

**Investigation into the circumstances surrounding the
death of a man in December 2010
at St Leonard's House,
an Approved Premises under the management of the
Thames Valley Probation Area**

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

April 2012

This is the report of an investigation into the death of a man who was found dead in his room at St Leonard's House Approved Premises, Reading, in December 2010. He was 45 years old.

I extend my condolences to the man's family and friends and all those affected by his death. I apologise for the delay for the delay in issuing this report and for any additional distress this might have caused.

This investigation was undertaken by one of my senior investigators. I would like to take this opportunity to thank all of the staff at St Leonard's House for their co-operation during the investigation.

The man had been at St Leonard's House for around six weeks at the time of his death. He had some difficulty at first in adjusting to life at the premises as he seems to have resented the rules and regulations necessary for the running of the establishment. However, nothing of substance occurred to cause staff any concern about his welfare.

On an evening in December, staff went to the man's room to find out why he had not collected his prescribed medication. Staff discovered him in a kneeling position on the floor. He had no pulse and his body was cold to the touch. Ambulance paramedics arrived soon after and, having made attempts at resuscitation, confirmed that he was dead.

Following toxicological analysis of blood and urine samples and post mortem examination, the man's death was attributed to the combined toxic effect of consuming both heroin and cocaine.

This report makes two recommendations to ensure that lessons are learned, although neither are directly linked to the man's death: one is about ensuring that prescribed medications are robustly and effectively managed and the other is about possible guidance for staff when searching or examining residents.

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.

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SUMMARY

1. In August 2010, the man was granted conditional release from prison having served four years of an eight year sentence. He was subject to a licence condition that he reside at an approved residential rehabilitation unit (a premises focussing on assisting those with substance misuse problems). Unfortunately, he could not settle at the unit and he moved out. This put him in breach of his licence conditions. He was arrested and taken back into prison custody.
2. Six weeks later the man was placed at St Leonard's House Approved Premises in Reading. He arrived there on 2 November 2010.
3. The man had a long history of drug abuse and he gave contradictory messages to staff about his attitude towards addressing this problem. He also found it difficult to settle at first as he seems to have resented the rules and regulations that govern the running of an approved premises. It appears that he responded appropriately, however, when warned that his continued residence was potentially in jeopardy.
4. The man spent a good proportion of his time on the day of his death away from St Leonard's House. He returned to the premises at 6.40pm, before the curfew, and, after using the communal telephone, he went to his room.
5. By around 10.00pm, the man had still not collected his prescribed medication so a member of staff went to his room to remind him. He was found in a kneeling position on the floor. His body was cold to the touch and he had no pulse. An ambulance was called. The paramedics attempted to resuscitate him, but without success.
6. Toxicological analysis of the man's blood and urine detected the presence of a number of substances, including a very high level of morphine that was probably attributable to heroin use. A consultant pathologist stated that in his opinion his death was due to the combined toxic effects of heroin and cocaine.
7. When the man's room was searched, a box of diazepam tablets were found that had apparently been prescribed by a doctor the day before. A 'to-do' list was also found showing tasks he was intending to carry out the following day.
8. This report makes two recommendations. One is about arrangements for delivery of prescribed medications direct to the premises. The other is about possible guidance for staff when searching or examining residents.

THE INVESTIGATION PROCESS

9. The Ombudsman's investigator made a preliminary visit to St Leonard's House on 23 December 2010, when he met several of the staff including the manager of the premises.
10. Notices about the investigation and its terms of reference were displayed around the premises and invited staff and residents to contact the investigator should they wish to do so. No residents came forward to speak with the investigator.
11. The investigator subsequently returned to the premises when he interviewed eight members of staff and the man's Offender Manager (Probation Officer). He provided feedback to the premises manager on his initial findings.
12. HM Coroner for Berkshire was informed of the nature and scope of the investigation. A copy of the post mortem was obtained from the Coroner's office. A copy of this report will be sent to the coroner to assist with his enquiries into the man's death.
13. The investigator also made contact with police investigators who attended St Leonard's House immediately following the man's death. The police provided him with a copy of a document that was later discovered by the premises manager and passed by her to them. In the document, the man listed a number of tasks he wished to arrange, indicating that he was planning for the future.
14. The Ombudsman's Senior Family Liaison Officer contacted the man's sister. She said that she did not think there was anything anyone could have done for her brother due to his drug addiction. She spoke positively about the help and support she received from the Manager of St Leonard's House and asked for this to be mentioned in the report.
15. We apologise for the delay in the issue of this report. The delay was due to workload pressures.

ST LEONARD'S HOUSE

16. St Leonard's House is an approved premises located in Reading. It is managed by the Thames Valley Probation Trust. Approved premises were formerly known as probation and bail hostels. They provide an enhanced level of residential supervision in the community in a supportive and structured living environment. Residents must be over the age of 18 and include those who have committed serious, violent and dangerous offences and who have completed the custodial part of their sentence. The majority of residents are required to stay as a condition of a court order or prison licence.
17. St Leonard's House consists of a main building together with an annex. It can accommodate up to 22 residents and accepts offenders on bail, those subject to community orders and those on licence following prison sentences. Communal areas, including corridors, are covered by CCTV and an alarm sounds when the front door is opened.
18. Each resident is required to sign in and out of the house at all times and all are subject to curfew conditions. Standard curfew hours are from 11:00pm to 7:00am but other curfew hours may be enforced for particular residents. In addition, some residents are required to report-in to the premises at a specified time in the day. During the day, residents are free to go out unaccompanied, although they must state where they are going and must sign out and sign back in upon their return. Premises have a strict policy forbidding possession on site of alcohol and drugs. Residents are not forbidden from visiting a public house and consuming alcohol away from the premises.
19. Staffing at St Leonard's House includes managerial staff, offender supervisors (previously known as key workers) and support staff. Two members of staff remain on the premises throughout the night. The duties of the night staff include checking that residents are in their rooms during the curfew hours.
20. Residents are required to attend a morning meeting at 10.00am each day. That is followed by compulsory in-house projects on topics such as job hunting, house hunting and home domestics.
21. Residents register at one of two local doctors' surgeries. Most prescribed medications are held by the premises which staff issue to residents on a daily basis. Controlled medication, such as methadone, is generally given to residents at the local pharmacy.
22. The man's death was the second at St Leonard's House since the Ombudsman took on the responsibility for the investigation of deaths in custody in April 2004. The first death was in April 2005. That resident died while away from the premises and in circumstances entirely different to those surrounding this death.

KEY FINDINGS

23. The man was born in Nottingham in January 1965. In August 2006, he was convicted of causing death by dangerous driving. He had long standing problems with drug abuse and he admitted to having used crack cocaine and heroin in the time leading up to the accident. He was sentenced to eight years imprisonment.
24. Having served four years of his sentence, the man was granted conditional release in August 2010. His last prison was HMP Littlehey in Cambridgeshire. When a prisoner is granted conditional release, one of the conditions of their licence will be the requirement that they reside at an approved address. He was found a place at residential rehabilitation unit in Berkshire. It would seem, however, that he found the regime at the unit too restrictive which led to him leaving. This put him in breach of his licence conditions and, within a month of his release, he was rearrested and taken back into prison custody.
25. Six weeks later the man was found an alternative placement. This was St Leonard's House, an approved premises in Reading in Berkshire. He arrived there on 2 November 2010. During his induction interview, he was asked a number of questions about his health. In answer to a question about physical health problems, he reported having a blood clot in his leg. (It seems he had a deep vein thromboses in his legs which was a long term problem caused through injecting drugs over many years.) He was receiving warfarin (a blood thinner) and betnovate ointment (a cream that eases itching and swelling) for the problem. In answer to questions about mental wellbeing, he reported that while he had no thoughts about self-harm, he occasionally suffered from low mood and said he was receiving anti-depressant medication. He was asked about his use of substances. He reported a 12 year history of using heroin and crack cocaine. He denied having problems with alcohol, indicating that he only drank occasionally.
26. The curfew hours set for the man were 9.00pm to 7.00am (standard curfew hours are 11.00pm to 7.00am). In addition, he was required to report to the premises at 5.00pm each day. The manager of St Leonard's House told my investigator that it was common practice to set more stringent conditions for new residents during their first week. This would allow staff to assess how the person is settling in before relaxing the conditions.
27. Speaking about the 10.00am morning meeting, the manager said that residents are given a ten minute warning of the start of the meeting by a knock on their doors. She said that one of the advantages of the meeting is that it forces residents to get out of bed. She said that if particular residents find it difficult to get up from bed at that time, it can alert staff to possible drug or alcohol misuse.

28. The man registered with one of the two doctors' surgeries which take residents from St Leonard's House. He received repeat prescriptions for several medications including warfarin and citalopram, an anti-depressant. In keeping with usual practice, these medications were dispensed from the local pharmacy direct to St Leonard's House. The medications were then stored in the premises office and dispensed to him on a daily basis.
29. The man's probation officer told the investigator that he worked for Thames Valley Probation and the man was allocated to his workload when he was found a place at the residential rehabilitation unit (Berkshire falls within Thames Valley Probation's catchment area). He remained the man's probation officer throughout the time of his brief recall to prison and then after his new placement at St Leonard's House. He said that in their initial meetings they spoke about the man's longstanding history of misuse of heroin and crack cocaine. The man was frank about his attitude towards drug use saying that he would not guarantee not using drugs again. The probation officer asked him if he would at least try to cut out class A drugs and he agreed to that and agreed to consider attending Narcotics Anonymous. He also mentioned having the means to obtain prescribed medication from a private source.
30. The probation officer said that negativity and depression appeared to be features of the man's personality. Conversations with him would usually start with a lot of complaints. He was an "independent thinker" who would "not hold back" in expressing different points of view about matters such as the regime at St Leonard's House, boundaries (and, it appears, different life styles including use of recreational drugs). However he would listen to argument and acknowledge counter opinion. The probation officer said that his conversations with him would end in a much more positive vein than in which they had begun. He understood that staff at St Leonard's House felt the same way from their discussions with the man.
31. On Tuesday 9 November, the man telephoned Narcotics Anonymous and discovered the address of the local branch and discovered that they met every Wednesday. The following day he attended one of their meetings. When he later completed a "weekly activity diary", he noted as an achievement for the week that he had gone to a Narcotics Anonymous meeting and that he had "... enjoyed it [and] intend to go weekly ...". (It is unclear how many further meetings he attended after this date.)
32. On 13 November, the man completed a form about his present needs. He mentioned on the form that one of his needs was for accommodation after St Leonard's House. The form also explored drug use. One of the questions asked on the form as whether he wished he could stop taking drugs. He marked the form to show that that was something he always wished.

33. The relief assistant warden at St Leonard's House told my investigator that her substantive job was that of offender manager with the probation service. In addition to that, she worked occasional shifts at St Leonard's House to cover staff absences. She believed that she met the man on a total of three occasions, one of which was on 13 November. At just before his curfew time of 9.00pm, he telephoned the premises to say that he was lost in the Reading area, that he had missed his bus and had started walking back. He got back to St Leonard's House at just after 10.00pm and apologised for missing his curfew.
34. The man's offender supervisor¹ at St Leonard's House told the investigator that his first formal one-to-one key-work session with the man took place on 15 November. He said that the man seemed positive, confident and self-assured. He said that he was finding the premises "okay" and was feeling healthy following his time in prison. He said he would like to maintain his use of a gym, so the offender supervisor found details of gyms in the area, including their fees. The offender supervisor asked the man whether he had any concerns about the premises. The one matter that he mentioned was about the morning meetings. He said that there seemed to be a number of people who were always absent from the morning meeting and questioned why they were allowed to get away with that. The offender supervisor asked the man about his use of drugs and alcohol. He said that on two occasions since leaving prison he had had "a couple" of pints. This had made him feel "tipsy" as he was not a big drinker.
35. In the late evening of 19 November, the man and a number of other residents breached the premises rules by leaving their rooms after 11.00pm and associating in the passage way, as well as going in and out of one another's rooms. One of the two members of staff on duty told my investigator that, although the man was involved, he was on the periphery of the group and was among the number who returned to their own rooms sooner rather than later.
36. On 20 November, the manager issued the man with a formal written warning. A number of incidents were referred to in the letter. These included the incident of the previous night when he was associating with other residents after the 11.00pm curfew, as well as an incident when he had allowed another resident to enter his room. She also referred to other minor infringements of curfew times as well as mentioning that the man had been drinking alcohol and that this was linked to poor compliance with premises rules. Although consumption of alcohol away from the premises is allowed, she advised in her letter that he should try to avoid replacing one addiction (drugs), with another addiction (alcohol). She advised him that his evening curfew time had been brought forward an hour to 8.00pm. In addition, he was now required to

¹ All approved premises residents are allocated an offender supervisor. The role of the key-worker includes periodic meetings with the resident, assisting them with any problems, helping them to reintegrate into society and liaising with other agencies.

report to the office three times during the day: at midday, at 3.00pm and at 6.00pm.

37. The investigator spoke with an assistant warden at St Leonard's House. She made entries in the man's records on 22 and 23 November reflecting his annoyance at receiving a written warning about his behaviour. She also recorded that she reminded him that he should not ask junior members of staff questions outside of their authority (it seems he had asked a residential assistant if he could leave the premises during curfew hours so he could meet a female friend).
38. At a meeting with his probation officer on 24 November, the man reported feeling "emotionally low". He told his probation officer that he had stopped taking his prescribed anti-depressants as the medication was affecting his libido (sex drive). In his notes about the meeting, the probation officer recorded that he had suggested to the man that stopping the anti-depressants was not a good idea as "getting on a good functioning level" was a higher priority. The probation officer spoke with the man about his behaviour. He told him that his behaviour appeared to be on a downward spiral, resulting in sanctions from the premises fuelling further poor behaviour. The probation officer encouraged the man to try to improve his behaviour. He also noted that the man needed financial assistance to purchase groceries due to a delay in refunding him some expenses he was owed. Arrangements were made for him to be issued with food vouchers.
39. When the man returned to the premises that evening, one of the staff noted that he smelled of alcohol.
40. On 30 November, the assistant warden spoke with the man about the deterioration in his behaviour compared to when he first arrived at the premises. The man said that he had noticed that the residents who were aggressive and demanding would get what they wanted so he had decided to behave that way too. The assistant warden's record of this conversation concluded by noting that:

"... I told him he was being very negative, he then stated that he would be better off in prison and stormed off. He later told staff ... that he was never going to stop using drugs ... he said he told [the local doctor] he can go to London to get drugs and will leave it with friends to take whenever he likes so the [premises] won't know anything about it."
41. Later on that day the man spoke with the relief assistant warden. She told the investigator that he was a little agitated and approached her to complain about an encounter earlier that day with another member of staff. He seemed to believe that he was being discriminated against as other residents were being treated more leniently than him. She made a note in his records saying:

“... I encouraged him to use his time from now on as a fresh start ... I explained the consequences of him being rude to staff and not sticking to his reporting and curfew times and he seemed to recognise the benefits of compliance.”

42. On 2 December, the man was called to a meeting with several members of staff to discuss his general behaviour. The manager, probation officer and offender supervisor all attended.
43. The manager described the man's behaviour at St Leonard's House as "low level non-compliance". Examples of this included non compliance with the regime at the premises, being rude to staff and banging doors to gain attention. In addition, staff were concerned that he was consuming alcohol. While residents were permitted to consume alcohol when away from the premises, and while there were no occasions that the man returned to the premises in an intoxicated state, there was a concern that drink might have been affecting his behaviour. She told the investigator that the premises had commenced the "enforcement" process and that if his behaviour had not improved he might have been removed from the premises. He might also have lost his place in the residence if there had been evidence that he had resumed use of class A drugs, although referral to a drug support agency would have been attempted in the first instance. She said there had been an occasion in the days leading up to the meeting when she told him that she would undertake a drug test due to his attitude. He denied that he had taken drugs, but also refused to be tested. She told him that she would treat his refusal as a failed test. She told the investigator that she did not take the matter any further that day given the impending meeting with the probation officer. (Some days later, the man admitted to her that he had taken drugs that day.)
44. At the meeting, the premises rules were reinforced to the man. One of his complaints was that he was finding the curfew and report-in requirements too restrictive. The manager told him that she would put a "time-frame" on these and said that if his behaviour improved, she would lift the conditions.
45. The probation officer told my investigator that the man's behaviour at this time was such that his continued residence at St Leonard's House was in jeopardy. He said that the staff at the premises had worked very hard with the man and tolerated some pushing of the boundaries but at the meeting they reasserted that this might be his last chance. He said that it was made clear to the man that, if he lost his place at St Leonard's House, it might be difficult to find another premises to take him and if no other place could be found he would be recalled to prison custody. The probation officer told the investigator that he was not certain at the end of the meeting whether or nor the man would begin complying with the conditions of his residence.

46. The offender supervisor was also at the meeting. He told the investigator that the manager told the man about the purpose of the meeting and told him that this was his opportunity to make a fresh start. The offender supervisor said that the man initially went “off on a bit of a tangent”, as he could sometimes do, by talking about his alternative views on how he wanted to live his life. (Different staff mentioned him referring to himself as a nomad and a person who wanted to live outside of society.) The offender supervisor said that the man was allowed the chance to express his thoughts but was then brought back to the purpose of the meeting and he was eventually persuaded to sign up to the rules of the premises. The offender supervisor said that at that point the man disclosed an incident a few days previously when he had come very close to injecting himself with heroin. He said that he stopped himself and just afterwards two police officers came around the corner. He also said that he was getting prescribed medication from a doctor in London.
47. Staff told the investigator that the man’s behaviour improved following the meeting and a few days later his 9.00pm curfew time was extended to 10.00pm. In addition, the extra report-in times were removed, leaving a single report-in time of 5.00pm.
48. At a key work meeting on 8 December, the offender supervisor noted that the man appeared low in mood and when asked for the reason he said that he found some of the other residents irritating. It seems he believed that some of the younger residents were taking advantage of the rules so his view was that different age groups should be kept together in separate premises. The offender supervisor pointed out that approved premises cater for people of all ages and backgrounds. The man spoke about his non conformist views on society, including his belief that it was acceptable to take drugs providing he was not committing a crime in obtaining the drugs. He had also said at the beginning of the meeting that he “might do something, although it was not what he (the offender supervisor) was thinking”. The offender supervisor asked him what he meant, but he would not elaborate saying only that it would not affect staff or other residents. The offender supervisor told my investigator that he did not think the man meant that he would harm himself and by the end of the meeting he was quite buoyant.
49. In a telephone conversation with the probation officer the following day, the man said that his session with the offender supervisor the day before had not been very productive as he (the man) had been in a bad mood. The probation officer’s entry in the man’s electronic record noted that he had encouraged him to ask for a further session with the offender supervisor to discuss a number of issues such as finding accommodation after his time in St Leonard’s House and dealing with the problems with his budget.

50. An entry in the man's records on 12 December, referred to him reporting to staff that he was feeling much happier. His explanation for this was that he had not previously been eating properly due to money shortages but was now eating properly again.
51. On 13 December, the man was prescribed a different anti-depressant by his doctor. The new medication was mirtazapine and the doctor advised that weekly blood tests were required to see how the new drug interacted with his ongoing warfarin treatment.
52. On 14 December, the man attended the 10.00am morning meeting. This was followed by a project on "being positive" when applying for jobs and attending job interviews. He left the premises at midday, telling staff that he was going into "town". It seems he must have forgotten something, however, as he returned to the premises ten minutes later before leaving once more within a minute or so. He returned to the premises at just after 2.00pm.
53. The man was due to attend a meeting with the probation officer at the probation office that afternoon but he telephoned him to say that he needed to go to the doctor's and he asked to rearrange the appointment. The appointment was rearranged for two days later.
54. At around 4.00pm, the man left the premises. He told staff that he was going to the doctor's. To accord with his conditions of residence, he should have reported to the premises at 5.00pm. He failed to do so and 25 minutes later a staff member telephoned him to find out where he was. The man said that he was on his way to a friend's house to borrow some money and was then going to a police station to pay an overdue fine. He said that if he did not pay the fine a warrant would be issued and that might result in him being recalled to prison. The staff member asked him to bring evidence from the police station that he had been there. He returned to the premises at 6.40pm. When the staff member asked him for proof of where he had been he said that he had not gone to the police station but that the fine had nothing to do with the premises staff. The staff member noted that the man's eyes were "very heavy lidded and droopy", although there was no smell of alcohol. She told the investigator that the man had been complaining for several days that he was not sleeping well at night, which explained why he appeared tired. She said that she had no reason to be alarmed. Had she been concerned she would have set up half-hourly welfare checks.
55. The manager told the investigator that as she was leaving that evening the man was in the reception area. She said that he smiled and said "Goodnight, see you tomorrow". She responded in similar terms and left the premises.
56. At around 7.00pm, the man spent 15 minutes using the residents' telephone (it is understood that the call was to his father). After

completing the call he returned to his room for the remainder of the evening.

57. The investigator spoke with a residential assistant at St Leonard's House. He told the investigator that he usually worked night shifts, which at that time meant 9.00pm to 9.00am. His duties included observing the CCTV footage to ensure residents were complying with the rules and dispensing medication. He said that if he had a spare moment he would go out of the office to spend some time engaging with the residents. He said that he would exchange a few comments with the man, but he seemed a person who would interact more with other residents than with staff.
58. The residential assistant came on duty at 9.00pm on 14 December, as did the offender supervisor. Following a handover meeting with the day staff, the residential assistant observed the CCTV to determine the whereabouts of all the residents. He told the investigator that the man sometimes played pool in the evening but was not doing so that evening. As usual, he checked whether residents had collected their medication and saw that the man had not done so. (The man's records show that it was not unusual for it to be some time after 10.00pm before he collected his medication.)
59. The man had still not come for his medication by around 10.00pm, so the residential assistant went to his room to remind him. He knocked on the door but there was no answer. He then went into the room and saw the man in a kneeling position on the floor. The residential assistant said that it was not unusual to find residents asleep on the floor, especially if they have been drinking. He thought at first that that was the case with the man and he called his name twice to wake him. The man did not respond so the residential assistant went to call the offender supervisor for assistance and they both returned to the room.
60. The offender supervisor said that when he checked the man's wrist for a pulse, he found none and noticed that his hand was cold. He also checked without success for a neck pulse. While making these checks, the offender supervisor cut himself on a syringe that had been in the man's hand. The offender supervisor telephoned emergency services who advised him to move the man onto his back. He then went back downstairs to be ready to let in the ambulance paramedics upon their arrival. He said that paramedics arrived within a few minutes and attempted to resuscitate the man, but without success.
61. The investigator asked the residential assistant whether he considered attempts at resuscitation while waiting for arrival of the paramedic. He said that the man was "frozen" and he did not believe that resuscitation would have been successful.
62. The manager was at home when staff telephoned to inform her about what had happened. She drove to the premises and, on arrival, advised

the offender supervisor to go to the local accident and emergency department for his wound to be treated. Police officers were present by then and were reviewing the CCTV recording².

63. Once the officers had completed their investigations, they informed the manager that they were satisfied that no person had entered the man's room and that there had been no 'foul play'.
64. The police took details of the man's next-of-kin and said that they would break the news. Both the man's father and sister were informed of his death.
65. Over the following days, the manager had several lengthy telephone conversations with the man's sister. She offered support to the staff and other residents.
66. The manager told the investigator that when she was gathering together the man's belongings for return to his family, she discovered a box of prescribed diazepam tablets. She said that it appeared he had been handed the prescription form by the doctor allowing him to collect the medication from the pharmacy himself. She confirmed that this was contrary to the agreement between St Leonard's House and the two doctors' surgeries supplying services to the premises. She further confirmed that the premises would arrange a meeting with the doctors' surgeries to clarify processes and arrangements.
67. While gathering together the man's belongings, the manager also found a 'to do' list on which he had noted plans for the following day. (For instance he was planning to telephone the Department for Work and Pensions about an appeal.)

² Following a death at an approved premises, police officers attend as a matter of course to consider whether the death might have occurred in suspicious circumstances.

TOXICOLOGY AND CAUSE OF DEATH

68. Toxicological analysis of the man's blood and urine revealed the presence of a number of substances. A very high concentration of morphine was detected, which probably arose from the use of illicit heroin shortly before death.
69. Methadone is a powerful, synthetic opioid analgesic prescribed for moderate to severe pain. It is also used as a substitute for morphine and heroin in managing addiction to those drugs. The concentration of methadone found in the man's blood was consistent with that found in patients on methadone maintenance therapy.
70. Cocaine and benzoylecgonine were detected (the body rapidly breaks down cocaine to produce benzoylecgonine). The toxicologist explained that the concentration of cocaine was consistent with that occurring following "recreational use". The toxicologist also explained that as cocaine is broken down rapidly by the body, the concentration may have been higher at an earlier point, that it was likely that the drug had been used close to death and the man was likely to have been under the influence of cocaine at the time of his death.
71. Presence at therapeutic levels was found of the man's prescribed medications, mirtazapine and diazepam. (Therapeutic level means a level one would expect where the medication has been prescribed by a doctor or other clinician.)
72. A very low concentration of alcohol was also found. The toxicologist explained that microbiological action following death could have produced this result without any alcohol having been consumed. He also explained that, even if the level resulted from genuine alcohol consumption, the amount involved would not have had any significant pharmacological effect on the man.
73. A post mortem examination was carried out by a Consultant Histopathologist. (A histopathologist specialises in the diagnosis and study of disease through the interpretation of cells and tissue samples.) The Consultant Histopathologist concluded that the man's death was due to the "combined toxic effect of heroin and cocaine" and noted that:

"The findings at post mortem and subsequent histological investigations indicate an asphyxial cause of death³. Evidence of recent needle puncture wounds were identified in both antecubital fossae⁴. The toxicological analysis of blood and urine samples taken at post mortem ... has revealed that the man had taken heroin and cocaine soon before death. The level of morphine detected in his blood was in a range expected to cause death even in an individual with some tolerance."

³ Death through suffocation.

⁴ The depression in the arm at the bend of the elbow.

ISSUES

The man's use of illicit drugs

74. There is some evidence that the man wished to address his long standing problem with misuse of illicit drugs. He answered on a form asking about this that he "always" wished he could stop taking drugs. In addition, he attended at least one meeting at the local branch of Narcotics Anonymous, having been encouraged by staff to do so. However, in conversations with staff he gave some indication that he had no intention of ceasing to use illicit drugs. He had one such conversation with his probation officer who tried to persuade him to at least avoid class A drugs.
75. There was also an occasion when the man informed his offender supervisor of a day when he had been on the point of injecting himself with heroin, when he managed to stop himself.
76. The man mentioned on more than one occasion that he was able to obtain prescribed medication from a doctor in London, but there is no direct evidence of him actually doing this.
77. Although there was one occasion when the premises manager threatened to ask the man to take a drug test, there did not seem to be any occasions when staff had any genuine cause to believe him to be under the influence of drugs. She explained to the investigator that if it was known that he had resumed use of class A drugs, he would have been referred to a support agency. (Contact with such a service was not an aspect of his existing licence conditions.) Continued use of such drugs could have resulted in him losing his place at St Leonard's House which could potentially have triggered his recall to prison.
78. Despite the fact that the man's death was apparently caused through his use of two illegal drugs – heroin and cocaine – there seems to have been no obvious reason for staff to have known that he had obtained these substances and brought them into the premises.

The man's use of alcohol

79. When the man arrived at St Leonard's House he reported only occasional use of alcohol. There were a number of instances that staff smelled alcohol on his breath on his return to the premises after an evening out, but there would not seem to have been any occasions when he was inebriated. He was not therefore in contravention of premises rules. Even so, the manager was concerned that his alcohol use might have been adversely affecting his behaviour so he was advised in the warning letter of 20 November to try to avoid replacing his addiction to drugs with an addiction to alcohol.

80. Post mortem toxicological analysis revealed presence of a very low alcohol concentration in the man's blood. It is possible that this might have been produced by microbiological action after death without any alcohol having been consumed. However, even if the presence was from genuine consumption of alcohol, the amount involved would not have had any significant effect.
81. There is therefore no evidence of overuse of alcohol on the man's part, although staff at St Leonard's House acted diligently in monitoring and dealing with the potential problems with misuse.

The warning letter of 20 November and four-way meeting on 2 December

82. Having spent four years in prison custody, the man had difficulty in settling into an environment that was neither a custodial setting, nor a resumption of life in the community without restriction. He also seemed to see himself as a nomad and a person who could live outside of society. These difficulties manifested themselves in behaviours that the manager described as low level non-compliance, for instance infringement of curfew times. A more serious incident took place on the night of 19 November when he, along with other residents, were socialising in a communal area and going in and out of one-another's rooms outside of curfew hours. She dealt with the problem by issuing him a letter warning him about the consequences of future poor behaviour.
83. The man's attitude appears to have remained negative towards the premises, leading to the calling of a four-way meeting. The manager, probation officer and offender supervisor met with the man to discuss his behaviour and to discuss the possibility that he might be asked to leave the premises. (This could then have resulted in him being recalled to prison if an alternative placement could not be found.) It would seem that his behaviour began to improve after this.
84. It is likely that many residents will have initial difficulty in settling into an approved premises; as already mentioned, the person is neither in custody nor in the community proper. There are rules, regulations and standards of behaviour that need to be maintained and if one resident fails to comply that might lead to poor compliance on the part of others. In the circumstances, the premises acted appropriately in dealing with the man this way. Despite the ultimate outcome, it would seem that the warnings were successful in achieving an improvement in his general behaviour.

The man's comments on 8 December

85. At a key work meeting with his offender supervisor on 8 December, the man commented that he "might do something, although it was not what he (the offender supervisor) was thinking". The offender supervisor tried to explore with the man what he meant by the comment, but he would

not elaborate. He made the comment at the start of the meeting when he was complaining about the other residents and when the offender supervisor thought him to be low in mood. However, by the end of the meeting the offender supervisor thought the man to be quite buoyant and at no stage did he believe that the man was indicating that he might harm himself.

86. There are steps that staff should take if they identify that a resident might be at risk of harming themselves. The offender supervisor attempted to explore with the man the meaning of his comment, but without success. However, the offender supervisor assessed that the man's mood had lifted by the end of the meeting and there would seem to have been no reason for him to take any other action.

The prescribed medication found in the man's possession

87. Following the man's death, a box of diazepam tablets was found in his possession. It seems that these had been prescribed by a doctor from the local surgery at which he was registered. It would also seem that the doctor gave the prescription direct to the man allowing him to collect the medication from the local pharmacy. This was contrary to the agreement between the premises and the two surgeries serving the premises. The correct process would have been for the medication to be delivered to the premises for them to retain for daily issue to the residents.
88. The premises manager has told the investigator of her intention to organise a meeting with the doctors' surgeries to discuss their compliance with this arrangement. We make the following recommendation to ensure that this is done and that the meeting results in a more robust system for the issuing of controlled medication to residents.

The premises manager should ensure that the arrangements when residents are prescribed medications are robust and enable effective medicines management

The man's cause of death

89. The man's death has been attributed to the combined toxic effect of heroin and cocaine. Toxicological analysis of his blood and urine indicated that he had taken these substances very close to the time of death. Indeed, a needle and syringe were in his hand when he was found. The analysis also revealed the presence of methadone at a level expected in a patient being prescribed that medicine for morphine or heroin addiction. We do not know when or from whom he obtained these drugs.
90. While we do not know the man's intentions in taking these substances, none of the staff seemed to believe he was at risk of any act of

deliberate self-harm. His behaviour also seems to have settled somewhat following the warnings issued to him, which perhaps made him more aware of the need to comply with the premises' rules and regulations. Moreover, a 'to do' list was found in his room that included tasks he had planned for the following day.

The injury sustained by the offender supervisor

91. While trying to examine the man for signs of life, the offender supervisor cut himself on a syringe that was in the man's hand. It is important that staff learn from this incident and are given appropriate advice on the potential risks to safety in dealing with residents, particularly those with a history of drug misuse. We therefore make the following recommendation:

The premises manager should ensure appropriate advice and guidance is given to staff about the potential for injury when examining residents, particularly those with a history of drug misuse.

CONCLUSION

92. Having served four years of an eight year sentence, the man found it difficult at first to settle at St Leonard's House. It seems that he found the premises' rules and regulations an irritation. However, having received written and oral warnings about the consequences of continued poor behaviour, it seems he began to settle.
93. The man reported a long-standing history of heroin and cocaine abuse and gave slightly contradictory messages about his attitude towards continued misuse. That said, there were no occasions when staff clearly identified him as being under the influence of drugs.
94. The man's death appears to have resulted from the combined toxic effect of heroin and cocaine. Staff had not identified him as being at risk of deliberate self-harm, but his intentions in taking both heroin and cocaine, in addition to a high dose of methadone remain unclear.

RECOMMENDATIONS

The following recommendations were made in the draft report. Response to the recommendations from Thames Valley Probation Trust is included in italics following each recommendation.

1. The premises manager should ensure that the arrangements when residents are prescribed medications are robust and enable effective medicines management.

Response to recommendation: We have an informal agreement that prescribed medications are issued direct to the premises and are pursuing a contractual agreement with a Reading GP practice which would include formalisation of that, but even with a contractual agreement the onus would be on GPs to ensure prescribed medications were issued direct to the premises, not on the premises manager.

2. The premises manager should ensure appropriate advice and guidance is given to staff about the potential for injury when examining residents, particularly those with a history of drug misuse.

Response to recommendation: Accepted. Although we already had advice in place relating to room and property searches which required staff to wear protective gloves to avoid personal injury when undertaking them, the staff member in question would not have been able to check for a pulse while wearing protective gloves, so we need to review our guidance in light of that.