

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Keith Degg, a resident at Staitheford House Approved Premises on 5 April 2018

**A report by the Prisons and Probation Ombudsman**

## Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

## Our Values

We are:

**Impartial:** *we do not take sides*

**Respectful:** *we are considerate and courteous*

**Inclusive:** *we value diversity*

**Dedicated:** *we are determined and focused*

**Fair:** *we are honest and act with integrity*



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Keith Degg, who had been a resident at Staitheford House Approved Premises since 30 November 2017, was found hanged in a wooded area in Stafford on 2 April 2018. He was taken to hospital, where he died on 5 April. He was 39 years old. I offer my condolences to Mr Degg's family and friends.

Although there is little hard evidence, it is hard not to conclude, in the round, that illicit drugs, and Psychoactive Substances (PS) in particular, played a role in Mr Degg's decision to hang himself. He had a history of substance abuse, found it hard to resist the opportunities to access illicit substances in the community, attributed an earlier suicide attempt to his frustration at having his drug treatment withdrawn, and implied in his suicide note and comments to staff that he was struggling to keep away from drugs.

I do not consider that the support Mr Degg received before his death was sufficiently joined up. The decision to withdraw his Subutex treatment caused him significant anxiety and although those responsible for his management were alert to the risks drug abuse posed to him and sought to manage him appropriately, the lack of facilities at Staitheford House to test for PS meant that they may well not have understood how acute those risks were.

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

**Sue McCallister CB**  
**Prisons and Probation Ombudsman**

**December 2018**

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# Summary

## Events

1. On 17 February 2016, Mr Keith Degg was sentenced to 4 years imprisonment for robbery. On 30 November 2017, he was released on licence from HMP Oakwood to live at Staitheford House Approved Premises (AP), Stafford.
1. Mr Degg had a history of illicit drug use and had used heroin and other illicit drugs from the age of thirteen. At the time of his release, Mr Degg had a licence condition that required him to engage with services to address his drug and alcohol misuse. He received a regular prescription of Subutex (a heroin substitute) and began to engage with One Recovery (a community substance misuse partnership). Mr Degg continued to struggle with his use of illicit drugs but he engaged with his offender manager and keyworker who offered continuing support.
2. On 15 December, Mr Degg was told that his regular prescription for Subutex had not been received by the local pharmacy. Mr Degg was upset and distressed and an appointment was arranged for him to be re-prescribed his Subutex by One Recovery on 20 December. However, when he attended the appointment he provided a urine sample that indicated that he was negative for opiates and One Recovery staff said that he therefore no longer needed Subutex treatment in line with NICE guidelines.
3. On 6 January 2018, Mr Degg told staff that he had attempted to take his own life. Staff supported Mr Degg under care action plan (CAP) procedures (used by the AP for managing and supporting residents considered at risk of suicide and self-harm). They discussed with him the reasons for his actions and he was monitored over the next 48 hours to ensure he was safe. On 8 January, the AP manager and his keyworker reviewed the CAP and discussed with Mr Degg his frustration about not having his Subutex medication. Staff confirmed that the Subutex treatment was to be reinstated following a three-way meeting with One recovery, and Subutex was re-issued on 9 January.
4. On 11 March, Mr Degg was issued with a formal warning for his continued drug use after testing positive for cannabis and benzodiazepine and acknowledging that he had drunk alcohol and taken other drugs. Staff continued to provide ongoing support and on 22 March, Mr Degg provided negative test results for all illicit substances. No further concerns were identified by staff over the following week.
5. On 2 April, Mr Degg left Staitheford House in the morning with three other residents. At around 4.30pm, one of the residents returned to the AP in a distressed state and told staff that he had seen Mr Degg hanging from a tree along the canal. Staff immediately contacted emergency services. The residents who had stayed with Mr Degg alerted a member of the public who also called the emergency services.
6. Mr Degg was taken to hospital, where he remained unconscious and in a critical condition. He failed to respond to treatment and, on 5 April, Mr Degg died.

7. Police found a note written by Mr Degg in his pocket, in which he said that he had let his son down because of his lifestyle choices.
8. No post-mortem investigation or toxicology tests were carried out.

## **Findings**

### **Management of risk of suicide and self-harm**

9. Staff appropriately supported Mr Degg under the Care Action Plan (CAP) procedures when he disclosed to them that he had tried to take his own life on 6 January. He was monitored over the next 48 hours in accordance with his perceived risk and was reviewed on 8 January. We are satisfied that staff at Staitheford House appropriately assessed Mr Degg's risk of self-harm in line with national instructions.
10. There was little to indicate that Mr Degg was at heightened or imminent risk in the period before his death.

### **Substance misuse and risk management**

11. Mr Degg's history of illicit drug use was seen as a potential trigger for reoffending and it was clear from his records that he struggled to remain drug free. Mr Degg was supported by both his offender manager, keyworker and One Recovery.
12. After Mr Degg was issued with a warning following his drug misuse in March, there were no further reported failed drug tests or concerns raised about Mr Degg's use of illicit drugs.
13. We are concerned, in light of the prevalence of psychoactive substances (PS) in prisons, that the National Probation Service has still not developed an effective strategy to deal with suspected PS use in approved premises which includes a testing regime.

## **Recommendations**

- The National Probation Service should ensure that it works closely with any secondary services working with the offender to share relevant risk information and inform decision-making.
- The National Probation Service should review its strategy to reduce the supply and demand for PS in Approved Premises, including developing mechanisms to test for PS use.

## The Investigation Process

14. The investigator issued notices to staff and residents at Staitheford House informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
15. The investigator visited Staitheford House on 24 April and met members of staff and the AP manager.
16. We informed HM Coroner for Staffordshire of the investigation. We have been provided with the cause of death. As Mr Degg died in hospital, the coroner told us that no post-mortem or toxicology investigations have been completed. Hospital clinicians confirmed the cause of death as being 1a Anoxic encephalopathy (brain damage caused by a lack of oxygen) and 1b Hanging. We have sent the coroner a copy of this report.
17. One of the Ombudsman's family liaison officers contacted Mr Degg's next of kin to explain the investigation and to ask whether there were any matters they wanted the investigation to consider. Mr Degg's mother said that since her son's death, she had been made aware of his previous suicide attempt and asked for information about it. She did not raise any other concerns.
18. Mr Degg's family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.
19. The initial report was shared with the National Probation Service. NPS have pointed out some factual inaccuracies and this report has been amended accordingly.

## Background Information

### Staitheford House Approved Premises

20. 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. Residents are responsible for their own health and are expected to register with a GP.
21. Staitheford House is one of three Approved Premises in Stoke and Stafford. It has 12 double and one single room and is managed by the Midlands Area of the National Probation Service. Each resident is allocated a key worker/offender supervisor to oversee their progress and wellbeing and to ensure that they adhere to licence conditions and the premises' rules. Probation Service employees are on duty at Staitheford House 24 hours a day.

### HM Inspectorate of Probation

22. HM Inspectorate of Probation's annual report published in 2017, said that their inspection of a sample of hostels, found staff doing exceptionally good work to protect the public, and who were quick to act when necessary to protect people from harm. The majority of Approved Premises were also doing some good work to reduce reoffending.

### Previous deaths at Staitheford House

23. Mr Degg's death is the third death at Staitheford House since 2007. The previous deaths, in 2016, were related to illicit drug use. In one of these investigations we made a recommendation about high risk residents with a history of drug use being screened as part of induction process and referred for support when needed. The National Probation Service accepted this recommendation and drug screening in approved premises is now routine and referrals are made when necessary. Ongoing drug testing is in place for those residents considered to be at high risk, as well as more frequent observations.

### Psychoactive Substances (PS) and Approved Premises

24. Psychoactive substances (formerly known as 'new psychoactive substances' or 'legal highs') are a serious problem. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Persons under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

25. In July 2015, we published a Learning Lessons Bulletin about the use of PS (still at that time NPS) and its dangers, including its close association in prisons with debt, bullying and violence. The bulletin identified the need for better awareness among offenders and those working with them of the dangers of PS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.
26. APs do not currently test for PS, which requires a urine sample, as they only have oral swab drug testing procedures in place. The National Probation Service says that this is because the nature of the buildings and staff make it impractical to implement urine testing across APs.
27. In a Learning Lessons Bulletin, published in November 2017, we raised concerns about the implications of PS for the AP estate. We found deficiencies in information sharing about substance misuse by AP residents and in the effectiveness of welfare checks in APs. We identified the need for the National Probation Service to review its drug testing policy and to consider introducing testing for PS and to give staff better guidance on PS use.
28. Her Majesty's Prison and Probation Service (HMPPS) issued guidance on PS to prisons and APs in August 2017 but it did not specify that APs should start testing for PS. The National Probation Service accepted our recommendation from a previous investigation in January 2017 that they should review drug testing arrangements in APs and take steps to enable staff to identify PS use and advise residents of the dangers of using PS.
29. There are currently no procedures in place at Staitheford House AP for PS testing of residents.

### **Care Action Plan (CAP)**

30. According to Her Majesty's Prison and Probation Service (HMPPS) policy, each approved premises must have a strategy for managing and supporting residents considered at risk of suicide and self-harm. The care action plan (CAP) is used at Staitheford House, and is the care-planning system to support residents identified as being at risk of suicide or self-harm. The purpose of CAP is to try to determine the level of risk, how to reduce risk and how best to monitor and supervise the resident. After an initial assessment of the resident's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the resident anticipating when they will occur. As part of the process, a plan of care, support and intervention will be put in place.

## Key Events

31. On 17 February 2016, Mr Keith Degg was sentenced to 50 months imprisonment for robbery and was sent to HMP Dovegate. On 27 February 2017, he was transferred to HMP Oakwood.
32. Mr Degg had a history of drug and alcohol abuse, most notably 'Monkey Dust' (a psychoactive substance that is said to distort reality for the user who has no recollection of their actions while under the influence), that had led to his most recent offending. While in custody, Mr Degg had engaged with drug services and had been prescribed Subutex (an opiate substitute) as part of a drug maintenance programme. Mr Degg had no recorded history of self-harm or suicide attempts while in prison.
33. On 30 November 2017, Mr Degg was released on licence from HMP Oakwood. His licence conditions required him to live at Staitheford House Approved Premises (AP), Stafford. He had a curfew requiring him to be at Staitheford House between 9.00pm and 6.00am every day, which was later extended to 11pm every day. He was required to report to his local probation team on the day of his release to complete a drug test, attend offending behaviour courses, and engage with alcohol and drug intervention services.
34. On 1 December, Mr Degg's offender manager (OM - probation officer), conducted his induction and told him about the restrictions, expectations, health and safety issues, and the support available from AP staff. Mr Degg signed to confirm that he understood and had received copies of the rules and policies. She reminded him of his specific licence conditions, curfew times and the medication policy. He was also assigned two keyworkers for additional support.
35. Mr Degg registered with a local GP practice and was prescribed mirtazapine (an anti-depressant), flucloxacillin (an antibiotic), dermal lotion (to treat varicose eczema) and paracetamol. His drug treatment was managed by One Recovery, an independent agency working in partnership with the NHS, and he continued to be prescribed Subutex as part of a reduction programme with the aim of becoming drug free.
36. Because of Mr Degg's history of problematic drug and alcohol use, he was identified as needing enhanced health and wellbeing monitoring for the first week at Staitheford House (in line with Midlands Division's strategy for reducing the risks of death associated with drug and alcohol use following a resident's release from custody). This involved additional drug testing, visual checks overnight and two hourly checks to account for the resident's whereabouts.
37. Mr Degg had two drug tests during his first week at Staitheford House and on 12 occasions thereafter. He provided five positive results for cocaine between 5 December and 6 January 2018. He also provided positive test results for cannabis on three occasions and once for benzodiazepines. Mr Degg disclosed to staff in February and March that he had used "Mamba" (a psychoactive substance) and a benzodiazepine-type substance he referred to as "Gaba." Staff discussed with him the reasons why he had used drugs and focused his attention on positive things in his life such as maintaining contact with his son. Mr Degg continued to engage openly with staff.

38. On 15 December, Mr Degg was unable to collect his Subutex prescription, which should have been delivered to a local pharmacy by One Recovery. AP staff were told by One Recovery that the prescription had been sent to the pharmacy, but the pharmacy said that they had not received it. Mr Degg was upset and distressed at not being able to have his Subutex medication.
39. Mr Degg attended One Recovery on 20 December, so that Subutex could be re-prescribed. As a urine test indicated a negative result, staff at One Recovery considered that as he had no opiates in his system, and he was therefore clean, he no longer required Subutex. The decision was made by his keyworker at One Recovery, in line with NICE guidelines. Staff at One Recovery informed Mr Degg that the Subutex programme would not be continued.
40. When they were told by Mr Degg that his Subutex programme had ceased, the OM and a keyworker contacted One Recovery to say that in their opinion, Mr Degg needed to remain on a Subutex programme for his well-being and to counter his overall risk of greater drug use. In the interim, Mr Degg was prescribed Diazepam by his GP to alleviate symptoms of withdrawal that he told staff he was having.
41. On 6 January, Mr Degg returned to Staitheford House at around 8.20am. He told an AP residential worker that he had attempted suicide by hanging himself from a bridge, but his attempt had failed because a member of the public had stopped him and had untied the cord from around his neck. Staff at the AP immediately initiated enhanced monitoring under CAP procedures. Staff contacted the out of hours manager and crisis team for medical advice, an assessment of his needs was completed by the residential worker and paramedics were called. When paramedics arrived, they advised Mr Degg to go to the local hospital. Initially he declined but, after further persuasion, he was taken by ambulance to hospital.
42. Mr Degg left the hospital before being seen by a clinician and returned to Staitheford House at around 11.50am. The police had been alerted to his suicide attempt and spoke to Mr Degg on his return to the AP. Mr Degg told them that his actions had been a 'moment of madness' but staff recorded in the CAP that they were not sure this was the case and decided that hourly monitoring would continue while he was on the premises. Over the weekend, Mr Degg told staff that his actions were because of the problems he was having in obtaining Subutex. Despite his denials that he had no further suicidal thoughts or intent, monitoring continued while he was on the premises during the day and night.
43. On 8 January, the AP Manager and a keyworker held a CAP review. Mr Degg asked for the enhanced hourly checks to be stopped. He said that his actions were out of frustration at not being able to obtain his Subutex medication and lack of sleep. He said that he thought his actions would have resulted in his prescription being reinstated, but felt that the situation had improved as he had an appointment with One Recovery the following day, and it was anticipated that his Subutex prescription would be reinstated.
44. Mr Degg's Subutex treatment was restarted after his case was referred to a clinician (prescribing GP) following a three-way assessment held on 4 January, attended by Mr Degg and two AP staff. A clinical review was arranged for 9 January, and Mr Degg's Subutex prescription was restarted.

45. On 16 February, Mr Degg told staff that he had used "Mamba". He was observed regularly throughout the night as a safeguarding measure. On 19 February, a keyworker spoke to Mr Degg about his use of psychoactive substances.
46. Mr Degg said that he was disappointed in himself as he had not used anything like that since being released from custody. A keyworker recorded that Mr Degg spoke about his plans for the future and that she reinforced that these plans would not be helped by his continued use of illicit drugs.
47. On 10 March, Mr Degg arrived back at Staitheford House within curfew time but accompanied by a female friend. An AP residential worker recorded that Mr Degg was slurring his speech, was unsteady on his feet and appeared intoxicated. Mr Degg told him that he wanted his friend to stay in the hostel as she was unable to get home. Staff explained that this would not be possible. Mr Degg provided a breath sample for alcohol, which indicated 9/100ml (the drink and drive limit in the UK is 35/100ml). The residential worker recorded that Mr Degg remained 'very hyperactive' but he denied having used drugs when asked. It was recorded that he finally settled at around 2.30am and staff continued to monitor his wellbeing throughout the night.
48. The following morning, Mr Degg went to the AP office to sign himself out of the premises. An AP residential worker spoke to him and recorded that he still looked 'flushed'. Mr Degg told her that he had been in the local park the previous day drinking beer and vodka, and a group of men had offered him some vodka, which he had drunk. He said that they then told him that the drink contained 'Gaba'. Mr Degg said that he passed out and when he had woken up, it was dark and his coat and mobile phone were missing.
49. A keyworker spoke to Mr Degg later that the morning and recorded that he continued to say that he had drunk a liquid that contained 'Gaba'. She asked Mr Degg if he had taken anything else. He said he had not but he tested positive for both benzodiazepine and cannabis. She recorded that Mr Degg was still clearly affected by what he had used, was sweaty, very red faced and a bit incoherent. She spoke to his OM the following day about the recent events and it was agreed that Mr Degg would be issued with a formal warning.
50. On 15 March, the keyworker spoke to Mr Degg and discussed how he was feeling following the events of the previous weekend. Mr Degg said that he needed to sort himself out and felt that he had let his son down. Mr Degg accepted that he was responsible for his use of illicit substances, but said that it was not easy when he was around other people who were using drugs.
51. The OM visited Mr Degg the following day and spoke to him about his formal warning and the events that had occurred over the weekend. He told her that he was now considering moving back to the Stoke area to be closer to his son. She said that this was positive, but he needed to consider the risks of being around old associates and how this could increase his risk of illicit drug use. She said she would ensure that a travel warrant was provided so that he could visit his son.
52. On 22 March, Mr Degg provided negative test results for all illicit substances (although he was not tested for PS). Over the following week, staff raised no

further concerns about Mr Degg being under the influence of illicit substances or alcohol or in relation to his wellbeing generally.

53. On 2 April, Mr Degg left Staitheford House along with three other residents. What they did during the day is unclear but Mr A told the AP manager that they had spent the day together and had been by the canal in a wooded area. This area is frequently used by drug users but he did not say whether they had been taking drugs. He told her that they had been drinking and that Mr Degg had spoken about his son and how his son would be better off without him. When the other residents challenged Mr Degg about this, he said that he was 'only joking'.
54. Mr A told the AP manager that he and the two other residents decided to go back to Staitheford House, but Mr Degg said that he was going to stay in the woods for a while longer and that if he was late for the curfew they would know where to find him. Mr A told her that they did not initially think this was strange and began to walk back along the canal towards the AP. However, as they walked back, they talked about how Mr Degg had not been his usual self and decided to go back for him. When they arrived at the woods, they saw Mr Degg suspended from a tree with a ligature around his neck. He immediately ran back to the AP to summon help.
55. Mr A arrived at Staitheford House at 4.42pm. He told two AP residential workers that he had seen Mr Degg hanging from a tree along the canal and that two other residents were still there. Staff said Mr A was clearly in a state of shock and they attempted to get further information from him but he was not sure whether an ambulance or the police had been called. One residential worker immediately telephoned the duty manager while the other contacted the emergency services.
56. Meanwhile, the other two residents had alerted a member of the public, who called the emergency services. They released the ligature from around Mr Degg's neck and started resuscitation attempts. Paramedics arrived and established a pulse before taking Mr Degg to hospital.
57. Police later attended Staitheford House and told staff that they had found what they believed to be a suicide note addressed to his son in Mr Degg's pocket. In it he said that he had let his son down because of his lifestyle choices.
58. The OM telephoned the hospital, who said that Mr Degg was in a critical condition but his family were with him. Later that evening, Mr Degg was transferred to a high dependency ward at another hospital.
59. Mr Degg failed to respond to treatment and he died in the afternoon of 5 April.

### Contact with Mr Degg's family

60. In the days leading up to Mr Degg's death, the AP manager spoke to his family and offered support. Mr Degg's partner contacted the AP manager at 4.40pm on 5 April to say that Mr Degg had died. The AP manager told the family that support was available to them and financial assistance with funeral costs would be provided.
61. The family visited Staitheford House later that day to collect Mr Degg's belongings. The AP manager offered her condolences and the support of staff. The family visited the AP again following his death to meet the AP manager and two of Mr Degg's friends, who were residents at Staitheford House.
62. The National Probation Service contributed to the cost of the funeral in line with national guidance.

### Support for residents and staff

63. The residents who had found Mr Degg in the woods were provided with ongoing support by staff at Staitheford House. All other residents were informed of Mr Degg's death and support was offered.
64. The AP manager supported her staff and discussed what had happened.

### Cause of death

65. HM Coroner informed the investigator that he had not directed a post-mortem following Mr Degg's death. He had accepted the cause of death as directed by the clinicians treating Mr Degg as:
  - 1a Anoxic encephalopathy
  - 1b Hanging.
66. Mr Degg had severe anoxic brain injury due to the length of time his brain was starved of oxygen. In such cases the prognosis for recovery are poor. As Mr Degg was being treated by a specialist team in hospital, the Coroner directed that the need for a post-mortem to ascertain the cause of death was not necessary. The Coroner also gave no directions for any toxicological testing (testing for drugs), which would normally form part of a routine post-mortem.

## Findings

### Management of risk of suicide and self-harm

67. Probation Instruction (PI) 32/2014 Approved Premises Manual, which sets out the National Probation Service framework for delivering safer procedures, lists a number of risk factors and potential triggers for suicide and self-harm. These include previous self-harm, recent monitoring in prison custody under ACCT, conviction of a violent offence and a history of alcohol or drug abuse. Staff are expected to interview new residents as part of the induction process to assess their risk of suicide or self-harm. All staff are expected to be alert to the increased risk of self-harm or suicide posed by residents with these risk factors and to act appropriately to address any concerns.
68. When Mr Degg disclosed that he had attempted to take his own life on 6 January, staff appropriately supported him under the care action plan (CAP) procedures. He was monitored over the next 48 hours in accordance with his perceived risk. On 8 January, staff reviewed his risk of suicide and self-harm and were satisfied his risk had reduced and closed the CAP.
69. We are satisfied that staff at Staitheford House appropriately assessed Mr Degg's risk of suicide and self-harm in line with national instructions.
70. Following his death, Stafford Police found a note in Mr Degg's pocket, in which he spoke fondly of his son and said that he felt that he had let him down and would continue to do so. However, we found nothing to indicate to staff that Mr Degg was at heightened or imminent risk in the period before his death. He gave no indication to anyone that he had any suicidal thoughts and gave no indication that his feelings about his lifestyle and his son might lead him to take the actions he did.
71. We make no recommendation.

### Substance misuse risk management

72. Our Learning Lessons Bulletin discusses the importance of effective testing of residents for drug use. The AP Manual says that testing known drug users on arrival, or when they are suspected of renewed substance misuse, is a targeted and prudent use of resources. It says that staff should have discretion to test residents if there is a reasonable suspicion of substance misuse, and accepting this regime is a condition of living in APs.
73. Mr Degg had a history of drug and alcohol abuse. His history of sporadic illicit drug use was a potential trigger for reoffending. He was subject to regular drug testing at the AP and his frequent positive tests results for cannabis and benzodiazepines indicated that he struggled to remain drug free.
74. One Recovery's involvement with Mr Degg was aimed at reducing his substance misuse as opposed to the maintenance programme he was on when in prison. It was separate from the role of the probation team which was to support him in addressing his substance misuse but also to reduce the risks to himself and of re-offending.

75. Although the role of One Recovery and their actions fall outside our Terms of Reference, they are material to our remit of finding out what happened. We note that One Recovery's decision to stop Mr Degg's Subutex prescription was made in line with their own guidelines, and national NICE guidelines. We have seen no evidence that the decision was additionally informed by the potential risks this posed to Mr Degg's mental well-being, risk of illicit drug use, and re-offending.
76. We note that probation staff did not initially share with One Recovery staff the perceived risks Mr Degg posed if he was not engaged with a drug support service. After the decision had been taken to stop his Subutex, Mr Degg's OM and keyworker at Staitheford House said that they liaised with One Recovery to highlight the risks and impact of this decision.
77. We consider that distress caused to Mr Degg during this period could have been prevented if there had been closer working between the various agencies and a on Mr Degg's risk would have helped. We make the following recommendation:

**The National Probation Service should ensure that it works closely with any secondary services working with the offender to share all relevant risk information and inform decision making.**

78. In response to the recommendation the NPS have said:

**Probation Instructions. PI 03/2018 & PI 15/2016 and Approved Premises (AP) Manual April 2013 already in place advising on information sharing with secondary services.**

**AP Manual is currently under review and will ensure this is addressed and incorporated within the updated AP Instructions.**

**Information Sharing Agreements should already be in place within Local Delivery Units and secondary services. Heads of Public Protection will review.**

### **Psychoactive and other illicit substances and alcohol**

79. Mr Degg used various varieties of PS, including 'Monkey Dust' and Mamba. He abused alcohol, tested positive for a range of illicit substances and associated with others who provided opportunities to access a range of drugs. He was found to be under the influence of alcohol and illicit substances on a number of occasions by AP staff, which led to him receiving a formal warning.
80. Staff provided on-going monitoring and support and advised Mr Degg about the risks associated with PS. He was encouraged by both his offender manager and key workers to focus on the positive things he had achieved and his relationship with his son. After receiving a formal warning, there were no further reported failed drug tests or concerns raised about Mr Degg using illicit drugs in the two weeks leading up to his death. We consider that staff acted appropriately in light of the information and interventions available to them.
81. Nevertheless, although we do not know that Mr Degg was under the influence of PS or other substances prior to or at the time of his death, in the circumstances,

we consider it possible if not likely that drugs played a significant role in his decision to take his life on 2 April.

82. Since September 2016, drug testing kits in prisons have been able to detect PS from urine samples, and technologies continue to evolve. The National Probation Service's analysis of PS use in APs does not currently address the gaps in PS testing. We recognise the National Probation Service's ongoing work to address the issue of PS but consider the failure to test for these substances in Approved premises a serious drawback to identifying patterns of usage and providing appropriate support and interventions.
83. Our Learning Lessons Bulletin on substance misuse in APs (published in November 2017) discusses the challenges faced by Her Majesty's Prison and Probation Service in managing the risks posed by psychoactive substances. It recommends that the National Probation Service revise the AP Manual to provide up to date guidance on the management of PS use, review its drug testing policy within Approved Premises and consider introducing testing for PS. We make the following recommendation:

**The National Probation Service should review its strategy to reduce the supply and demand for PS in Approved Premises, including developing mechanisms to test for PS use.**

84. In response to the recommendation the NPS have said:

**The National Probation Service Manual review will review the supply and demand strategy for approved premises building on the AP Safe Working Practice Document and in conjunction with the AP governance board substance misuse sub group which is reviewing the AP drug testing policy. As part of this review, mechanisms to test for PS use will be explored.**

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