

**Investigation into the circumstances surrounding the
death of a man in April 2010
at an Approved Premises,
Northumbria Probation Trust**

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

May 2011

This is the report of an investigation into the death of a man. The man was found dead in his room at an approved premises managed by Northumbria Probation Trust in April 2010. He was 39 years old.

I would like to offer my sincere sympathy and condolences to the man's family and friends for their loss. I apologise for the delay in issuing this report, and for any additional distress this might have caused.

This investigation was conducted by one of my senior investigators. I would like to thank the then manager of the approved premises and a senior offender manager. I also thank the staff at the approved premises for their help and cooperation.

The man moved into the approved premises two days before his death, having been released from prison after serving an eight year sentence. He registered with a local medical practice and received a prescription for 84 tablets of tramadol (an opiate-based pain killer, which can cause drowsiness) which he collected from a local pharmacy (instead of the hostel's usual arrangement for receiving medication). Hostel staff were told that the man had obtained the prescription and asked him for the medication. The man gave them 62 tablets for safe keeping but 22 were still unaccounted for.

On the day of his death, the man stayed in his room for most of the day and was last seen alive by duty staff at 1.00pm. The staff changed over at 4.00pm, when the man was described as "sleeping off" a mixture of tramadol and alcohol. He was checked again just after 7.00pm during a standard room check and found to have died. A post mortem examination concluded that the man had taken a fatal overdose of heroin, in addition to quantities of tramadol and three other prescription drugs. His intentions when taking the drugs remain unclear.

I make six recommendations as a result of this investigation. I am especially concerned about medication administration, that the staffing levels did not comply with the minimum set by the National Offender Management Service and supervision of residents who are thought to be under the influence of alcohol. I have also made a recommendation concerning first aid training.

The man did not comply with the terms of his licence as he used drink and drugs. I do not believe that he would still be alive if breach action had been taken but, nevertheless, recommend that it should have been considered. My concerns about the circumstances of the man's death are such that I am, unusually, sending my report to the Chair of the Probation Board as well as to the Chief Executive of NOMS.

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

Jane Webb
Acting Prisons and Probation Ombudsman

May 2011

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SUMMARY

On 25 November 2004, the man was sentenced to eight years imprisonment at a crown court for serious offences. He served his sentence at HMPs Durham, Frankland, Rye Hill, and Acklington. He was treated in prison for a variety of medical complaints. Just prior to his release, he was prescribed tramadol (an opiate-based pain killer, which can cause drowsiness) for neck and back pain.

In preparation for his release, the man's offender manager made an application for a place at one of Northumbria Probation Trust's approved premises. The man was offered a place at an approved premises and this offer was used to support his application for early release on parole licence in 2009.

The man was refused parole, although the place at the approved premises remained available. He was eventually released on licence to the approved premises on 19 April 2010. The man reported as instructed and was met and inducted by a staff member. She advised him to register with a medical practice who were contracted to deliver services to the approved premises. The man did so the next day. He did not see the doctor with responsibility for liaison with the approved premises, but saw another doctor at the surgery. The doctor gave the man a prescription for 84 tablets of tramadol. As part of the contract between the surgery and Northumbria Probation Trust, the prescription should have been sent by courier to a local pharmacy and then be delivered by the pharmacy to the approved premises.

When staff at the medical practice realised that the man had been given a prescription in error they alerted staff at the approved premises. When he returned, the man was asked by staff to give them the tramadol. He handed over 62 tablets, telling staff that he took three tablets a day. He was not challenged about the remaining tablets and the missing number was incorrectly calculated.

On the day of his death, the man stayed in his room for most of the day and was last seen by the staff at 1.00pm. There was only one probation trust officer on duty during the afternoon. The next shift came on duty at 4.00pm, and the man was described as "sleeping off" a mixture of tramadol and alcohol. The staff did not go to see him and he was found dead just after 7.00pm during the routine room check. He had been at the approved premises for just two days.

I make six recommendations as a result of this investigation. They relate to managing medication, complying with the national minimum staffing levels, supervising residents who might have consumed alcohol, ensuring that correct action is taken if a resident breaches the terms of their licence, first aid training for staff and the use of OASys. (Offender Assessment System the electronic offender record system used by the National Probation Service.)

THE INVESTIGATION PROCESS

1. The investigation was opened by one of my investigators on 27 April 2010. The then manager at the approved premises provided a file containing various documents relating to the man's time there. Notices were sent to the approved premises to inform both staff and residents of the investigation.
2. My investigator also requested the man's medical record from HMP Acklington, in order to gather relevant information about the medication he was prescribed prior to his release on licence.
3. Six staff from the approved premises were formally interviewed by my investigator. None of the residents at the approved premises agreed to be formally interviewed during the investigation.
4. One of my family liaison officers contacted the man's family to explain the purpose of the investigation and to offer the opportunity to raise any concerns they might have regarding their son. The man's father declined the offer of contact and told my family liaison officer that the family preferred to have no further contact with this office.

THE APPROVED PREMISES

5. Approved premises are approved by the Secretary of State for Justice under section 9 of the Criminal Justice Act and Court Services Act 2000. They provide a structured, supported environment in the community for high risk offenders many of whom have been released from prison to approved premises as part of a supervision plan agreed with the offenders supervising offender manager.
6. There are four approved premises in the Northumbria Probation Trust (NPT) area. The trust has an assistant chief executive who oversees all of the approved premises. Probation Circulars (PCs) and Probation Instructions (PIs) communicate formal, significant or long-term instructions, guidance and requests for action or information from the Director of Probation to probation Chairs, Chief Officers, Board Secretaries and, as necessary, other probation staff. They are now known as Probation Instructions. PC07/2009 is entitled "Procedures in Approved Premises", and they set out various instructions and guidance. Mandatory instructions are written in italics. The mandatory minimum staffing level for every approved premise is set down in section 3 of PC07/2009 which states that "In all APs there must be at least two members of staff on duty at all times".
7. The approved premises where the man resided has a manager, three probation trust officers (PTOs), seven supervisors and three night care workers. All the staff work to a shift pattern and staff coming on duty are briefed by their colleagues as to events of that day and advice about individual residents who may need support or guidance or whose behaviour may be causing some concern. This is known as the hand over.
8. Staff are also expected to carry out regular and frequent room checks. This means entering residents' rooms to check on their whereabouts and condition as well as a check to ensure residents are complying with the AP rules and regulations. Staff can also undertake unannounced room searches if the resident is thought to be in possession of alcohol drugs or any other material which might place them in breach of the terms and conditions of their licence.
9. The approved premises where the man resided is a purpose built facility accommodating 24 offenders, 22 of whom live in single rooms. There are communal lounges, a dining room, interview rooms and office space. Most of the bedrooms are located on the first floor. There is a ground floor annexe housing up to six residents.
10. NPT operates a centralised referral process. Offender managers refer offenders for a place and, if accepted, offenders are then allocated a place in one of the four approved premises.
11. On arrival, every new resident undertakes an induction which ensures that they understand and accept the rules and regulations relevant to their residence and the expectations placed upon them. Every resident is allocated a key worker, a member of staff who the resident meets to discuss their progress, well being,

participation in the regime of activities and group work. Failure to follow the regime is expected to be taken seriously and can represent a breach of rules.

12. Each resident has his own key to his room which must be handed in when they leave the house and collected on return. Residents can have visitors as long as they have the permission of the manager. Visitors must also abide by the curfew between 11.00pm and 6.00am. Approved premises have strict rules regarding alcohol and illegal drugs. The possession of alcohol, solvents and controlled drugs is not allowed. This is reinforced by random but regular room searches.
13. Approved premises operate a policy entitled Medication In Possession (MiP). This is a policy that sets out guidance for staff as to how to manage residents' medication. The policy clearly identifies prescribed medication that must not be allowed to be in residents' possession whilst they live in the approved premises. This policy is particularly relevant to this investigation as this man was prescribed tramadol, which is prohibited by the policy from being held in possession by a resident. Some prescribed medication must be handed in to staff for safe storage, following which compliance with medication is closely monitored. The approved premises has a contract with a local medical practice for the provision of medical services to residents. The man was advised to register with the practice as a part of his induction.
14. Night duty is carried out by two night supervisors. At the beginning of their shift, the night supervisors receive a briefing from the day staff about the events of the day and advice about individual residents who may need support, or whose behaviour is causing concern. Their duties also include patrolling the premises at night, conducting checks on residents and writing up their observations in the log book.
15. This is the first death at this approved premises since the Ombudsman took responsibility for investigating all deaths in approved premises in April 2004.

KEY EVENTS

16. The man was sentenced to eight years imprisonment in 2004 following conviction for serious offences.
17. In March 2007, whilst he was at HMP Frankland, the man reported to a registered mental nurse (RMN) that he was low in mood and had fleeting suicidal thoughts. He had a number of follow up appointments with mental health staff and, in November 2007, the man told a psychiatric nurse that his low mood was due to chronic neck and back pain. He was referred for physiotherapy and also treated with pain killers.
18. The man completed his sentence at HMP Acklington and was released on licence from prison in April 2010. A condition of his release was that he must reside at the approved premises.
19. Having been convicted of very serious offences, the man was automatically referred for consideration to be managed under MAPPA. MAPPA is the Multi Agency Public Protection Arrangements, under which offenders who are assessed as representing a tangible risk to the public or individuals should be discussed regularly by the agencies involved with them. Those subject to MAPPA are categorised by belonging to one of three levels. Level three is the most serious. As a level two MAPPA case, the man was managed by the probation service, the police, victim liaison, children services, housing and, before his release, HMP Acklington.
20. The man was originally referred to the central referral unit for approved premises by his offender manager in January 2009. This was for a place on a parole licence. NPT approved premises accepted the referral and offered a place at the approved premises, subject to the Parole Board's decision. The man's application for parole was refused although the offer of a place at the approved premises remained open.
21. My investigator was provided with the man's OASys (Offender Assessment system, an electronic document which the man's offender manager updates on a regular basis with new information about him and managing the risk he posed to himself and others). The OASys document has a section entitled "Risk of Harm Screening" (Section R 10). This section provides a check list for those filling in the form and for those reading the form who, in turn, might deal with the man. On 11 August 2009, in section R10 of the OASys document, the offender manager updated her assessment and assessed the man as a medium risk to the public and children and as high risk to known adults (which means the victim of his last offence). Medium risk is defined as follows:

"The offender has the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances, for example failure to take medication, loss of accommodation, relationship breakdown, drug or alcohol misuse".

High risk is defined as follows:

“There are identifiable indicators of risk of serious harm. The potential event could happen at any time and the impact would be serious”

22. The man was released on licence from prison on 19 April under the provisions of Section 33(2) of the Criminal Justice Act 1991. His licence was to remain live until 12 January 2011, and he was under the supervision of an offender manager until that date. The man’s licence was due to expire on 19 November 2012.
23. The man had a number of conditions attached to his licence as well as conditions specific to his supervision. They included that he must reside at the approved premises, should not approach the victim of his offences and not enter two districts. The man was also required to comply with requirements to address his alcohol, drugs, anger and sexual offending behaviour problems.
24. The man arrived at the approved premises and was inducted by a Probation Trust Officer (PTO). He cooperated during the induction process, was allocated a room and the PTO wrote in his personal record (known as part c):

“Arrived, fully inducted. Claims he will be compliant and wants to progress through AP residence. Advised to register with the police (sex offender unit) within the required time 3 days.”

The Probation Trust Officer also introduced herself as the man’s key worker.

25. Later on the same day, at 7.15pm, the Approved Premises Supervisor (APS) wrote in the personal record that the man went out to the pub and returned at 9.30pm. She also wrote:

“Appeared under the influence of alcohol, glazed eye smelled of alcohol not problematic fine on contact.”

There is no evidence of action being taken regarding the man’s breach of the hostel rules.

26. At 11.40pm, the man set off the smoke alarm in his bedroom and so the night supervisor went to see what had happened. The man told him that he had set the alarm off by burning a tag off a new t shirt.
27. The next day, a Prison Trust Officer (PTO) spoke to the man and wrote in the personal record:

“Present 08.10 check. “Advised” re setting fire to things in room! Around periodically most of the day.”

28. It seems that the man made an appointment to see a doctor at the medical practice. Later the same day, the Probation Trust Officer (PTO) who had carried out the man's induction to the approved premises wrote in his personal record:

"Rcd [received] tel [telephone] call from [woman's name] at GP surgery. [A doctor] has issued the script to [the man] in person. We expect him to hand in 84 tramadol."

29. A later entry by an Approved Premises Supervisor (APS) states that the man was:

"around most of the shift, handed in 62 tramadol but without the box. Says he takes three a day other than that fine on contact not problematic".

This entry was not timed.

30. A Probation Trust Officer (PTO) added to the personal record later that day. He wrote:

"[The man] present 08.10. Says he will address the missing 12 tramadol! Very low presence. Still very much "sedated" in his bed at 13.00 check, breathing normally in my opinion however. I'll assume that is where the missing 12 tramadol were destined."

These entries were also not timed and there is no record of any other checks of the man's wellbeing. The PTO's record that 12 tramadol tablets were missing is incorrect. Having handed in 62 tablets, 22 remained unaccounted for rather than 12 as he stated in the record.

31. At 2.50pm, the PTO finished his shift and went off duty. The PTO who had carried out the man's induction to the approved premises said that this left her in sole charge of the residents for nearly two hours until 4.00pm when the next shift came on duty. Her duties included supervising any resident who was in the approved premises and checking two particular residents every hour as they were identified as at risk of harming themselves. She described these responsibilities as "very difficult".
32. The PTO said in interview that she knew it was her responsibility to hand over to the staff coming on shift at 4.00pm and update them about the man. She had discussed him with her fellow PTO and said that she did not have any real concerns about his well being. She knew that, as his keyworker, she had to speak to him about the medication in his possession which he should not have had. She said that, at one point during the afternoon, she had intended to speak to the man about his medication but other events prevented her doing so. She also said that, as a lone female staff member, she did not want to make herself vulnerable with the man, who had been convicted of serious crimes against a woman. She thought that she would challenge him the next day, when there would be more staff on duty.

33. The PTO handed over to the Approved Premises Supervisor (APS) and a further member of staff at 4.00pm. She told both staff members about the missing tramadol. The APS said in interview that she was told that 12 tramadol tablets were missing and that the man had been drinking the night before. She told my investigator that the man was suspected of taking the missing 12 tramadol tablets, that there was nothing to worry about, and he was sleeping off the effects of his alcohol consumption the night before.
34. Both the member of staff and the APS told the investigator that no concerns or urgency about the man were voiced at the hand over they received from the PTO. They started their shift in the normal way, preparing to supervise residents' meal times, checking emails and preparing to undertake room checks which were due three hours later. They did not check on the man's wellbeing.
35. The APS and the member of staff started their room checks at 7.00 pm. They each took responsibility for checking different rooms but they progressed at the same time in ascending order until they reached the man's room. The APS opened the door but did not go straight into the room. She told my investigator that she could see that there was something wrong, that the man was very pale and did not look as if he was breathing. The APS called to the member of staff who went into the room whilst she stayed just inside the room by the door.
36. On going into the man's room, the member of staff thought that he was unconscious. He checked the man and told my investigator that he looked very white and his lips were blue. The member of staff tried to get a verbal response from the man but was unsuccessful. He tried to find a pulse in the man's arm and neck and listened for signs of breathing, but could not detect any. The member of staff decided that the man had died and decided not to attempt resuscitation. The APS and the member of staff told my investigator that they have received training in first aid and resuscitation, but both staff said in interview that they thought they needed refresher training.
37. The APS told my investigator that both staff ran initially down the hallway in order to call the emergency services. However, the member of staff returned to lock the man's room in preparation for the police arriving and to prevent any contamination of possible evidence. The emergency services were called and the paramedics arrived at about 7.10pm. The member of staff told my investigator that the paramedic said that the man appeared to have been dead for at least two hours.
38. The police officers arrived at the approved premises and searched the man's room. They recovered 12 tramadol tablets from the shelf of a vanity unit and an empty box in a bin which had held 10 tramadol tablets which were unaccounted for. The police also seized a small amount of white powder, and a box of the drug omeprazole (used to treat ulcers).
39. The on call manager for approved premises in NPT was notified, as was the head of offender management for Gateshead. The manager of the approved premises was also notified and he arrived about half an hour later.

40. The man's next of kin, his father, was told of his son's death in person by Northumbria police. All the staff who were involved in the events prior to the man's death were offered support by NPT.
41. A toxicology report was prepared as part of the post mortem. The test results showed that the man had consumed potentially fatal levels of heroin as well as levels of tramadol, citalopram (an anti depressant), amitriptyline (an anti depressant) and olanzapine (used to treat mental illness). The man was not prescribed olanzapine and the police found no traces of the drug when they searched his room.

ISSUES

Managing the man's consumption of drugs and alcohol

42. As part of the terms of his release, the man had to:

"comply with requirements specified by your supervising officer for the purpose of ensuring that [he] address[ed] [his] alcohol, drugs, sexual, anger and offending behaviour problems."

As well, the approved premises rules required that the man, like other residents, should not be in possession of drugs or alcohol in the hostel. The conditions were explained during a face to face meeting with the man on 19 April with an offender manager and his keyworker. The record of the meeting indicates that the man understood what was expected of him.

43. A number of staff told the investigator that the man consumed alcohol quite soon after his induction to the approved premises. The record of the evening of his arrival refers to him smelling of alcohol and appearing to be under its influence. However, he was not challenged about the possible risk he might pose or the potential breach of the terms and conditions of his licence. The man also failed to hand over all his tramadol tablets when he was asked to do so by staff. He faced no significant challenges about his behaviour nor was his room searched to retrieve the missing tablets.

44. When offenders are released from prison into the community, conditions are often placed on their licence. This helps to ensure public safety and confidence in the criminal justice system, and also helps to rehabilitate the offender. Should there be a potential breach of the conditions, it is imperative that probation staff including those at approved premises react quickly and challenge inappropriate behaviour.

Northumbria Probation Trust should ensure that appropriate action is taken when offenders released on licence to approved premises fail to comply with the conditions of their licence and instructions from staff.

Managing the man's medication

45. Approved premises are bound by a National Offender Management Service instruction entitled Medication In Approved Premises (Probation Instruction 09/2009) The instruction became effective on 21 December 2009 and sets out arrangements for how staff in approved premises are to manage residents who require medication. The policy lists, at Annex 5, drugs which are for "supervised supply and consumption only". Tramadol is on this list and it is specified as a high risk medication. Residents should not have tramadol in their possession whilst living in an approved premises. Any tramadol should be held in secure storage and administered by the staff.

46. It is unfortunate that the man was incorrectly handed a prescription for tramadol by the doctor at the medical practice. He was a new resident who had been told

many rules and so, giving the benefit of the doubt, he may not have realised the doctor's error. However, staff at the practice did realise their mistake and telephoned the approved premises to say that the man had been given the prescription.

47. The then manager of the approved premises told my investigator that the agreement between the medical practice and the approved premises did not work properly on one other occasion. Then, as on this occasion, a resident was given a prescription outside of the agreed process. I am pleased that NPT have planned further discussions with the lead General Practitioner and practice manager in the light of this man's death.
48. All the staff interviewed for this investigation confirmed that they were aware of the Medication in Possession policy and that the use of tramadol by residents must be supervised. When the man returned to the approved premises, and the surgery notified the error, staff discussed the tramadol with him. However, he only handed over 62 tablets. Staff accepted this and did not challenge him to hand over the remaining 22 tablets which he retained. Staff took no further action nor did they refer the matter to the manager or question the man further. Their omissions were compounded by the incorrect calculation and record that only 12 tablets were missing. This is also contrary to the standards set out in Probation Instruction 09/2009, and I make another recommendation to ensure that NPT staff comply with the instruction.

Northumbria Probation Trust should ensure that staff are aware of and fully understand the medication in possession policy for approved premises.

Monitoring the man when he was under the influence of drugs and alcohol

49. When the man was last checked by the Probation Trust Officer (PTO) at 1.00pm, he was described as being "sedated on his bed". The PTO also wrote "I'll assume this is where the missing tramadol were destined", despite the missing tablets and knowing that he had consumed alcohol. No checks were made between 1.00pm and 7.00pm when the daily room check was scheduled. I endeavour to avoid using the benefit of hindsight in my investigations. Nevertheless it is difficult to understand why the two staff on duty in the early afternoon did not check the man nor why the staff coming on duty at 4.00pm did not check either. The man was not checked for six hours, despite four members of staff being aware that he was in possession of a prescribed drug and believing that he was sleeping off the effects of alcohol.
50. While a check may not have prevented his death, I believe that the staff should have been more aware of the danger that the man might have taken an overdose of tramadol, especially as they knew this might have been mixed with alcohol.

Northumbria Probation Trust should ensure that staff at the approved premises are fully aware of the requirement to check residents regularly when they are thought to be under the influence of alcohol, have used prescribed medication and are not in sight of staff. Consideration should

be given to any training needs for the staff on duty on the day of the man's death.

Staffing levels

51. In interview with my investigator, the Probation Trust Officer (PTO) said that his shift pattern is slightly different to that of other staff. I understand that, on some days, he starts his shift earlier than normal thus allowing him to finish early. On the day when the man died, the PTO finished his shift at 2.50 pm leaving his colleague on her own as duty PTO supervising the residents in the hostel until the 4.00pm shift change.
52. The then hostel manager told the investigator that the PTO's shift pattern was in place when he took up the post of manager. He said it was under review because it can cause difficulty in managing the staffing levels at the approved premises. As I have said, the mandatory minimum staffing levels in approved premises are set down in PC07/2009 "Procedures in Approved Premises". Section 3 states "In all APs there must be at least two members of staff on duty at all times". It is clear that, in accommodating the PTO's working patterns, managers at the approved premises left other staff to cope for periods of time without adequate cover. There was the potential for the remaining staff member left to deal with a demanding and pressurised situation such as happened on the day of this man's death. This is contrary to the mandatory provisions of PC07/2009 and needs to be urgently addressed.
53. In response to the draft report, Northumbria Probation Trust explained:
- "... Paragraph 5 further clarifies that, '...under all arrangements, at least one member of staff on duty during daytime hours must be a key worker or Offender Supervisor.' Northumbria Probation Trust recognises and fulfils its duty to ensure adequate staffing in its Approved Premises. During the period of time that the PTO claimed to be in sole charge of the residents, there were two other members of staff in the building. An administrator (who is paid an enhanced salary agreed by job evaluation to reflect her role to provide building cover) and the manager."

In addition, NOMS stated:

"There would appear to be some confusion here ... It would appear that the PTO was probably describing her responsibilities rather than how many staff were on duty at the time. In any event, the response from NPT confirms that other staff were on duty so perhaps this recommendation ought to be withdrawn from the final version of the report."

54. The PTO told my investigator that the Approved Premises had been operating with fewer staff than usual. It is clear that she considered herself, at certain times, to be solely in charge of supervising day to day events concerning residents and thought that the other members of staff were either not available or able to actively supervise residents. She said that the manager was called upon for serious matters. In light of this, I accept that the requisite number of staff

were on duty at the approved premises. However, it is clear that there is some uncertainty over roles, as well as anxiety about sufficient cover. I have therefore recast my original recommendation:

Northumbria Probation Trust should ensure that there are sufficient staff on duty to safely supervise residents and that staff are fully aware of their roles and responsibilities.

Managing the man's risk

55. The OASys document that was in force for the man at the time of his death was dated August 2009. At the MAPPA meeting on 2 March 2010, there were no action points specified for the offender manager to update OASys. Had it been updated, staff at the approved premises would have been able to manage the man with the benefit of an up to date and, hopefully, accurate OASys assessment.

Northumbria Probation Trust should satisfy itself that the management of OASys was appropriate to the level of risk posed by the man and that MAPPA guidelines were followed.

Whether cardiopulmonary resuscitation should have been attempted

56. Neither of the staff who found the man made an attempt to resuscitate him. One of them checked for signs of life, but did not find any. He believed the man had died and decided not to attempt resuscitation. The manager of the approved premises stated in an email to the investigator that the decision to attempt resuscitation is up to the individual staff member dealing with the situation. Both members of staff had been trained in resuscitation, but thought they required refresher training.

57. Probation Circular PC2006-35 is entitled "Preventing Deaths of Approved Premises Residents". Paragraph 17 considers the issue of first aid. It says:

"Both PPO [Prisons and Probation Ombudsman] reports and correspondence from coroners following inquests have highlighted the importance of staff having appropriate and up to date first aid skills. Probation areas should refer to the Health and Safety Risk Assessment "Approved Premises Management Guidance" which has been circulated to Areas and is also available on EPIC. This states that "all supervisory staff must be trained, as a minimum, in basic first aid". "

58. My investigator discussed this instruction with a member from the Approved Premises Section, Public Protection and Mental Health Group at NOMS. He said that he would expect staff to attempt resuscitation if they have had the appropriate training. In this case, it seems that the two members of staff had received training, but that they thought that their certificates had expired. If so, this would be contrary to the provisions of PC2006-35. If their certificates were still valid, the expectation is that resuscitation should have been attempted. I believe that NPT should ensure that staff in a supervisory role are trained in first

aid, and are provided refresher courses where necessary. I also believe, however, that NPT should make it clear that trained staff should attempt resuscitation. Although it is unlikely it would have helped this man, it might prove vital to another resident in the future.

Northumbria Probation Trust should ensure that all supervisory staff at the approved premises have received up to date first aid training and are aware of the expectation that they should attempt resuscitation when required.

CONCLUSION

59. The man was released on licence from prison having served a substantial sentence for very serious crimes. He was directed to reside at the approved premises as a condition of his licence. The man was assessed as a medium risk offender who posed a high risk to the victim of his offences.
60. Very early on during his stay at the approved premises, the man showed a disregard for the rules and regulations of the hostel by failing to hand over in full prescribed medication to staff when asked to do so. Staff also thought the man was consuming alcohol despite a condition in his licence to address his alcohol problems.
61. I have found that there was a significant failure by staff at the approved premises to challenge the man about the tramadol he did not hand to staff when asked. This, in conjunction with his alcohol use, would in my opinion have merited issuing a warning to comply with the terms of his licence and the rules of the approved premises or face recall to prison.
62. The post mortem report highlighted that the man had used heroin and olanzapine, a drug used to treat mental illness. Staff at the approved premises were unaware that the man had obtained heroin and olanzapine and cannot be criticised for this.
63. However, whilst it is difficult to say whether had the man been supervised differently the outcome would have been different, I make several recommendations about managing the man during his short time at the approved premises. In particular, I criticise the apparently careless approach which left him in possession of prohibited medication and the staffing levels which did not meet the minimum national standard.

RECOMMENDATIONS

1. Northumbria Probation Trust should ensure that staff are aware of and fully understand the medication in possession policy for approved premises.

Northumbria Probation Trust accepted this recommendation and commented:

“[The manager of the Approved Premises] wrote to [a doctor] on 19 January 2010, using the draft letter format set out in Probation Instruction 09/2009, to inform him that the MiP policy was to be implemented in [the approved premises] from February 2010. Prior to this, the staff team had discussed the instruction fully and adapted their internal practice and procedures. Prior to [the man’s] arrival, MiP was discussed in team meetings held on 13 January, 24 February, 31 March and 7 April 2010. It continues to be a standing item on team meeting agendas. A new Guide to Medicine and Drugs was purchased by the AP in November 2010.”

2. Northumbria Probation Trust should ensure that appropriate action is taken when offenders released on licence to Approved Premises fail to comply with conditions of their licence and instructions from members of staff.

Northumbria Probation Trust did not accept this recommendation and commented:

“[The man’s] licence contained a standard condition to comply with requirements specified by his supervising officer for the purpose of ensuring that he addressed his alcohol, drugs, sexual, anger and offending behaviour problems. This generic condition is standard in many such licences and its application is subject to discussion between the Offender Manager and AP staff. [The man] did not have a specific ‘no alcohol’ condition in his licence as may sometimes be the case, nor did he breach any AP rules relating to alcohol use. [The man] handed over the majority of his Tramadol to [a member of staff] when asked to on the evening of 20 April. The issue then became one of audit. Regular medication audits take place at [the approved premises] and staff have been reminded of the need to ensure the number of tablets are correctly counted and recorded. [The member of staff] stated in his evidence that [the man] was not intoxicated at the time of this discussion. In his evidence [the manager of the approved premises] made it clear that he would not have expected staff on evening duty to have conducted a room search to recover the missing Tramadol. Rather, the issue would be one for the day staff to follow up with [the man] the next day, as this was considered to be the most appropriate practice.”

NOMS' additional response

“A report ought to have been made to the OM, perhaps, but it cannot be categorically stated that [the man] was in breach of his licence judging by the evidence presented in the report. Is this of any consequence, we wonder, given that the Ombudsman herself notes that breaching him would have made no difference? It is also most unlikely that [the man] would have been recalled on this first occasion, so his situation would probably have been no different. In conclusion, we do not see how this recommendation can improve matters for other residents of APs. Therefore, it too should perhaps be withdrawn from the final version of the report.”

Although this may have been a generic licence condition, it was nevertheless a requirement. For the reasons given above, in terms of public safety and confidence, the expectation should be that residents comply with all licence conditions, standard or otherwise. If staff fail to address such compliance, this could impact on or have consequences for future residents.

3. Northumbria Probation Trust should ensure that there are sufficient staff on duty to safely supervise residents and that staff are fully aware of their roles and responsibilities.

This recommendation was recast following consultation on the draft report.

4. Northumbria Probation Trust should ensure that staff at [the approved premises] are fully aware of the requirement to check residents regularly when they are thought to be under the influence of alcohol, have used prescribed medication and are not in sight of staff.

Northumbria Probation Trust accepted this recommendation and commented:

“A change in practice has been introduced at [the approved premises] since the death of [the man]. Routine checks of all residents on the premises are now made at 8am, 12 noon, 4pm, 7.30pm and 11pm.”

5. Northumbria Probation Trust should satisfy itself that the management of OASys was appropriate to the level of risk posed by the man and that MAPPA guidelines were followed.

Northumbria Probation Trust partially accepted this recommendation and commented:

“At the MAPPA meeting on 2 March 2010, there were no action points specified for the probation officer to update OASys. However, in view of this case, a reminder will be issued to local Level 2 and 3 Chairs and a template will be introduced including a standard action in the risk management plan section of the minutes template which will require a date to be entered to indicate the timescale and an action owner. We will be able to incorporate this in the format of the proposed new national template currently being piloted.”

NOMS' additional response

“It is difficult to see a link between updating OASys and being able to prevent [the man's] death. There is nothing in the report between paragraphs 21 and 53, most particularly no discussion of the effect that a lack of updates had; and even if there were, we find it hard to see how the way risk of harm to others was dealt with is relevant to [the man's] death. Consequently, perhaps this recommendation ought to be withdrawn from the final version of the report too.”

Given that this recommendation was partially accepted, it has not been removed as requested by NOMS. The fact that the OASys document had not been updated

might not have been directly linked to this death, but has implications in terms of the safety and duty of care towards other and future residents. It is within the remit of the office to comment on matters which might impact in the future.

6. Northumbria Probation Trust should ensure that all supervisory at the approved premises have received up to date first aid training and are aware of the expectation that they should attempt resuscitation when required.

Northumbria Probation Trust did not accept this recommendation and commented:

“Not accepted (unnecessary). First aid training is a mandatory requirement for all Approved Premises staff. A central list of registered first aiders is maintained by the Trust’s Health and Safety Team and reminders issued when updates are required. The training delivered is compliant with Resuscitation Council guidance. All persons trained are made aware of the expectation that they should attempt a method of resuscitation when required. It is noted in the report that [the member of staff] indicated in interview that he had checked [the man] for vital signs prior to calling for medical assistance. Furthermore, [the member of staff] indicated that in the opinion of the paramedic [the man] had been dead for at least two hours.”