

A Report by the  
Prisons and  
Probation  
Ombudsman  
Nigel Newcomen CBE

**Investigation into the death of a man  
at Stafford House Approved Premises, Liverpool,  
in March 2014**

## ***Our Vision***

*'To be a leading, independent investigatory body,  
a model to others, that makes a significant contribution to  
safer, fairer custody and offender supervision'*

This is the investigation report into the death in March 2014 of a man, a resident at Stafford House Approved Premises, Liverpool. He died of a drug overdose. He was 42 years old. I offer my condolences to his family and friends.

Staff at Stafford House co-operated fully with the investigation.

The man had been at Stafford House since 11 November 2013, after his release on licence from prison. He had a history of illicit drug misuse and had been prescribed methadone and several other medications for physical and mental health conditions. He engaged very well with staff at the approved premises and the Resettle project that he attended daily, whose staff were principally responsible for his supervision. Several times during his stay at Stafford House, he admitted to relapses and failed drug tests. Staff gave him support and advice about relapse prevention. They did not take action to recall him to prison as it was not prolonged or regular drug misuse and he had been open and honest.

On the day of the incident, in March 2014, the man had been out for much of the day. At around 8.00pm, one of his friends telephoned the Resettle crisis line to say she was concerned about his emotional state. When he returned to Stafford House that evening, he was distressed and admitted that he had used drugs. He would not reveal everything that he had taken or the quantity and he refused to go to hospital. He did not appear physically unwell and, after consulting a manager, the staff began suicide and self-harm prevention procedures and placed him in a room with a CCTV camera so they could monitor him easily and went to check on him every 30 minutes. In the early hours of the morning, he appeared to be unwell and a member of staff was unable to gain a coherent response from him. The staff called an ambulance which took him to hospital. Sadly, he died in hospital.

I am satisfied that, overall, the man was appropriately managed at Stafford House and that, when staff found out that he had used illicit drugs and was low in mood, they acted promptly to put appropriate measures in place. Although he had admitted to taking drugs, this was not the first time, and there was little to indicate that he had taken a serious overdose. It does not appear that staff could have predicted his death and it would therefore have been very difficult to take any additional action to help prevent it.

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.

**Nigel Newcomen CBE**  
**Prisons and Probation Ombudsman**

**October 2014**

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## SUMMARY

1. The man was released on licence from prison on 11 November 2013, to live at Stafford House Approved Premises in Liverpool. He had a history of illicit drug misuse and was on a methadone maintenance programme. He had also been diagnosed with mental and physical health problems.
2. As part of his licence conditions, the man was required to attend a daily programme at Resettle, a community project to support high risk ex-offenders with personality related difficulties. Resettle staff were jointly responsible for supervising him and he did not attend group or individual sessions at Stafford House. He settled well and received favourable reports. However, he occasionally lapsed into using illicit drugs. When he did, he either telephoned the Resettle crisis line, or told his key workers the next day. Staff conducted frequent drug tests but did not recall him to prison as they considered that his lapses were not indicative of a return to regular drug use.
3. At 8.00pm on 26 March, a Resettle worker received a telephone call from a friend of the man's who was concerned about his emotional state. Around an hour and a half later, he returned to Stafford House and went straight to his room. One of the night staff followed him to check how he was. He told her that he felt low and had taken some tablets the previous evening, but he was vague about what they were or how many he had taken. He also admitted that he had used cocaine and other drugs that evening. The worker who had taken the crisis line call telephoned him and he repeated what he had told the other staff. She advised him to go to hospital, but he would not. Although he was clearly upset, staff thought he showed no obvious physical symptoms of a drug overdose. They consulted a manager and started suicide and self-harm prevention procedures. They moved him to a room with CCTV coverage to monitor him more closely and checked him physically every 30 minutes.
4. At 1.30am, one of the night staff noticed that the man appeared unwell and he could not get a coherent response from him. An ambulance took him to hospital, where he died. Staff at Stafford House found 17 empty blister packs of prescribed medication in his room. Toxicology tests later indicated that he had taken a number of prescribed and illicit substances and the cause of his death was most likely an overdose of propranolol (used to treat high blood pressure and anxiety).
5. The investigation found that Stafford House has clear policies and procedures for the safe management of medication, including regular checks of residents' rooms and medication safes. (A check on the morning of 26 March had revealed nothing untoward.) Staff at Stafford House and Resettle supported him appropriately when he relapsed into drug misuse and, in response to his distress on 26 March they made every effort to monitor him. They promptly contacted the emergency services when his condition deteriorated in the early hours of the morning, but sadly he died later in hospital. We do not consider that staff at Stafford House could have predicted or prevented his death.

## THE INVESTIGATION PROCESS

6. Notices announcing the investigation were issued to staff and residents at Stafford House Approved Premises, inviting anyone who had information relating to the man's death to contact the investigator. No one responded.
7. The investigator visited Stafford House on 3 April 2014. He interviewed the manager and project workers at Resettle. He liaised with staff at Stafford House during the investigation.
8. We informed HM Coroner for Liverpool of the investigation and we have sent a copy of this report to him. An inquest held in front of a jury into the man's death concluded that the nature of his death was 'misadventure through drug toxicity'.
9. One of the Ombudsman's family liaison officers and the investigator visited the man's family on 16 May 2014, to explain the purpose of our investigation and invite them to identify any relevant issues that they wanted the investigation to consider. The family were concerned about the actions of staff on 26/27 March and asked why they had not sent him to hospital when he disclosed that he had taken illicit substances.
10. Following the issue of the draft report the man's family submitted a written response to our findings. The points raised have been dealt with in separate correspondence and have not led to any factual changes within the final report.

## **STAFFORD HOUSE APPROVED PREMISES**

11. Approved premises (formerly known as probation and bail hostels) accommodate offenders released from prison on licence and those directed to live there by the courts as a condition of bail. Their purpose is to provide an enhanced level of residential supervision in the community, as well as a supportive and structured environment.
12. Stafford House is an approved premises in Liverpool, managed by Merseyside Probation Trust. It accommodates up to 17 residents and has a manager and probation service officers. Residents are required to abide by the rules, including an overnight curfew between 11.00pm and 6.00am. There is a sophisticated CCTV system, which records the movements of residents in and out of the premises, therefore routine signing in and out (which is often the case at other approved premises) is unnecessary. Some residents are required to sign in at specific times to help manage their risk. Staff can review the CCTV footage if they need to check a resident's whereabouts at a later time or date. They also conduct hourly, physical room checks for health and safety and to account for residents within the premises.
13. Stafford House is a designated Psychologically Informed Planned Environment (PIPE) or enhanced approved premises. There are currently eight PIPE units in England in prisons and probation approved premises which provide a particularly safe and supportive environment for offenders after a period of intense treatment. Staff receive additional training to develop an increased psychological understanding of their work and the more complex behaviours of offenders with a personality disorder and a psychologist works on site.
14. Most residents are allocated a dedicated key worker, a trained member of staff who acts as their primary point of contact and assists with practical issues. Regular key worker sessions give residents the opportunity to discuss any difficulties and key workers offer support and guidance to help them comply with their licence conditions. The man's key workers were at Resettle.
15. Residents are responsible for their own health and register with a local GP. Generally, subject to a risk assessment, they are allowed to keep medication in a safe in their room and staff conduct routine checks to ensure compliance. Controlled drugs are held in the office and dispensed by staff.
16. There have been no previous deaths at Stafford House.

## **RESETTLE**

17. Resettle is a Merseyside Probation Trust project funded by the Ministry of Justice and the NHS. The project aims to address the mental health and social needs of high risk ex-offenders with personality disorders to help them reintegrate into the community and reduce the risk of offending. The Resettle staff are multidisciplinary, including police, probation officers and health professionals.

## KEY EVENTS

18. On 12 April 2011, the man was sentenced to four years imprisonment for several offences of wounding and causing grievous bodily harm. He had a history of drug misuse and was on a methadone maintenance programme to treat heroin addiction. On several occasions, he was managed under Prison Service suicide and self-harm prevention procedures. On 17 January 2013, he was released from prison on licence and required to live at Stafford House Approved Premises. He breached his licence conditions by taking drugs and failing to return to the approved premises. His licence was revoked and he was recalled to prison on 7 February 2013.
19. The man was released again on 11 November 2013. Staff from the Resettle team collected him from HMP Liverpool and took him to Stafford House. He attended induction meetings and met the manager.
20. The man's standard licence conditions required him to live at Stafford House, engage with the Probation Service and comply with the rules and regulations of the approved premises. Additional licence requirements were to attend the Resettle project daily and engage with a psychiatrist. As is standard practice, he had to provide urine samples for drug testing at the discretion of premises and Resettle staff. Due to the previous breach of his licence, an emergency recall system was in place as a safeguard, so that probation staff could initiate an immediate recall if he failed to comply with his licence conditions. His licence was due to expire on 17 January 2015.
21. On 12 November, the man attended the Resettle programme for the first time. Later that day, he had an appointment with a local GP. He had been prescribed a number of medications for physical and mental health conditions, including a daily dose of methadone. The methadone was managed by Resettle, in conjunction with Liverpool Drug and Alcohol Response Team (DART). His GP prescribed all his other medications and staff at Stafford House helped manage them.
22. Staff at Resettle were responsible for the man's key work sessions, so he did not have to attend any offending behaviour courses or groups at Stafford House, other than routine residents' meetings. The manager explained to the investigator that this was to avoid duplication of work and confusion for the resident but he would deal directly with any issues relating to Stafford House.
23. During November, the man received favourable reports about his engagement in group work, his behaviour and attitude. He appeared to get on well with staff at Resettle and Stafford House. He was occasionally tearful and told staff that he sometimes felt overwhelmed by the subjects discussed.
24. On 21 November, the man telephoned the Resettle crisis line and told duty staff that he had used crack cocaine. The next day, he discussed this during a meeting with one of his key workers at Resettle. He explained that, after a disagreement with his mother, he had met someone he knew and had used some crack cocaine. He said that he had reflected on his actions overnight and

had written down a number of things that he 'needed to get straight in his head'. These included that he was suffering from toothache and sore feet. He also said that he had drunk two to three pints of lager at the weekend when he normally only had one. He said that he was also anxious about a forthcoming hospital appointment about his hepatitis C. They discussed his concerns and the key worker gave him advice and collected a urine sample for a drug test.

25. The test was positive for opiates, methadone and benzodiazepines. This was consistent with his prescribed medication, but staff decided to begin a programme of random mouth swabs to detect any illicit drug use. They reassured the man that by admitting his lapse, he could receive additional support. He then continued to comply with the Resettle programme and the approved premises' rules. He participated well during group work and individual sessions. He mentioned having cravings at times but denied that he had used any illicit substances. Drug tests confirmed he had only taken prescribed medications.
26. The man was allowed to stay overnight with his mother in mid-December and during the Christmas period. Due to his continued good behaviour and compliance with the programme and his licence conditions, on 3 January 2014, staff removed the emergency recall provision that had been imposed when he was first released from custody. He provided negative drug tests for illicit drugs, although there were some concerns about the efficiency of the mouth swabs.
27. The man said that, staff at Stafford House conducted the mouth swab tests, while Resettle used urine tests and sent samples away for analysis at an independent laboratory. The latter were considered to be more reliable.
28. On 14 January 2014, the man's supervising psychiatrist chaired a mental health review which he, his mother, his social supervisor and his offender manager at Resettle attended. He indicated that he was keen to continue psychiatry sessions and he did not want any changes in his medication at that stage. It was agreed that further reviews would take place every three months.
29. On 23 January, at a meeting with his Resettle key worker and a member of DART, he admitted that he had used £10 worth of heroin and crack cocaine the previous evening and he was struggling to cope with some issues. He said that he had walked past a group of people who were buying drugs and this had been a trigger for him to do the same. He added that he had ended a relationship as he did not feel ready and he was concerned about ongoing health problems. He felt lonely and found it difficult to trust anyone. The key worker and the drug worker agreed to liaise with a healthcare worker to obtain more information on his behalf.
30. The key worker advised the man about relapse prevention methods and he said that he had used such techniques the previous evening, including giving his cash card to his mother so that he had no access to money. She encouraged him to use the crisis line if he found himself in similar situations in the future and he agreed he would.

31. Although they are allowed to have medication in possession, residents are not allowed to collect prescriptions personally. Each resident has a 'flag' against them at the local GP surgery, indicating that they are not to be given prescriptions. These are sent to a local pharmacy, which delivers the medication directly to the approved premises. Staff then record the medication on the individual's medication charts before dispensing the items.
32. At 3.40pm on 24 January, one of the man's key workers telephoned Stafford House to tell staff that his GP had given him a prescription for a week's supply of propranolol (a beta blocker used to treat high blood pressure and anxiety) and diazepam (a benzodiazepine used as a sedative) which he should hand in to staff when he got back to the premises. Stafford House received a further telephone call from the surgery to say that the doctor had also prescribed him 75mg pregabalin (an anti-convulsant used to treat seizures, nerve pain and anxiety) and asked staff to get the prescription from him when he returned.
33. When the man got back that evening, he told staff that he had been given propranolol tablets and 12 diazepam but no pregabalin. He said that he had taken two of the diazepam, but they had made him feel strange so he had disposed of them at his mother's house. Staff contacted his mother who agreed this account. He handed in 40 propranolol tablets. Later that evening, he handed staff six diazepam tablets. He gave no explanation.
34. A member of staff from Stafford House telephoned the surgery on Monday 27 January to discuss the man's prescription. Surgery staff confirmed that he had been prescribed propranolol and diazepam, but not pregabalin as previously reported. Later that afternoon, staff received a further telephone call from a GP who informed them that no further diazepam would be prescribed for him. She confirmed that he had not been prescribed pregabalin and the information had been given in error.
35. The man continued to engage well with the Resettle project. Staff at Resettle, the area drug team and Stafford House considered that his recent drug use had been isolated incidents and he was not using drugs regularly. He complied fully with drug tests and was allowed a further period of home leave in January.
36. On 18 March, the man tested positive for cocaine, but disputed the result and denied any use of illicit drugs. The next day, one of his key workers accompanied him to a routine hospital appointment. She noted his positive test and that a further test would be needed which could hinder his home leave planned for that weekend.
37. On 20 March, Resettle key workers talked to the man about his recent lapses but agreed his home leave. He undertook not to betray the trust placed in him and to take a drug test before he went home and immediately when he got back.
38. When the man attended Resettle on Monday 24 March, after his home leave, he told staff that he had used cocaine at the weekend. During a key work

session with one of his key workers, he said that he was struggling to cope with personal problems and he had drunk some beer at his mother's house and then went into Liverpool city centre where he had used crack cocaine. He said that he did not want to have further home leave for the time being. They discussed strategies for dealing with his problems, including contacting the crisis line before any illicit drug use rather than afterwards.

39. In relation to the possibility of recalling the man, the manager explained that Resettle was responsible for enforcing his licence and their view was that his admission of drug use was not linked to any other criminality. He did not appear to have returned to daily drug use and he had continued to cooperate with staff at Resettle and Stafford House. Therefore, they did not consider it necessary to recall him. The manager said that staff were very aware of his mental health problems, which meant that he became stressed about certain situations and reacted negatively, which had been the case when he had previously been recalled to prison.
40. On 24 March, a member of Stafford House's relief staff received a telephone call from the GP's surgery asking if the man could be given permission to collect his own prescription. He sought advice from an experienced supervisor at Stafford House, who agreed this could be done as long as he handed the medication to Stafford House staff when he returned.
41. Although this was not in line with the medication policy, the supervisor said he allowed the man to collect his medication as he was already at the surgery and had previously displayed a responsible attitude. He handed all the medication to staff when he returned to Stafford House.

### **Events leading up to the incident**

42. The man spent most of the morning at Stafford House as he did not have to go to Resettle that day. He told the manager that he was going on a date with a woman who had written to him while he was in prison and that he was informing him as it was a condition of his licence. The manager said that he seemed excited and had clearly made an effort to look smart.
43. When the man came back to Stafford House that afternoon, he went straight to his room. Staff said that this was not unusual, as he preferred to spend time in his room rather than socialising with other residents. He left the premises again around teatime but did not say where he was going.
44. During the day, staff conducted a routine check on the medication safes in residents' rooms. Staff are not expected or required to count every tablet, but made a quick check to ensure that medication has been stored correctly and had not been stockpiled. One said that she had checked he was safe, his medication appeared to be in order and she and her colleague had not noticed any other medication in his room. The manager told the investigator that they had planned to conduct another check the next Monday to ensure that he had taken his medication correctly in the days between the two checks as recent drug tests had indicated that he might have been misusing pregabalin.

45. At 8.00pm, one of the man's key workers received a telephone call on the Resettle crisis line from one of his friends (not the woman he had met earlier in the day). She told the key worker that she was concerned about his emotional state as he had told her the previous evening that 'his head was all over the place and he did not want to go on'. She said that she had spoken to him again around teatime before he left Stafford House, and he had sounded in a low mood. During a telephone call at 7.30pm, he had said that he was at a friend's house and sounded slightly better.
46. The key worker telephoned the man at 8.30pm and said his voice sounded slurred. He told her that he was using the toilet and asked her to call back in half an hour. She then telephoned Stafford House and briefed them about the situation. She also spoke to her line manager who advised that when he returned to Stafford House staff should check him immediately and continue to monitor him, and that one of the Resettle staff should visit him at the premises the next day. She called him back at 8.55pm, but he did not answer. At 9.10pm, she telephoned his friend and told her that she had been unable to get through to him. His friend said that he had told her he had given away all his money to help someone out.
47. The man arrived back at Stafford House around 9.30pm and went straight to his room. A supervisor followed him to check how he was. He was tearful and said that he felt really low and did not have the strength to carry on. He admitted that he had taken some tablets the previous evening, but said that he did not know what they were or how many he had taken. He said that he had also used cocaine that evening with friends. Premises staff said that although he was very upset, he did not show any obvious physical symptoms of drug taking at that time. He had sent a message to his key worker to tell her that he was back at Stafford House and while staff were speaking to him, he received another telephone call from her at 9.40pm.
48. The key worker told the investigator that the man had sounded more lucid than when she had spoken to him earlier. He said that he had taken a few pills the previous day, but not many. He had also used crack cocaine and other drugs that evening but refused to say what the other substances were. She tried to persuade him to go to hospital but he refused and said that he was okay, although he felt low and tired. He said he had no energy to carry on and he had felt like this for a couple of weeks. He told her that he was happy with the Resettle programme, but felt he was running out of steam and finding it very hard. He said that he still wanted to attend his course the next day and she told him that he should return to Stafford House after the course and someone would come and visit him. She advised him to tell Stafford House staff if he felt unwell.
49. The key worker then spoke to the supervisor, who was concerned about leaving medication in the man's room, so they removed it and other items that he could use to harm himself. The supervisor then telephoned the on-call manager, who instructed her to open an Assessment, Care and Teamwork (ACT) document, the Probation Service suicide and self-harm prevention

procedures. The staff then moved him to the group room on the ground floor, which had CCTV and allowed them to observe him better. CCTV footage showed that he went willingly and there was no indication that he was in any distress at that time. In addition to the CCTV monitoring, staff went to check him every 30 minutes and recorded the checks in the ACT document.

50. The manager said that the staff did not call an ambulance or a taxi to take the man to hospital as he had insisted he did not want to go and he had shown no physical signs of drug misuse. They would not have been able to accompany him to hospital and it would have been a risk to send him on his own. Therefore, they decided it was better for him to remain at Stafford House under observation.
51. At 1.30am, a member of staff who was on duty in the staff office, noticed on the CCTV that the man appeared very restless. He went into the room but was unable to get a coherent response from him. He alerted the supervisor and they called an ambulance immediately. Paramedics arrived just after 1.50am and treated him for some time in an effort to stabilise him. They asked him if he knew what he might have taken and he went up to his room, where he found 17 empty blister packs of various prescribed medications in his waste paper bin and cupboard. The ambulance crew then took him to hospital.
52. At 4.30am, the police arrived at Stafford House to inform staff that the man had died.
53. Toxicology tests detected that the man had recently consumed alcohol and had taken 13 prescribed and illicit drugs. These included significant and toxic levels of methadone, propranolol, fluoxetine (an antidepressant) and risperidone. The toxicity from mixing some of the other drugs was potentially fatal. The toxicologist concluded that the cause of his death was primarily an overdose of propranolol.

#### **Events after the man's death**

54. As the man had died in hospital, Merseyside Police broke the news to his family in the morning. The manager said that later that morning, he received a telephone call from the man's aunt asking staff not to touch his belongings as his family wanted to visit Stafford House to pack them personally.
55. The manager reminded the staff on duty of the employee assistance scheme if they needed support and altered their shifts so they did not have to return to work immediately. He held an emergency residents' meeting the next morning to break the news of the man's death and the approved premises' psychologist held some drop in sessions to give individual support to some residents. The Assistant Chief Officer and health and safety team visited the premises to speak to staff. The man's key workers at Resettle also received individual and group support.
56. The manager subsequently spoke to the man's family several times and the Assistant Chief Officer of Merseyside Probation Trust wrote to them to offer

assistance with funeral expenses. The family visited Stafford House on 30 March to meet the staff and collect his belongings.

57. Staff from Resettle also contacted the man's family and representatives from both Stafford House and Resettle attended his funeral.

## **ISSUES**

### **The man's supervision**

58. When the man was released from prison, Resettle staff accompanied him to Stafford House. He was inducted and his licence conditions stipulated that he should attend the Resettle project daily, receive psychiatric help and take drug tests. Generally, he complied with the approved premises' rules and his licence conditions and attended both group and one to one meetings. However, on several occasions he admitted to staff that he had taken illicit substances. On those occasions, Resettle staff advised him about relapse prevention and provided additional support. Both probation and Resettle staff conducted drug tests.
59. The man's key worker said that they did not consider recalling him to prison as he had been open and honest about his lapses which they had regarded as isolated incidents rather than prolonged use. We consider that he was appropriately supervised and supported to help him to comply with his licence conditions and that staff could not have foreseen or prevented his actions in March.

### **Management of medication at Stafford House**

60. The Approved Premises Manual gives guidance on the safe-keeping and issuing of prescribed medication, including any controlled drugs that may be prescribed for any resident. It sets out detailed procedures about the collection, delivery and storage of medication and provision for administering it under supervision at a pharmacy or doctor's surgery. It states that, even where residents are allowed to manage their own medication, it should still be delivered or collected by staff, in order to accurately record each resident's medication.
61. The policy and procedures at Stafford House are in line with those in the manual. All residents are risk assessed over several weeks before they are allowed to keep their own medication. Their rooms have a safe to store medication, which is accessible to staff, who conduct checks against the resident's medication chart. There are arrangements with the local GP practice and designated pharmacy to ensure that residents are not given medication directly and that all medication is delivered and accounted for. However, the investigation identified two occasions when these procedures were not followed and the man obtained a prescription and medication. Both times, he handed in his medication when he returned to Stafford House.
62. The manager of Stafford House acknowledged that the medication policy had not always been followed and he had taken action, including reminding all staff of the correct procedures. The local GP practice had accepted that errors had been made by locum GPs, who were not fully aware of the 'flagging' system for Stafford House residents. This had been addressed by internal training and induction. As these breaches have been formally addressed and Stafford

House has a clear policy for the safe management of medication, we make no recommendation about this.

### **Access to medication in March**

63. When the man returned to Stafford House on the evening before his death, a member of staff immediately followed him to his room and CCTV footage confirms this. The timings would suggest it was unlikely that he had had enough time to take any medication before they entered his room. Earlier that day staff had conducted a medication check and had accounted for his pregabalin tablets as they had been concerned that he might have been misusing them. All his medication appeared to have been stored correctly and neither staff member had noticed any medication or packets elsewhere in the room.
64. Before the man was taken to hospital, staff checked his room and found 17 empty blister packets of medication, including one for propranolol, that had been legitimately prescribed to him. We do not know whether or when he took those tablets or if there was another reason why he had emptied them from the packs. We consider that staff reasonably monitored and checked his medication, but the investigation has been unable to confirm what had happened to the medication from the empty blister packs. It is possible that he took the medication before he left the premises earlier that evening.

### **Actions of staff in March**

65. On the evening before his death, the man's friend alerted his key worker at Resettle, who was also the duty officer that evening, to concerns about his well-being. She tried to telephone him and promptly alerted staff at Stafford House. When he returned at around 9.30pm, the staff on duty checked him and she called him again. He was tearful, low and tired. He admitted that he had used illicit substances earlier and during the previous evening but he would not say how much or give details about what he had taken. Staff encouraged him to go to hospital, but he refused. In view of this and the absence of any physical symptoms of distress, or drug misuse staff moved him to a room with a CCTV camera so that they could monitor him from the office. They were concerned about his emotional state rather than his physical condition and started suicide and self-harm prevention procedures and physically checked him every thirty minutes.
66. The man's family were concerned that he was not sent to hospital that evening and asked why the Resettle duty staff did not go to Stafford House to assess him and encourage him to seek medical advice.
67. Resettle's Joint Service Director explained to the investigator that the out of hours service is telephone-based. It aims to assist individuals to deal with their crisis and, wherever possible, signpost them to the appropriate service for support. Resettle staff do not attend in person to deal with emergencies. She said that the key worker had followed the correct procedures in notifying Stafford House and senior staff of the man's circumstances and he had

declined medical help when she offered it. The key worker had also made plans for him to be fully assessed by Resettle staff the next day.

68. The manager said that all staff at Stafford House are aware of the procedures for escalating incidents to the on-call manager and if a resident was considered to be seriously unwell, an ambulance would be called, irrespective of the resident's views. He added that if a resident presented as agitated or upset but there appeared to be no acute medical need, the usual protocol would be to monitor them and if appropriate, start suicide and self-harm procedures.
69. On the evening before his death the man was visibly upset. He told staff that he had used illicit drugs, but showed no signs of being physically unwell. He had previously admitted to drug use during his stay at Stafford House and there was nothing to indicate that he had used an excessive quantity of drugs on this occasion. The staff on duty that evening sought and implemented the advice of the on-call manager and we are satisfied that they acted appropriately and in his best interests on the information available to them at the time.