

**Investigation into the death of a man in April 2011
in Albion Street Approved Premises, in the West
Yorkshire Probation Area**

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

October 2012

This is the report of an investigation into the death of a man who was a resident at Albion Street Approved Probation Premises. He died in April 2011 of the toxic effects of methadone, diazepam and codeine. I offer my condolences to the man's family and all those affected by his loss.

The investigation was undertaken by one of my senior investigators. Both he and I would like to thank the Manager of Albion Street and her staff for their participation. One of my family liaison officers contacted the man's brother to explain our role and to offer the family the opportunity to raise any questions or concerns. I apologise for the delay in producing this report.

The man was released from HMP Lincoln in April. Plans were in place for him to reside in Albion Street Approved Premises, a probation hostel, and his family met him at the prison and took him there. He seemed to settle into the hostel, and there were no apparent problems. The man was undergoing a programme to help him stay off drugs, and the next day he took his prescription for methadone from the chemist, and returned to the hostel.

Hostel staff checked on all residents through the night. However, at approximately 8.30am on the morning of the man's death, a member of staff went to wake him and found him unresponsive. He summoned a colleague, who provided first aid until paramedics arrived. The man was transferred to an ambulance and taken to hospital, but sadly attempts at resuscitation were unsuccessful.

The man was only at Albion Street hostel for a short period. Preparations for his arrival and his induction were carried out well, including arrangements for managing and addressing his drug habit. Overall, this investigation found that staff were not at fault in his death, although there was scope to improve practice in a small number of areas. Thus, recording practice on residents' medication charts could be improved. Signing in and out of the hostel needed to be better managed and staff conducting wellbeing checks at night required a means of quick communication. Finally, in line with National Offender Management Service policy, assistance with funeral expenses should be offered on such sad occasions.

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 prisoners involved in my investigation.

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Prisons and Probation Ombudsman

October 2012

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SUMMARY

1. The man served a sentence in Lincoln prison. As a part of his release conditions, he had to reside in an Approved Premises (formerly known as probation hostels). Arrangements were put in place for him to reside at the Albion Street Hostel in Dewsbury, West Yorkshire.
2. His offender manager (formerly known as probation officers) liaised with staff in the prison to ensure that his transition to the community would be as smooth as possible. The man had suffered problems with drugs, and the preparation for release included work with the team in Lincoln prison who help prisoners with substance misuse problems, known as the CARAT team (Counselling, Assessment, Referral, Advice, Throughcare). While resident in the hostel, he would work with the Drug Intervention Programme (DIP) team at Dewsbury Lifeline.
3. Having been estranged from his family for some time, the man had made some steps towards reconciliation towards the end of his prison sentence. In April 2011, he was released from Lincoln prison, and his family met him at the gates and drove him to Albion Street.
4. The man was allocated a room, and given an induction into the hostel. Having been diagnosed with mental health problems, he was taking various medication, and it was agreed that staff would keep his medicine and give it to him as necessary. The hostel rules were explained to him.
5. He knew some of the residents, and spent some time with them. He seemed to settle in, and no problems were reported. The following day he attended his appointment at Dewsbury Lifeline, and discussed his ongoing treatment to help stay off drugs. This included a maintenance programme of methadone (a substitute for heroin). He then attended a meeting back at the hostel with his offender manager, and his link worker in the hostel. (Each resident has a link worker, who is his designated main contact.) He then returned to Lifeline, collected his prescription for methadone and went to the chemist. Lifeline confirmed that he collected his prescription.
6. Through the night, the member of staff conducting wellbeing checks heard the man snoring. This was the case at the last wellbeing check at 7.20am. At approximately 8.30am a member of staff went to wake the man, but found him unresponsive. He summoned a colleague, who was a trained first-aider. He attempted to resuscitate the man whilst an ambulance was called. Paramedics arrived and took over treatment. The man was transferred to an ambulance and taken to hospital. Unfortunately, resuscitation attempts were unsuccessful, and he was declared dead at 9.44am.

7. We make four recommendations. These refer to the maintenance of residents' medication charts, residents signing in and out of the hostel, staff having a means of communication with colleagues when conducting wellbeing checks, and assisting families with funeral expenses.

THE INVESTIGATION PROCESS

8. The investigation was opened by my senior investigator at Albion Street Approved Premises on 20 April 2011, where he was provided with all documentation related to the man. Notices were issued informing both staff and residents of the investigation. They asked anyone who had information pertinent to the investigation to contact the investigator, but no responses were subsequently received.
9. The investigator also wrote to the Acting Coroner on 15 April, to inform him of the nature and scope of the investigation and to request a copy of the post mortem report. The post mortem was not received until 13 December 2011. Unfortunately, this caused a consequent delay in publishing this report. Throughout the course of the investigation, the investigator remained in contact with the Coroner's office. Upon completion, this report will be sent to the Coroner to assist his enquiries into the man's death.
10. One of our family liaison officers (FLO) contacted the man's brother to explain the role of the office and the purpose of our investigation. The man's brother said that the family did not wish to raise any concerns. The draft report was sent to the family, and again they did not wish to raise any concerns in response.
11. The investigator formally interviewed six members of staff at Albion Street, as well as the man's Drug Intervention Programme case manager from Dewsbury Lifeline. Those interviews were recorded. The interviews were transcribed and interviewees invited to sign and return copies, confirming their accuracy. The investigator provided feedback to the hostel manager during the investigation.

THE MAN

12. The man was born in August 1974, although he had also given other dates of birth. Information obtained from West Yorkshire Probation Trust shows that he was one of four children. After leaving school, he went to college and later worked as a pharmaceutical representative for a number of years. However, after suffering some problems, which included mental health problems, he lost his employment.
13. The man's pre-sentence report (prepared by the probation service for the court) shows that in 2004 he was diagnosed with bipolar affective disorder (a serious, long term condition with "low" periods of depression and "high" periods of mania or hypomania), and prescribed medication. Around a year later, he reported that he started to abuse drugs. The man also indicated that he had previously harmed himself and had attempted to take his own life.
14. The man had served a number of prison sentences. His previous convictions show a history of mainly financially motivated offences, linked to his drug use. He indicated that he had a difficult relationship with his family, but during his most recent prison sentence he had been in contact with his mother in an effort to try and resolve differences.

ALBION STREET APPROVED PREMISES

15. Albion Street Approved Premises is situated in the West Yorkshire Probation Trust area and can house 24 male residents at any one time. All residents are provided with breakfast and an evening meal during the week with the addition of lunch over the weekend.
16. Approved premises (formerly known as Probation and Bail Hostels) are premises approved under Section 13 of the Offender Management Act 2007. They offer residential provision to selected offenders in order to provide enhanced levels of protection to the public and reduce the likelihood of further offending.
17. Approved premises work to National Standards and Approved Premises Regulations. They provide enhanced residential supervision by:
 - Working closely with offender managers (formerly known as probation officers);
 - Providing 24 hour staff oversight;
 - Monitoring curfews and ensuring compliance with rigorously enforced rules;
 - Undertaking ongoing observation and assessment of attitudes and behaviour;
 - Providing programmes of regular supervision, support and monitoring aimed at reducing offending behaviour and risk to the public.
18. Residents are provided with a link worker, an allocated member of staff, who meets with the resident on a weekly basis to support them and help them with any problems. Drug tests are carried out by staff if a resident has a history of abusing substances or if it is suspected that they may have used drugs. All residents are expected to attend money matters, alcohol and tenancy awareness programmes. Recreational activities such as pool, bingo and film nights are organised regularly.
19. Albion Street curfew times are 11.00pm to 6.00am, although some residents may have additional curfews. During these hours residents are expected to be on the premises. Staff undertake a curfew and wellbeing check at 11.00pm and then every hour throughout the night. Unless the resident is thought to be at risk of harming themselves, this generally involves staff listening outside residents' rooms. If staff are unable to hear movement they will knock and enter the room to check the resident's wellbeing.
20. During the night a member of staff from a contract service provider called Legion supervises the hostel and conducts the checks. In addition, a residential officer (RO) is also on duty in the hostel. They complete a shift during the day, then after the residents are in their rooms for the night they retire to a room in the hostel to sleep. They remain on call if needed throughout the night. All ROs are trained in first aid. At 7.00am a further

check is made and at 8.00am staff are expected to physically see all residents.

21. The man is the first resident to die in Albion Street since the Ombudsman took over responsibility for investigating deaths in custody in 2004.

KEY EVENTS

22. In January 2009, the man was sentenced to 66 months imprisonment. He served this sentence in a number of prisons, the last of which was HMP Lincoln. Whilst in prison he underwent treatment for his drug problems, which included being prescribed methadone (a synthetic opiate, used to help withdrawal from heroin).
23. The electronic case record shows that the man's offender manager (formerly referred to as probation officers) held a sentence plan review meeting on 28 January 2011. During interview, she told the investigator that this was held using a telephone conference system with Lincoln. Amongst a number of issues, she noted on the case record that the man was being seen by the prison's counselling, assessment, referral, advice and throughcare services (CARATs), who specialise in the treatment of substance abuse. The man's offender manager wrote that the man was complying with a detoxification programme. He had initially been prescribed 90mls of methadone daily, but this had been reduced to 34mls. She added that the dosage was being decreased on a weekly basis and the man hoped to complete the programme prior to his release. She noted that he was also engaged with the prison's mental health in-reach team. He had been prescribed Depakote and olanzapine (medications for bipolar disorder) as well as diazepam (treatment for anxiety).
24. A condition of the man's release was that he should initially reside at an Approved Premises (formerly known as a probation hostel). The man's offender manager referred him to Albion Street Approved Premises. The referral form indicates that he was content with this. She noted his date of release and provided a number of required documents including his pre-sentence report, list of previous convictions and his Offender Assessment System (OASys) assessment (used to measure the risks and needs of offenders). Under the hostel management issues section, she identified a number of concerns including the man's psychiatric history, drug misuse and risk of overdose. She highlighted his diagnosis of bipolar affective disorder, his methadone prescription, and his reports of previous self-harm. She made a note of his engagement with Lincoln's mental health in-reach and CARAT teams, and that both would be referring him to community support teams prior to his release. A week later, on 4 February, the electronic case record shows that the man was accepted for a place at Albion Street.
25. The man's offender manager spoke to a worker from the Lincoln's CARAT team on 16 February. She provided details of the man's release address so that he could arrange drug treatment support in the community. The following day, she spoke to a member of the mental health in-reach team and also gave him the same information so that he could refer the man to the appropriate community mental health team.

26. On 22 March, the man had reported to staff that his methadone prescription was only working until the early hours of the morning. He requested an increase in his dosage prior to his release to reduce the risk of his returning to illicit drug use. Plans were made for his prescription to be gradually increased accordingly. This is in line with guidance to reduce the risk of individuals resorting to illicit drug use on release and potentially overdosing.
27. The records also show that the CARAT worker contacted the man's offender manager on 24 March, and told her that he had referred the man to the Dewsbury Drug Intervention Programme (DIP) at Lifeline. On the same day, the man's offender manager received written notification from the prison that the man had also been referred to Dewsbury Mental Health Team.
28. The man's drug work case manager from Dewsbury Lifeline, told the investigator that she did not have any direct contact with the man whilst he was in prison. However, she confirmed that a referral had been received from Lincoln's CARAT team, and she had made an appointment with the man to follow his release.
29. On 1 April, the man telephoned his offender manager to confirm the arrangements for his release. He told her that a friend would collect him from Leeds station and take him to Albion Street. She noted that the man had been unwell, suffering from asthma, and he sounded "chesty".
30. The following week, on 8 April, the man's offender manager spoke to the Albion Street hostel manager to confirm the man's release arrangements. She also made a note on the electronic record that she had contacted Lincoln's CARAT team and they indicated that the man would be released with sufficient methadone until he had his DIP appointment.
31. The man was released on licence from Lincoln on 11 April. This meant that, although his prison term was not complete, he was allowed to finish his sentence under supervision in the community. One condition of his release was that he was to be resident in Albion Street Approved Premises for up to 90 days. (Although the hostel would, if necessary, have been able to accommodate him for a longer period if this was required to help him put in place appropriate plans for after leaving the hostel). He telephoned his offender manager that morning and told her that he was on his way to Albion Street.
32. Having been met by them at the prison, the man's family drove him to Albion St. The hostel manager told the investigator that he arrived at the hostel with his parents at approximately 12.15pm. She explained that the RO A carrying out inductions that day was engaged with another resident when the man arrived. Therefore, once his parents

had left, she showed the man to his room and settled him in until the Residential Officer was available. The man was allocated to a room.

33. When she was free, shortly after 2.00pm, RO A undertook the man's induction. The approved premises rules were explained to him and he signed various documents to show that this had been done. The man said that he felt okay, but this was dependent on him taking his medication. If he did not do so, his mental health deteriorated fairly rapidly. He was given a form to register with a local doctor, which he signed. She told him to register as soon as possible. He was encouraged to speak to and engage with staff in the hostel.
34. The approved premises manager also completed a suicide/self harm form, which is done for all residents. The form shows that the man had disclosed thoughts of self-harm during the previous four to five months but had not acted upon them. He said that he felt okay, and would approach staff if he was struggling with the pressures he faced. In the action plan section, RO A made a note that staff would be alert to the man's moods and if there were any concerns this would be discussed immediately with one of the hostel's managers.
35. As part of the induction process, RO A also conducted a risk assessment to determine if the man should be allowed to keep his prescribed medication in his own possession. She indicated that the man seemed "extremely confused in general and/or about" his medication. She also noted that he had a history of self harm within the last 12 months and had been prescribed "high risk medication". She concluded that he should not be permitted to keep his medication in his own possession. Rather, staff would hold the medicine, and the man would take it when required in front of staff. This decision was approved by the approved premises manager. The man's medical record shows that he handed in seven olanzapine 20mg tablets, 12 amoxicillin (antibiotic) 500mg, 49 prednisolone (anti-inflammatory) 5mg, seven diazepam 5mg, seven fluoxetine (anti-depressant) 20mg, seven valproate semisodium (mood stabiliser) 250 mg and seven valproate semisodium 500mg.
36. The RO A said in interview that the man was a little anxious about being at the hostel. She said that he also spoke about previous tensions with his family, but that they were trying to rebuild their relationship.
37. The investigator asked RO A if she specifically discussed drug use with the man. She said that she went through the hostel rules in relation to drugs. She explained that this included the hostel's response to residents who were under the influence of drugs or alcohol and engagement with specialist substance abuse provisions. She said that she did not talk about tolerance levels as this is usually covered by the link worker and/or DIP workers. (Regular use of heroin leads to an increased tolerance to the drug. If it is not used for a period, such as a

prison sentence, the user's tolerance level drops. If they then attempt to use the same amount they used previously, they risk an overdose.)

38. The man knew some of the residents in the hostel from his time in prison. During the afternoon he associated with two residents whom he knew. As part of the hostel rules, residents are required to sign out when they leave the hostel and sign in when they return. The signing in and out form for the man's room shows that he left the hostel at 2.50pm on 11 April, but the time when he returned was blank. There were no further entries on this document.
39. In line with hostel rules, a drug test was undertaken. This is done if there is a history of substance abuse or it is suspected that a resident has used drugs. In interview, RO A said that the drug test was carried out by another colleague later that same day. The man appeared anxious about it. She noted on the electronic case record that it was negative for all substances. The man was, however, anxious and disclosed that he had smoked cannabis in prison a few days previously. He was concerned that he might get into trouble, but she tried to reassure him. She stressed that the results were negative, and encouraged him to be honest with staff, explaining the rationale for the test. Throughout the day, she recalled that the man was perspiring a lot, but she said that she did not know if this was due to his medication, nerves or a combination of both.
40. The man's medication chart identifies when hostel staff gave him his tablets. It shows that he had one dose of amoxicillin and valproate semisodium (250 mg) at 9.50am, olanzapine at 8.22pm and valproate semisodium (500mg) at 10.25pm.
41. In interview, RO A said that she checked on all residents at 11.00pm, the hostel's curfew time. This included the man, and she confirmed that all residents were in the premises.
42. The RO A was the hostel's duty RO that day, and spent the night in the hostel itself. The following morning, 12 April, she came back into the office at 7.00am. No issues were raised by her night colleagues. She saw the man and said in interview that he was given his medication. However, the entry on his medication chart to indicate that he was given his drugs during the morning was erroneously entered for the previous day. She told the investigator that she had a general chat with the man about his first night and he seemed to be fine. She spoke to him again in the hostel's dining room and then again before 10.00am when he went into the office. She recalled that the man was still worried about the drug test and queried whether he was in trouble. She said she again tried to reassure him that he did not need to worry, encouraged him to be honest and repeated the reasons for the test. She added that she then completed her handover to staff coming on duty and left the hostel. She had no further contact with the man.

43. The man's drug work case manager told the investigator that the man arrived a bit late for his scheduled 2.00pm appointment at Dewsbury Lifeline, but she saw him for approximately one hour. The man had been provided with a methadone prescription by the prison, and they had provided confirmation of this. She noted that his prescription had been increased from 45mls to 55mls prior to his release.
44. The man's drug work case manager confirmed that drug tests would usually be given at the first meeting, but the man said that he needed to get back to the hostel quickly, so this was postponed. She described the man as out of breath and he told her that he had recently been treated in hospital for "some kind of throat/chest infection", and he was using inhalers to treat his asthma. She felt that he seemed "a bit dazed", which she attributed to his mental health medication, but he did not show any of the typical signs to suggest that he had used heroin. She recalled that the meeting was positive. The man appeared to be genuine when he said that he had not used heroin for two and a half years. She felt that he was quite motivated to come off drugs, but he wanted to continue with methadone, as his medication for his bipolar condition had just started to settle. The man also mentioned that he had recently reconciled with his family and he appeared to be happy about it.
45. The investigator asked the man's drug work case manager if she discussed tolerance levels with the man. She was very clear that this was done and also satisfied that he was fully aware that tolerance decreases after time in prison. She also indicated that she went through concerns about contaminated heroin with the man because this was an issue in the area at the time. (Heroin is sometimes mixed with other substances. Drug users are at risk of overdose and death because they are unaware of the strength and the actual contents of the heroin.)
46. After leaving Lifeline, the man returned to the hostel for a meeting with the man's offender manager and RO B and the man's link worker. (Each resident has a link worker, who will be their main contact and supervisor in the hostel.) The man's offender manager made a note of this on the man's electronic case record. The conditions of his licence were explained to him, she confirmed that he had registered with a doctor, and Dewsbury mental health team had indicated that he would be allocated a mental health worker over the next few days. Whilst the man was anxious about his release, he felt stable on his medication. RO B also documented details of the meeting on the electronic case record, noting that housing applications had been completed with two organisations for when he left the hostel.
47. The man said that his relationship with his parents had improved, and they had collected him from prison and brought him to the hostel. He hoped to continue to develop the relationship, aiming to eventually

enter the family business. The man commented that he liked it at the hostel and that he got on with the other residents.

48. During the man's offender manager's interview with the investigator, she said that although it had been hoped that the man would complete the detoxification programme before leaving prison, this had not happened. The CARAT team in the prison had therefore arranged for him to continue his treatment with Dewsbury DIP. The man had complied with his methadone prescription whilst he was in prison and in the meeting he remained very positive about staying drug free. The dangers of reduced tolerance were not discussed in the meeting, though she was satisfied that this would have been addressed by the CARAT team prior to release. RO B said in interview that he was content that this would also have been discussed by Lifeline. As had been pre-arranged before his release from prison, the man was due to return to Lifeline after the meeting to collect the prescription for his methadone. RO B told him to ensure that he had sufficient medication to cover the coming weekend.
49. The man's offender manager said that, whilst the man appeared to be physically well, he looked hot and he was sweating a lot. The man said that this was likely to be because he had not yet had his methadone for that day. Other than this, she said he confirmed that he was fine and all his medication had been arranged. He commented that he would be staying away from illegal drugs.
50. Following the meeting, the man returned to Lifeline and collected his methadone prescription. The man's drug work case manager explained in interview that the man would not have been released from prison with this drug in his possession. She added that Lifeline were unable to get him a clinic appointment to see a doctor to assess the dosage of his medication until Thursday that week. Therefore, the man was provided with a supervised "bridging" prescription for 12 to 13 April. (A supervised "bridging" prescription is taken to a chemist on a daily basis and the methadone is issued and taken in front of the pharmacist.) She said that the prison does not provide "bridging prescriptions". She gave the man directions to the pharmacist and Lifeline confirmed that he collected his methadone that night.
51. The contracted night staff worker at Albion St began his shift at 9.30pm on 12 April. He told my investigator that he recalled that the man collected his medication. The chart shows that at 10.25pm he was given one dose of olanzapine, amoxicillin and fluoxetine and three of diazepam. However, there was no record to indicate that he was given any valproate semisodium or prednisolone on 12 April, even though his medication chart shows that he was to take two and seven doses a day respectively. He said that the man appeared to be "okay".
52. The main door to the hostel was locked at 11.00pm, and RO B went round the hostel and ensured that all residents were present and did

not have any problems. He asked if they were due to be in the hostel for breakfast (some residents have jobs requiring early starts), and reminded those who had appointments. He spoke to the man, who reported no problems and appeared to be in a good mood.

53. During interview, the contracted night staff explained that his role on the night shift is as support to the RO. He said that once the door to the premises is shut at 11.00pm, the building's alarm is activated. He and the RO would then jointly carry out curfew and wellbeing checks to ensure that all residents are in the property. At 11.45pm residents have to leave all communal areas and go to their own rooms. After the RO retires for the night, he then conducts hourly checks. Between checks he monitors the hostel's closed circuit television (CCTV) screens to determine if there are any concerns. A further wellbeing check is then carried out at 7.00am. During this process the night officer said that he listens for indications of movement and/or breathing outside residents' rooms. If he cannot hear any noises he will knock lightly on the resident's door and quietly open it to check on the individual. At 8.30am all residents are individually woken up by a knock on their door.
54. The night officer said that during the course of the night of the man's death he followed this pattern. At around 1.00am, he said he saw another resident come from the man's room, but he had not seen him enter it. Whilst it is a hostel rule that residents must not go into each other's rooms, he said that this does sometimes happen. He said that the resident told him that he had used the man's telephone because his own one was "playing up". He felt that this was a plausible explanation.
55. A handwritten extract from hostel's approved premises log book shows that checks were carried out hourly from 12.10am on 13 April, through to 6.00am and no concerns were documented. The contracted night staff said in interview that he heard the man snoring quite heavily during the routine checks. RO B told the investigator that he was not called upon during the night, and came back downstairs at 6.45am. The contracted night staff then did a wellbeing check at 7.20am and again documented that all appeared to be in order. In interview, he said that he remembered hearing the man snoring during this check.
56. At 8.25am, the contracted night staff began to make the wake up calls for residents who were not already up. When he arrived at the man's door on the second floor, he noticed that it was quiet. He knocked firmly on the door and then opened it. He said that he saw the man lying on his back across his bed with his head facing his right shoulder. Most of the bottom half of his body, including his legs, was hanging over the edge of the bed. There was fluid coming from the side of the man's mouth. He called to him, but could not get a response. He went into the room and called the man's name several times, but again there was no response. He could see no movement in the man's chest and

his eyes were not fully closed. He left the man's room, shut the door and went downstairs to get the RO B.

57. RO B said that the contracted night staff came running down the stairs and into the office at 8.33am and asked him to quickly go up to the man's room. He told the investigator that he followed him and went into the room. RO B estimated that this took less than one minute. He then found the man lying across the bed with his head hanging down. He lifted up the man's head and noted liquid coming from his mouth. He asked the contracted night staff to call an ambulance, giving information as to the man's condition. The contracted night staff went back to the office and did so. He then returned to the man's room.
58. A trained first-aider, RO B checked the man for signs of life but was unable to find any. He turned the man so that he was lying on the bed. He recalled that this was quite difficult as the man was a large man, but he kept his head back over the end of the bed so that his airway remained opened. He then checked the man's mouth and he could not see any obstruction, so he started CPR. (CPR is a combination of rescue breathing, which provides oxygen to the lungs, and chest compressions, which keeps oxygenated blood circulating until an effective heartbeat and breathing can be restored)
59. Concerned that the man needed urgent medical attention, although the contracted night staff had already requested an ambulance, RO B dialled 999 on his personal mobile telephone and spoke to the emergency operator whilst he continued with CPR. He was asked if the hostel had a defibrillator and replied that they did not have one. (A defibrillator is an electrical device that is used to restore a normal heart beat by applying a brief electric shock.) He added that he was instructed to continue with chest compressions until the ambulance arrived.
60. In an emergency, the ambulance service sometimes sends a first response paramedic, who will be able to arrive more quickly than an ambulance. This happened here, and the contracted night staff showed her to the man's room. RO B helped her move the man onto the floor, and continued to perform CPR while the paramedic attached medical equipment to him.
61. The hostel's log shows that the ambulance arrived at 8.45am. On arrival at the man's room, the paramedics took over with the attempts to resuscitate him. They continued to provide medical aid until 9.30am, when they transferred the man to the ambulance and took him to hospital.
62. The electronic record shows that the hostel manager tried to contact the hospital several times to get an update on the man's condition. When she managed to get through to the accident and emergency department she noted that she was told that someone would contact

her, but this never happened. Later that morning, she noted that the police attended the hostel and they told her that the man had died, but there was no indication of the time of death. She added that the police confirmed that the man's next of kin had also been notified.

63. During the hostel manager's meeting with the investigator she recalled that the police removed a number of items from the man's room including what appeared to be a prison-issue pack of diazepam, an inhaler and co-codamol (pain relief medication).

Support for staff

64. It is usual in light of the death of a resident to hold a debriefing session with staff involved in his or her care. This ensures that staff have an opportunity to discuss any issues arising from the death, and for support to be made available.
65. The approved premises manager debriefed both RO B and the contracted night staff after the man was taken to hospital. RO A was not working that day or the next, so the hostel manager telephoned her to inform her of the man's death. She held a formal debrief with her the next time she was on shift. During interview all staff said that they had been offered support. In addition, the Operations Manager for Approved Premises, and the Offender Services Operational Manager, also attended the hostel to offer support. Support was also made available to staff via First Assist, an employee support organisation.

Support for residents

66. A residents' meeting was convened by the hostel manager during the evening of the man's death and they were notified about his death. They were provided with an opportunity to talk about it. In addition, a group meeting was held the following day. Residents had individual sessions with their link workers and access to a counselling service. An informal service was held at the hostel, when residents planted a shrub in the man's memory.

Family contact

67. The hostel manager wrote to the man's parents on 15 April, and offered her condolences. She offered them the opportunity to visit her at the hostel to discuss any issues. The man's brother attended the hostel three days later and collected the man's belongings.

Post Mortem

68. A post mortem was carried out and a post mortem report was issued on 9 December 2011. The doctor concluded that the man died from the toxic effects of methadone, diazepam and codeine. Although the

levels of diazepam and codeine in his system were not excessive, he had a higher level of methadone in his body than would be expected from his prescription. The combined effects were likely to have caused the man's respiratory system to have ceased to work effectively, causing his heart and lungs to stop operating.

Funeral

69. The man's funeral was held on 21 April. In line with the family's wishes, the hostel were not involved in planning the man's funeral, nor were they represented there. They did send a wreath, but did not identify it as being from the probation service.

ISSUES

Arrangements for the man's release from prison

70. There was a good level of liaison between the man's offender manager, the prison, and the man prior to his release. The man's offender manager also spoke to the CARAT team in the prison, and arrangements were in place for his registration with Lifeline in Dewsbury. His place at Albion Street was confirmed, and beyond his own natural anxiety about release, we are satisfied that everything possible was done to ensure a smooth transition from custody to the community.

Albion Street

71. When the man arrived at Albion Street, the RO due to take him through induction was engaged. The hostel manager therefore greeted him, showed him to his room, and helped him settle in.
72. The induction was then done the same afternoon, and covered the issues which needed to be addressed. A proper risk assessment was made in relation to his medication, and this was explained to him.
73. The man's signing in and out sheet only contains one entry, which was him leaving the hostel on the afternoon of 11 April. He did not sign back in. Although this played no part in his death, it does make tracking his movements difficult. It also means that the reasons for keeping signing in and out sheets are bypassed. We therefore recommend:

The hostel manager should remind residents to sign in and out of the hostel as required.

74. At his induction meeting, the hostel's drug policy was explained to the man. He was given a drug test, which was negative. The man attended Lifeline the following day, and in his interview with his drug worker they discussed tolerance levels. He was not allowed to retain his medication in his own possession, and handed in a quantity of medication to hostel staff. The hostel manager said that police found some diazepam in the man's room, which appeared to be issued from prison. There was no reason, though, for the hostel to have suspected that he had any further medication. He had just arrived at the hostel, had handed in a quantity of his medication, and seemed genuine in his desire to remain drug free. Moreover, the post mortem report notes that the amount of diazepam in his system was not excessive.
75. The medication charts are not, however, fully clear as to who issued the man's medication. They show that he was given valproate semisodium at 9.50am on 11 April, which was before he arrived at the hostel. There is no record to indicate that after arriving in the hostel on

11 April, the man was given prednisolone, diazepam or fluoxetine, which he should have received respectively seven, three and two times per day (although it is possible that he may have received this medication before arriving). Nor do the charts show that he received his medication at all on the morning of 12 April.

76. Effective record keeping is essential, particularly in relation to medication. It is hard to see how effective continuity of care can take place when key records are incomplete. The hostel manager should remind staff of the importance of maintaining medication charts.

The hostel manager should ensure that residents' medication charts are properly and legibly maintained.

77. The contracted night staff said that at 1.00am on the day the man died, he saw another resident coming out of the man's room. Residents are not supposed to be in each other's rooms at that time. This resident was a friend of the man, and the explanation he gave him seemed plausible. It was not possible for the investigator to interview this resident so we can offer no further clarification on this point. We have uncovered nothing to suggest that there was anything untoward in this visit.

The emergency response

78. The contracted night staff said in interview that he had noted the man snoring through both nights he spent in the hostel. On his round of wellbeing checks at 7.20am on the day the man died, he again heard the man snoring. There was no sign of any problem at that stage.
79. It was at 8.25am, when he went to wake residents who were not yet up, that the contracted night staff found the man unresponsive, and immediately ran down the stairs to get help.
80. The investigator asked the contracted night staff why he did not start emergency resuscitation immediately when he discovered the man. The contracted night staff said that he had undertaken first aid training in the past, but this had recently expired. He explained that his initial reaction was to get help. He added that he did not want to do anything without assistance. He told the investigator that the hostel provides mobile telephones for staff to use during checks, but he had left it in the office.
81. It is unfortunate that the contracted night staff did not have the mobile telephone with him to summon RO B, as this may have allowed him to commence resuscitation immediately. The hostel manager should remind all staff conducting wellbeing checks that they should make sure they have a means of communication with colleagues.

The hostel manager should ensure that staff conducting wellbeing checks have an effective means of communication with colleagues at all times.

82. RO B performed CPR on the man whilst he was lying on the bed. Good practice for resuscitation is that it should be performed on a hard surface. However, in this instance, the man was found lying across his bed. He was a large man, and it took some effort on the RO B's part to move him lengthways onto the bed. RO B's priority was to begin attempts at resuscitation, and he appears to have acted expeditiously in the circumstances to do the best for the man.
83. There does remain the question of whether it is wise to have wellbeing checks conducted by a member of staff who is not first aid trained. The hostel always has an RO on duty, and all ROs are first aid trained. If there is an emergency, a trained first-aider will be available, and that was the case here. It is unlikely that the time lost in his running down the stairs to fetch RO B was extensive, and he provided first aid until paramedics arrived. This report does not offer criticism on this count.
84. The post mortem examination noted that the man had levels of methadone in his system that were higher than would be expected from his prescription. The investigator confirmed that the man had been given his methadone prescription at 7.30am, prior to leaving prison. He handed in a quantity of medication when he arrived at the hostel, and staff had no reason to query whether he had any further medication. His Lifeline worker said that he would not have been released from prison with methadone. He was therefore given a bridging prescription, providing only enough methadone for one day. Lifeline also confirmed that he filled his prescription at the pharmacy as intended, and there is no indication that he was given more than he was due. It is not therefore possible for this report to say how the higher levels of methadone in the man's system might have come about.
85. The man's family indicated that they did not want the hostel involved in his funeral. The hostel respected those wishes. It also displays sensitivity that they sent a wreath to the funeral, but ensured that it did not make reference to the probation service.
86. The Approved Premises Manual 2011 says that probation trusts should offer to pay reasonable funeral costs of residents who die in their care. Reasonable is judged to be up to £3000. In this case, no offer appears to have been made to the man's family to assist with funeral expenses. The hostel manager should ensure that if such a situation arises again in the future, such an offer is made.

The hostel manager should ensure that an appropriate offer is made to assist with funeral expenses in line with guidance in the Approved Premises Manual 2011.

CONCLUSION

87. Having served a period of imprisonment, good preparations were made for the man to move to the hostel in Albion Street. Although it had not proved possible to complete his drug treatment in prison, Dewsbury Lifeline were notified in advance of his release and made preparations to continue his treatment. This included an ongoing prescription of methadone.
88. On his release, the man was met by his family and driven to Albion Street. He was given his induction, the hostel rules were explained to him, and it was agreed that staff would keep his medication and give it to him as required. He was given a drug test, which proved negative, although he did admit to having smoked cannabis some days previously. He was anxious about leaving prison, but had some acquaintances in the hostel, and seemed content.
89. The following day he attended his appointment at Lifeline. Again, things seemed to go well, and the man appeared to be genuinely determined to keep off drugs. He attended a meeting back at the hostel, then went back to Lifeline to collect his prescription. He went to the pharmacy and collected his methadone.
90. Wellbeing checks through the night gave no indication of problems. When staff went to wake the man the following morning, however, he was unresponsive. The member of staff who found him did not have a means of communication, and therefore had to physically go and collect a colleague. This colleague provided first aid until paramedics arrived and took over. The man was taken to hospital, where he was later pronounced dead.
91. The man was only in the hostel for a short period. Preparations for his reception were good, and on arrival all seemed to go well. This report identifies some minor administrative issues, but broadly speaking staff cannot be criticised for any of their treatment of the man. He appeared to be settling into the hostel well until the sad events of the morning of his death.
92. This report makes four recommendations. These relate to record-keeping, signing in and out of the hostel, staff carrying means of communication during wellbeing checks, and offering assistance with funeral expenses.

RECOMMENDATIONS

1. The hostel manager should remind residents to sign in and out of the hostel as required.

NOMS requested a change to the original recommendation, which was that the manager should “ensure” that residents sign in and out. They said that it was not practicable to ensure that this happened in every instance, but were confident that they had robust procedures in place to ensure that residents followed the expectations of Approved Premises.

2. The hostel manager should ensure that residents’ medication charts are properly and legibly maintained.

This recommendation was accepted. The hostel manager has ensured that all staff understand the importance of filling the medical record sheets correctly.

3. The hostel manager should ensure that staff conducting wellbeing checks have an effective means of communication with colleagues at all times.

This recommendation was accepted.

4. The hostel manager should ensure that an appropriate offer is made to assist with funeral expenses in line with guidance in the Approved Premises Manual 2011.

This recommendation was accepted, although the hostel stated that this should be directed at the Probation Trust. NOMS undertook to remind Approved Premises’ operators of the requirement to help with funeral expenses, and would include this in an update to the Approved Premises manual.