

**CIRCUMSTANCES SURROUNDING THE DEATH OF A MAN AT A HOSTEL IN THE  
NOTTINGHAMSHIRE PROBATION AREA ON 5 FEBRUARY 2006**

**REPORT BY THE PRISONS AND PROBATION OMBUDSMAN FOR  
ENGLAND AND WALES**

**AUGUST 2006**

This is the report of an investigation into the death of a man, who died aged 36 in his bedroom at a hostel in the Nottinghamshire Probation Area on 5 February 2006 (hereafter referred to as 'Hostel B'). He died six weeks after his release from prison on licence. The post mortem and toxicology reports indicate that the cause of death was a drug overdose consistent with a fatal intake of heroin.

I would like to offer my sincere condolences to this man's family and friends on their loss. I know that the staff and residents at this hostel and at his first hostel (hereafter referred to as 'Hostel A') share those sentiments.

The aim of my investigation was to discover whether the level of care provided by the Approved Premises was appropriate, and whether any lessons could be learnt to help prevent a similar death in the future. An investigator from my office carried out the investigation. I am grateful for the co-operation she received from all at Hostel B and from the Manager of Hostel A and from the man's Probation Officer.

This report raises issues regarding the monitoring of the use of medication, especially by offenders with a history of drug abuse. This has significant implications for public protection. I am also concerned by the delays in informing the man's family of his death. I make four recommendations and highlight three examples of good practice.

**STEPHEN SHAW CBE  
PRISONS AND PROBATION OMBUDSMAN**

**August 2006**

## **Contents**

Summary	4
The investigation process	5
The man himself	6
Approved Premises	7
<i>Hostel A</i>	7
<i>Hostel B</i>	7
Events leading to the man's death	9
Events after the man's death	13
Issues considered during the investigation	14
Conclusions	16
Recommendations and Good Practice	17

## Summary

1. The man at the centre of this report was born in 1969. He was 36 years old when he died in his bedroom at Hostel B on 5 February 2006. Post mortem and toxicology reports indicate that the cause of death was an overdose of heroin.
2. He had previously served three short prison sentences. His last sentence had been the longest. He had been convicted on 11 December 2003 and on 16 January 2004 was sentenced to 30 months imprisonment. He was initially held in HMP Nottingham then transferred to HMP Ranby on 10 February 2005. He was released on licence from Ranby on 10 March 2005.
3. On 16 July 2005, the man was recalled to prison for breaching his licence conditions. On 23 December 2005, he was re-released from Nottingham prison. One of the conditions was to reside at Hostel A in the Nottinghamshire Probation Area; another was to address his substance misuse. He also attended a clinic for those with drug and alcohol problems. He regularly attended this clinic for support, drug tests and his naltrexone prescription which was part of a detoxification programme.
4. Hostel A has a strict policy that no drugs may be used by residents. However, the man tested positive for heroin on several occasions and this was the main reason for his move to Hostel B on 26 January 2006. This is a drugs managed site which works with residents in an effort to stop misusing drugs.
5. Hostel B is in the Radford area of Nottingham. The man was familiar with this area and this was where he had committed some of his offences. He therefore felt vulnerable, and it was later agreed that he would transfer back to Hostel A.
6. Whilst a resident at Hostel B, the man reportedly kept himself to himself, either staying in his room or being away from the hostel. He had more social interaction while at Hostel A. Reports from both hostels describe him as being a friendly, polite and helpful man.
7. The night before he died, the man returned to the hostel just before curfew. He looked slightly 'blotchy' and staff suspected he might have been drinking. However, he was coherent and did not present any problems.
8. On the morning of Sunday 5 February 2006, during curfew checks, staff found the man in his room. He was 'slumped' over his bed and unresponsive. An ambulance was called immediately. Both members of staff on duty were first aid trained and began putting the man into the recovery position. Whilst moving him, the paramedics arrived. As soon as they reached the room, the paramedics realised the man had passed away and pronounced him dead at 7.59am.

## The Investigation Process

9. My investigator visited Hostel B on three occasions. She interviewed several members of staff as well as the Senior Officer at Hostel A and the man's supervising Probation Officer. She also visited HMP Nottingham to gather information from his prison records.
10. Information was sought from the clinic he attended in Nottingham. The coroner's office and police were also consulted.
11. The terms of reference for the investigation and notices to staff and residents were issued. The investigator was given unrestricted access to the man's records and to the Approved Premises.
12. One of my Family Liaison Officers spoke to the man's mother to ask if she wanted to raise any concerns about her son's care whilst in the Approved Premises. The following matters were raised:
  - She would like information about what happened to her son between leaving prison and his death;
  - She was upset about her son's clothing being laundered prior to her collecting them, as she understood from a letter received from the Area Deputy Director that nothing in his room would be touched;
  - She wonders why, when her son was found at 7.35am, she was not informed of his death until 3.45pm.
13. A draft of this report was sent to the man's family and Nottingham Probation Service to enable them to make any comments. The family has not requested any comments to be included in the final report. Nottingham Probation Service's response to recommendations is included in the recommendation section.

## **The man himself**

14. He was born in 1969 and raised in Cheshire, and was aged 36 when he died.
15. Reports of interviews with the man describe him previously living with friends in an environment where he was vulnerable to peer pressure and which involved drugs and crime. He apparently travelled abroad to escape from this. When he returned to England, he settled for a time in the South West where he formed a relationship and had a daughter. The relationship had ended and his ex-partner and daughter moved abroad.
16. The man had worked for building companies as a plasterer and installing double glazing. His last job had been in the South West, selling magazines. The job ended a few years ago and he had been both unemployed and homeless since that time.
17. During this period, he became involved with a homelessness charity that helped him apply to a charity-run local detoxification unit in Nottingham. The man arrived here in November 2002. Whilst there he became very ill and was admitted to hospital for treatment for endocarditis, an infection of the heart valves. His condition was exacerbated by drug use and he subsequently spent several periods in hospital for treatment for this and for septicaemia.
18. The man had been a habitual drug user since he was 21 years old. His main drug was heroin, used intravenously. He also misused cocaine and alcohol.
19. Housing was again a problem for the man upon his re-release from prison. However, as a condition of his licence, he was required to reside at Hostel A for the remaining six months of his sentence. During this time, his future housing needs were to be addressed. Prior to his death, several housing applications had been made to relevant agencies.

## **Approved Premises**

20. Approved Premises were formally known as Probation and Bail Hostels. They are approved by the Secretary of State within section 9 of the Criminal Justice Act 2000. Approved Premises provide a supportive, structured environment in the community for high risk and difficult to manage offenders. The management of those accommodated in Approved Premises is governed by the National Standards for Supervision of Offenders and the guidance contained in the National Approved Premises Handbook.
21. The purpose of Approved Premises is to provide an enhanced level of supervision for some of the most difficult and high-risk offenders in the community. They are not principally an accommodation resource.
22. It is Approved Premises procedure that, in the event of a death at the premises, the police are called. The Approved Premises staff will notify the police of next of kin details and the police are responsible for informing the next of kin.

## **Hostel A**

23. Hostel A is one of three Approved Premises managed by Nottinghamshire Probation Area. It is made up by two detached houses linked by a garage. It is set in a residential street and has a capacity for 14 residents. There are eight bedrooms, six of which are doubles and two singles.
24. Hostel A is a catered premises, providing breakfast and one cooked meal a day. The accommodation charge payable by residents is £22.56 per week.
25. The hostel has a strict no-drugs policy and residents are subject to drug testing. They have a test within 24 hours of arriving at the hostel, and then as required in consultation with their probation officer. 'Suspicion' testing can be carried out if a resident is suspected to be using drugs. Residents who are illegally using drugs risk their place at the hostel.

## **Hostel B**

26. This hostel is another of the sites managed by Nottinghamshire Probation Area. It is a large detached house on three floors, situated in the residential Radford area of Nottingham, and can accommodate 18 residents. Their main focus is on high risk offenders although they do accept offenders on bail. Residents are subject to community penalties or prison licences. Residents must be over 18 years of age.
27. At Hostel B there is a curfew from 11:00pm to 7.30am. Staff physically check all residents' rooms and speak to each resident in occupancy at both these times daily. There are also two hostel checks daily. As well as confirming the welfare of residents, these additional checks are intended to ensure that rooms are being used properly and that no banned items are being held in possession.

28. The hostel is a self-catering premises and residents have access to a kitchen. There is one kitchen to two residents, situated on the same floor as their bedrooms. The accommodation charge payable by residents is £5.18.
29. Closed circuit television (CCTV) has recently been installed, monitoring the main communal areas of the hostel including the kitchens as well as the offices. However, this was not in place whilst the man was a resident. The monitoring screens are fitted in the Deputy Manager's office which is not in constant use. As a consequence, the CCTV is not continuously monitored.
30. Each new resident is given an information booklet which outlines information about the Approved Premises and the hostel rules. Hostel B is a drugs managed site and Illicit drugs and drugs paraphernalia are not allowed on the premises. Staff have the authority to search a resident's room if it is suspected that they are breaking the hostel rules. Residents are also subject to random drug testing.
31. Residents' medication is securely stored within the office. It is handed to residents by staff according to the medication instructions. Each resident has a drug dispensing chart which a member of staff signs when the medication is dispensed. The Approved Premises Handbook states that it remains the residents' responsibility to collect and take the medication. There are no official means of monitoring and following up any missed medications.
32. Each resident has a dedicated keyworker to assist in meeting their specific needs. Keyworkers hold regular one-to-one meetings with their residents, and liaise with other agencies and the resident's probation officer to monitor and facilitate as appropriate the residents' reintegration back into the community and to address specific needs.
33. The staffing complement is:
- one Senior Probation Officer (Manager)
  - one Deputy Manager
  - one full time administration assistant
  - six Approved Premises Officers (formerly Resident Social Workers)
  - four waking night staff

There is a minimum requirement for two staff to be on duty at all times.

## Events leading to the man's death

34. This man was released on licence from HMP Ranby on 10 March 2005. His licence was revoked and he was returned to prison on 16 July. He was granted release on licence on 23 December 2005, with the extra condition to reside at Hostel A in Nottinghamshire for the remaining six months of his sentence.
35. He was supervised by his probation officer as part of the Prolific Offender Programme (POP). This manages prolific offenders and offers a more intense and structured monitoring regime. The man was required to tackle his substance misuse, and apply for accommodation, education and skills training. The man took this opportunity to become involved in sporting activities run by the POP team.
36. Through the programme, the man attended the local clinic for those with drugs and alcohol problems. He was already known to the clinic, having been in contact with them previously. He attended on 23 December 2005 (the day of his release) when it was arranged that he would receive a naltrexone (blocker) prescription to help him stop his drug use. On the way to the appointment, he disclosed to staff that he had used illegal drugs two days prior to his release from prison. Because his drug test was positive, he was prevented from commencing the naltrexone medication and was asked to return at a later date. The POP team then gave him a lift to Hostel A.
37. The man returned to the clinic on 3 January 2006. His drug test was negative and he was offered the naltrexone prescription. Because he had a history of kidney problems, he received a reduced dose of 25mgs of naltrexone daily, rather than 50mgs, and was to continue to have liver function tests. The man was informed about the effects of naltrexone and was warned about the risks of overdose.
38. The man soon settled into the regime of Hostel A and was described as pleasant, courteous and helpful both to staff and other residents. Unfortunately, despite the detoxification programme, he still used illicit drugs on several occasions. He was warned that to remain at Hostel A he needed to produce negative drug tests or he would lose his place.
39. The manager of Hostel A (a Senior Probation Officer) and the man's Probation Officer thought that the man was meeting the objectives set for him, and so were not keen to have to revoke his licence if he lost his place at Hostel A. However, towards the end of January, a space was needed at Hostel A for another offender. After much consideration, the man was selected to move out. He was continuing to use drugs, which was against the hostel rules, but was thought to be progressing well enough to be able to adjust to the move.
40. The man arrived at Hostel B at approximately 9.15pm on 26 January 2006. It is not clear why it was so late in the day, however he had attended POP activities during the day and was still within his curfew. Due to the late hour, the man did not undergo a full induction. However, he did sign the hostel rules. It was noted when he arrived that he smelled of alcohol. It was decided that staff would raise this matter at his induction the following day. The man did not take his naltrexone on 26 January.

41. On 27 January, the man went out of the hostel and failed to attend the induction meeting. He returned later, apologised and was given a slip to remind him to attend an appointment at 4.00pm that afternoon. He failed to attend this appointment and again did not take his naltrexone.
42. For the rest of that day and the next, the man had minimal contact with the staff. On 30 June, he was questioned about not attending his induction appointments and attended later that day. The man was not used to the self-catering practice at Hostel B and was concerned that he did not have enough money for food. Hostel staff were able to offer some food and also gave him a letter so that he could get a food parcel from the Salvation Army.
43. The man then left the hostel and returned at 11.20pm which is past the curfew of 11.00pm. He was issued with a verbal warning and his probation officer was informed.
44. On 31 January, the man's probation officer received a call from the clinic for those with drug and alcohol problems. They believed that the man was not taking his naltrexone prescription and did not want to prescribe more as they did not believe he was cooperating with the treatment plan. At the time he was in possession of a two week supply. It was agreed that this would be discussed the following day with the man at a scheduled three way meeting at the hostel between himself, his probation officer and a member of staff from Hostel B.
45. At the meeting on 1 February, the man discussed how he was finding the change of hostels quite stressful. He was used to having a meal cooked at Hostel A and did not know anyone at Hostel B. He was advised to try and mix with the other residents to help him adjust. His housing issues were discussed and he was told he had an appointment with one agency the following week. There is no mention of the naltrexone prescription in the notes of the meeting. However, his probation officer is sure it would have been discussed, but had not been minuted. That evening, when being given appointments, the man became confused about what he had to do. It was agreed that he would attend the office first thing in the morning to sort his appointments out. He then failed to attend the office the following morning.
46. The man returned to the hostel late that evening. Whilst speaking with the staff, he mentioned that he had arranged to go on a kayaking trip with Traffic Street (Community Services Probation team), which is part of the Prolific Offender Programme. He took his naltrexone that night, which was the second and last time he took it whilst at Hostel B, the other occasion being on 28 January.
47. The man also told staff that he felt more vulnerable at Hostel B than at Hostel A. It appears he was concerned about being in the area where he had committed some of his offences and had associates. He had not interacted as much with the residents at Hostel B and felt isolated. He was also struggling with the self-catering aspect of the hostel. The man's probation officer was worried that he was not yet ready for such independence.
48. On 3 February, a place had become available at Hostel A and the manager of this hostel contacted the man's probation officer. In consultation with the managers at Hostel B, it was agreed that it would be beneficial for the man to return to Hostel A. The fact that he was still not drug free was discussed and it

was agreed that he needed to provide a negative drug test by the following week to keep the place. The man himself was out on the kayaking trip, but his probation officer was able to contact him to inform him of the move and explain the importance of a negative drug test. The man was happy about the planned move back to his original hostel.

49. The Deputy Manager at Hostel B waited in until approximately 6.30pm on 3 February so that he could take the man to Hostel A. However, he had not yet returned since leaving in the morning for the kayaking trip. The Deputy Manager liaised with the Hostel A Manager to say that they would pay for a taxi or that he would take the man on Monday 6 February.
50. The man returned late that evening and said he would wait until Monday to move. This may have been because he was waiting for his Giro cheque to arrive at Hostel B the next day.
51. On Saturday 4 February the man was visited by two other men. Visitors are not allowed into the premises until 10.00am, so he sat outside with them until this time when they all entered the premises together. Approved Premises staff have the authority to ban visitors when appropriate. The staff were concerned about the visitors' motives, and told the man to be careful and let them know if there were any problems, or else to remain inside the hostel. However, at approximately 11.30am, the man received his Giro and all three men left.
52. Two Approved Premises Officers were on duty that evening for the 'sleepover' shift. The male officer's shift had begun at 5.00pm and the female officer's at 10.00pm. The man returned that evening at approximately 10.50pm and rang the bell to be let in. Staff looked out to see who was there and saw him speaking to a woman before coming inside. He did not walk past the office, so the male officer went to see where he was. The man had gone straight into the toilets by the front door, and the male officer checked to see if he was alright. The man confirmed that he was and said he would be out shortly.
53. The two officers then began the 11.00pm curfew check of the premises. They returned to the office at approximately 11.20pm, and the male officer went to see if the man was still in the toilets; he was leaving as the male officer arrived. The male officer thought that he looked 'blotchy' and he wondered if he had been drinking, although there was no smell of alcohol. He asked the man again if he was okay, and he replied that he was.
54. The man asked if the kitchens were locked and was informed that they were, as they are locked at curfew check each night. The man took a bottle of milk from a carrier bag and asked if he could put it in his fridge. The male officer walked up the stairs to the kitchen with him. The man then poured himself a cup of milk. There was a discussion between them about the woman the man had been talking to outside. The man said that he had just met her and gave no more details. He said goodnight and went to his room.
55. The two officers discussed the man when the male officer returned. The male officer felt that the man might have been drinking, but as he was coherent, and appeared fine, the staff were not concerned. The female officer asked whether he was unsteady on his feet, but the male officer said he had walked up to his room without any problems. If the CCTV had been in place at the time, there

would have been a record of the man's movements throughout the building during the night.

56. At 7.30am the following morning, 5 February, the two officers began their curfew check of all the hostel residents. They reached the man's room at approximately 7.35am. When they opened the door, they noticed that he was 'slumped' over his bed and was naked from the waist up.
57. The male officer called to the man to try and wake him. When this had no effect, he shook his shoulder. Again there was no response. The female officer ran downstairs to call an ambulance while the male officer, who has a first aid qualification, checked for a pulse. He could not find a pulse, and so attempted to put the man into the recovery position. The male officer struggled to move the man because of a back problem, and so ran downstairs to ask the female officer to help him and also to fetch a resuscitation mask.
58. The ambulance services were still on the telephone and they asked if anyone was first aid trained. The female officer handed the telephone to the male officer, and the call was transferred to a cordless handset and both members of staff returned upstairs.
59. The ambulance services advised the two officers to begin cardio pulmonary resuscitation (CPR). As they moved the man into the appropriate position, the paramedics arrived at the hostel and were taken directly to his room. When the paramedics saw the man, it was clear to them that there was nothing they could do and he was pronounced dead at 7.59am.

## Events after the man's death

60. The police attended Hostel B shortly after the paramedics contacted them. They initially treated the call as a 'suspicious death', which meant that statements were taken, records sought and contact was made with the coroner's office. In the man's room, the police found some foil and liquid, suspected to be lime juice, an unused syringe in his jacket and an empty bottle of white cider under his pillow. Before leaving the hostel, the police sealed the room so that it could not be entered without their permission.
61. The police officers who attended the hostel also took responsibility for notifying the man's family of his death. The sergeant in charge of the case states that steps were taken around lunchtime, but he could not provide specific information about the time. As the family lived outside the Nottingham area, the information had to be passed to another police force. Unfortunately, it appears that the information was initially sent to the wrong police force. Records show that the information was first sent by fax to Merseyside police. Merseyside police telephoned Nottingham police that the address was not in their area, and they believed it should be dealt with by Manchester police. The call from Merseyside was recorded at Nottingham at 2.53pm. The man's family were eventually informed of his death at 3.45pm.
62. A post mortem examination was carried out on 7 February. The cause of death was recorded as a drug overdose. The toxicology report comments that blood and urine results were consistent with a recent and fatal intake of heroin. Cocaine was also found but the toxicology report concludes that this was less likely to have been associated with significant acute toxicity. There is no suggestion that the man's previous health problems were associated with his death.
63. The man's bedroom remained sealed whilst the police carried out their inquiries. His family were informed that it was sealed in a letter from the probation area's Deputy Director of Interventions. They were told that, once the room was released, they would be able to visit it. Once the room was released by the police, hostel staff cleared the room and washed all the man's clothing. They informed his mother and she was considerably distressed as she had wanted to see his room as he left it. She also wanted to pack his possessions herself, which she had believed she would be able to do.

## **Issues considered during the investigation**

### *Positive drugs test on release from prison*

64. The man was released from prison at short notice. He had reportedly taken illegal drugs the day before leaving prison to 'celebrate' his release. He was not aware that the Approved Premises he was going to be released to was drug free, and informed his probation officer that he would not have taken the drugs if he had been aware of the hostel rules. The concern remains, however, that he was able to access illegal drugs whilst in prison custody, and as a result was unable to commence the detoxification programme on the day of his release.

### *Change of hostels*

65. The man was initially required to reside at Hostel A, and spent five weeks there before moving to Hostel B. He was moved due to a space being needed for another offender. Whilst there were concerns about moving the man, it was thought that he was making sufficient progress to be able to cope with the move. There was also the issue that he was producing positive drug tests and Hostel A was a drug free hostel.

66. It soon became clear that the man was not coping well at Hostel B and felt more vulnerable to peer pressure because he had associates in the area. When a place became available again at Hostel A, just after a week later, it was agreed that he could return. It was stressed that he needed to abstain from illegal drug use to maintain the place. Sadly, the man passed away before he could return to Hostel A.

### *Residents' medication*

67. The man was prescribed naltrexone, but did not regularly collect it. He had been warned of the risks of taking naltrexone and continuing to use illegal drugs. Whilst at Hostel B he only took naltrexone twice and continued to use illegal drugs. Staff at the clinic for those with drug and alcohol problems were aware from their drug tests that the man was not taking naltrexone, and informed his probation officer who in turn notified hostel staff.

68. I am concerned that hostel staff were not more proactive about monitoring the man's use of medication and reminding him of the importance of doing so. It was a condition of his licence that he address his drug use and, by failing to take the naltrexone, he was in danger of breaching that condition. I am also surprised that staff are not required to routinely monitor residents' collection and taking of medication, and to report any lapses to their supervising officer.

### *Informing the man's family of his death*

69. The family was understandably concerned that there was a delay in being informed of his death. When there is a death in Approved Premises, it is the responsibility of the police to inform the next of kin. In this case, the same police officers who were to investigate the death were also responsible for informing the family. They initially treated the death as suspicious and

therefore spent most of the morning taking statements, liaising with paramedics and the coroner's office. These delays were then compounded by confusion about the correct police force who would inform the man's family. I have said in other reports that I believe that the Probation Service itself should take responsibility for informing next of kin of the deaths of residents of Approved Premises. This case further underlines why I believe the Probation Service should follow the example of the Prison Service in this regard.

#### *The man's belongings and washing of his clothing*

70. The family believed that they would be able to see the man's room at Hostel B as he left it and to pack his belongings themselves. They were distressed when they were informed that the man's clothing had been washed.
71. My investigator has read the letter to the family, and we understand how the misunderstanding arose. In fact, staff at Hostel B acted according to probation policy on dealing with such unfortunate circumstances but they are sorry that their actions caused distress to the man's family and have taken heed of their concerns. The Nottinghamshire Probation Area has already decided that, in the event of similar events in the future, the next of kin will be consulted about how they would like to any belongings to be dealt with. Although this will offer scant comfort to this man's family, I commend the action that Nottinghamshire has now taken.

#### *CCTV*

72. CCTV was installed at Hostel B shortly after the man's death as part of a scheduled national implementation. Whilst any recorded information of this man's movements in the hostel, specifically on the evening of 4 February might have been useful, I am concerned that the CCTV monitors are in the Deputy Manager's office which is only used during the main working hours Monday – Friday. In my view, the Approved Premises Officers' office, which is in use throughout the waking hours until at least curfew checks at 11.00pm seven days a week, would be a more suitable place for the monitors to be installed. Staff would then be able to monitor the screens more frequently throughout the day and night, and when they had specific concerns.

## Conclusions

73. The man was a resident at Hostel B from 26 January 2006, having moved there from Hostel A where he had lived for the previous month. He moved hostels primarily due to testing positive for heroin, but also because a space was needed for another offender.
74. The man did not settle particularly well in Hostel B and felt vulnerable in the area. He also felt isolated and seemed to be struggling with independence. When a space became available again at Hostel A, it was agreed it would be in his interests to return but that he would need to remain drug free. He was due to return on Monday 6 February.
75. The man was a known drug user. Despite appearing motivated to stop his drug habit, he clearly struggled to remain drug free. He had also not been taking his naltrexone medication. Whilst it remains the resident's own responsibility to take his/her medication, there should be more monitoring by Approved Premises staff and questions posed to residents if they are regularly not taking medication as prescribed. In this case the prescription was part of the treatment to help address the man's drug use, which was part of his licence conditions. There was accordingly a public protection aspect to his use of medication.
76. During the licence period, the man engaged well with his probation officer and the services provided by the Prolific Offender Programme and the clinic for those with drug and alcohol problems. Despite his continued drug use, it would appear that he was making better progress than he had on his earlier release in March 2005.

## Recommendations

### Nottinghamshire Probation Area

1. **The Chief Officer should draw this report to the attention of the Governor of HMP Nottingham and make him aware that the man produced a positive drugs test the day he was released from the prison.**

Nottingham Probation Service have responded as follows: a letter has been sent to the Governor of HMP Nottingham to make him aware of the positive drugs test that the man produced on the day of his release. It has been suggested that a review of release procedures may be considered.

2. **The Chief Officer should ensure there is more regular monitoring of residents' use of their medication and that appropriate steps are taken when they are not doing so.**

Nottingham Probation Service have responded as follows: staff are required to follow the procedure for medication as outlined in the AP Handbook. The AP staff have undergone a team development day designed to address issues including the procedures relating to medication and guidelines have been reissued. Further to this, new keyworking guidelines have been issued as has a new recording system to quality assure the work done by staff.

3. **The CCTV monitors should be located where they can be seen frequently and regularly by staff.**

Nottingham Probation Service have responded as follows: CCTV installation had begun prior to the man's death and the AP Manager had taken advice from the contractor in terms of placing them. It was decided not to place them in the Duty room as the monitors would have to be above the windows, leading to possible neck injuries due to the strain of looking up constantly, and staff would have to stand on steps to reach and operate them and they would be facing the door that residents use to speak to staff. Therefore residents would quickly come to know where the monitors did not operate and there may be issues of confidentiality.

We are liaising with the NPD (National Probation Directorate) to try to overcome these problems. We will continue to pursue a better outcome if possible.

4. **The Chief Officer should draw the family's concerns about delays notifying them of their son's death to the attention of the Chief Constable of Nottinghamshire.**

Nottingham Probation Service have responded as follows: the Chief Constable of Nottinghamshire has been contacted to raise concerns surrounding the delayed notification of the man's death to his family. The NPD have recently considered the subject of family liaison and will be shortly issuing revised guidance on deaths in Approved Premises which suggests that probation areas may wish to consider appointing a named individual to each Approved Premises, as the point of contact with bereaved families. The role could

encompass giving information to families after the initial notification of the death by the police, arranging for the family to visit the Approved Premises and organising the return of property to the family.

Nottinghamshire Police have, as a result of the above, investigated this. In their view, because it was initially treated it as a suspicious death, a balance was struck between the management of a potential crime scene, enquiries to ensure the correct and proper identity of the deceased, and collecting sufficient information to properly and respectfully brief the family.

### **Good Practice**

5. I am pleased to note that, since this investigation began, hostel staff now carry a telephone on all hostel checks.
6. I am also pleased to note that comments made by the man's family regarding the removal and handling of personal possessions have been accepted and, should any such unfortunate events recur in the future, families will be consulted about this sensitive process.
7. Staff at Hostel A planted a rose bush in their garden in memory of the man. This was a gesture that I believe was appreciated by his family.