. The man then signed the contract and the entire induction checklist was completed, the interview ending just before 5:00pm. The man told the AM that he would stay for the evening meal, but quickly changed his mind and went out.
- 28 When he was interviewed by the investigators, the AM described the man as a happy, bubbly and positive person. He had asked him whether he had any thought of harming himself and been told that he did not. The man said that the anti-depressants he had brought with him were to help him sleep, and he was intending to ask the doctor to help him reduce the dose. He handed the cheque and medication in before leaving the approved premises at about 5:00pm.

- 29 At 9:30pm a man, later identified as the resident of the approved premises, was found dead outside a house around the corner from the hostel.
- 30 The AM remained on duty at the approved premises all evening. At 11:00pm he carried out the curfew check and discovered that the only resident who was missing was the man who had arrived that afternoon. The AM said that he got the man's file out of the cabinet, as he intended to consult the duty senior probation officer. By coincidence the duty senior probation officer was the manager or senior probation officer (SPO) for the approved premises. Before he had chance to make the call, the police telephoned the approved premises to enquire whether any residents were missing. The AM informed the police officer that the man was missing, and then telephoned the SPO to tell him.
- 31 In the early hours of the morning of 23 April, the police visited the approved premises to confirm the death, and they took responsibility for informing the man's family. He had named his grandmother as his next of kin, and so the police went to the sheltered housing where she lived. The warden advised the police that she was elderly and in poor health. The hostel located the contact details for the man's sister and she was informed.
- 32 The AM was asked by the police to identify the man, but declined on the advice of the SPO as it would have meant leaving one member of staff alone in the building which would not have been acceptable.
- 33 The man's family went to the hostel at about 2:00pm on 23 April, to ask for more information about his death and to collect his belongings. At the time his belongings had not been checked by staff, and could have been required by the police, and so the request was refused.
- 34 On Monday 25 April, the deputy manager, confirmed with the police that the property could be released and he examined it before taking it to the man's family. The SPO discussed the visit with him before he went and satisfied himself that appropriate safeguards were in place.
- 35 In the course of the week after the man's death, senior managers from the probation area contacted the SPO by telephone, and visited the approved premises to ask about the welfare of hostel staff and offer their support. The SPO also spoke individually to the staff on duty on the night that the man died. Most of the staff interviewed considered that these arrangements more than met their needs. However the deputy manager commented that, on previous similar occasions, staff received individual letters from senior managers, rather than all offers of support coming via line managers. It is suggested that, in future, staff receive an individual letter, giving confidential access to support and that letters are sent to all staff regardless of whether they knew the deceased.

Conclusion

- 36 The clinical review commends the CARATS staff at both Manchester and Holme House prisons for their active role in attempting to help the man. It also comments that the man himself participated in their programmes, making the majority of referrals himself. The review goes on to include a number of recommendations to healthcare staff at Holme House, which I endorse. The recommendations are set out in full in the review.
- 37 It is my view that the staff of Operation Rhodes also established full and detailed release plans for the man. They made effective use of the considerable resources of the multi-disciplinary project. However, it is not apparent that they were aware of all of his conduct at Holme House and they were certainly unaware that he had been prescribed anti-depressants.
- 37 The investigation team were impressed with the staff at the approved premises who dealt sympathetically, skilfully and professionally with the man when he was alive, and then fully implemented the necessary in response to his death. The AM was the senior member of staff on duty at the time. He had considerable experience of working in hostels but had only been in his current position since December 2004. His induction did not include training on dealing with deaths in approved premises, but he knew where the relevant procedures were located and was able to put them into place. It would be good practice if future induction programmes for new staff included such information, together with consideration of the emotional aspects of the role.

Good Practice

- 38 It is suggested that the Chief Officer of Greater Manchester Probation Area commend the Assistant Manager at the approved premises, for his comprehensive and sensitive induction interview. He followed the checklist for induction interviews, and provided additional information about impure drugs circulating in the neighbourhood.