



# Learning lessons bulletin

## Fatal incidents investigations issue 1

### Learning from fatal incidents in approved premises

I am delighted to introduce the Prisons and Probation Ombudsman's (PPO) first Learning Lessons Bulletin relating to fatal incidents. These bulletins reflect my desire to ensure

that we become more influential by encouraging services in remit to learn the lessons of our investigations<sup>1</sup>. The bulletins provide themed analysis of the findings of multiple investigations into complaints and fatal incidents<sup>2</sup>. Investigations focus on the experience of individuals at specific prisons, immigration removal centres, approved premises or under the supervision of particular probation trusts, but many investigations can be grouped by themes or issues so that wider lessons can be drawn and good practice shared. In this way services can be helped to reduce avoidable deaths and to avoid complaints by dealing with problems at source.

**This first fatal incidents Learning Lessons Bulletin examines the lessons that can be learnt from deaths in approved premises. This is the first time we have commented collectively on deaths in this context.**

**Nigel Newcomen CBE**  
Prisons and Probation Ombudsman

**Approved premises**, previously known as probation and bail hostels, have their legal basis in Section 13 of the Offender Management Act. There are approximately 100 approved premises across England and Wales, providing accommodation to some 2,000 offenders and people on bail.

### Deaths in approved premises

Thankfully, the number of deaths in approved premises is relatively low. We noted in our annual report 2011-12<sup>3</sup>, however, that the number of investigations into deaths in approved premises had increased by 36% compared to 2010-11, from 11 deaths to 15. While the increase is small it is notable, as the numbers of deaths in approved premises had remained constant from 2008-09 through to 2010-11. Despite this increase, as a proportion of the overall number of deaths investigated by this office, deaths in approved premises in 2011-12 remained relatively stable at 7% (it was 6% in 2010-11). This was due to an increase overall in the number of deaths in the services in remit.

<sup>1</sup>PPO Business Plan 2012-13 Strategic Objective 4 p11 <sup>2</sup>These Bulletins will replace the On the Case publication that used to be produced by this office.

<sup>3</sup>Prisons and Probation Ombudsman (2012). *Annual report 2011-12*. London: TSO.

**(Deaths in approved premises continued)** It should be stated that considerable caution must be exercised in inferring any pattern or trend from such small numbers.

All 15 deaths were of adult men. Seven were due to natural causes, four were self-inflicted and three were due to other non-natural causes. The final case had been suspended and so the circumstances remain undetermined.

Supervision of offenders in approved premises holds particular challenges for the staff who work there. Approved premises residents are exposed to more risks than those in custody and exposure to these risks can be difficult to control and to manage. This bulletin attempts to highlight these issues and provide learning points for the future.

## Drug toxicity

In 2011-12 the Ombudsman became aware of a significant number of deaths, primarily in prisons, which, following toxicology tests, were found to be due to drugs or mixed drug toxicity. He raised his concerns with the Chief Executive of NOMS who commissioned an investigation into the issue. The subsequent report<sup>4</sup> warns of the dangers of methadone toxicity which is of concern given its increased use in prison in recent years. However, the investigation was inconclusive about the impact of combined drug toxicity, about which the debate therefore continues.

Nine of the fatal incident investigations started in 2011-12, were confirmed to be the result of drug or mixed drug toxicity and a further six cases looked likely to be drug-related though they were awaiting toxicology results. This means that over 6% of all deaths investigated by this office in the year were drug-related.

There were a number of common themes in these deaths:

- Prisoners trading in prescribed or illicit drugs to achieve a 'high'
- The hoarding of prescribed medication to take in excess at a later date
- The combined effect of prescribed medication and illicit drug use.

While the majority of drug-related deaths took place in prison, it is noteworthy that there were also a number of drug-related deaths in approved premises (two of the 15) and a further two natural cause deaths that showed evidence of the behaviours listed.

### Case study 1

Mr A was a known drug user who had been receiving methadone while in prison. It was hoped he would finish his detoxification programme in prison but he did not and so arrangements were made for his methadone prescription to continue on his release to an approved premises. He was given a supervised 'bridging' methadone prescription until he was able to see a doctor to confirm his dosage. A supervised bridging prescription is taken to a chemist daily and the methadone issued and taken in front of the pharmacist.

Mr A was also taking prescribed medication for an existing mental health problem which, based on an assessment of risk, was kept by the approved premises staff and made available to him as necessary. On arrival at the approved premises, Mr A handed his prescribed medication to staff. The member of staff who conducted Mr A's induction noted he seemed "extremely confused in general and/or about" his medication. He was also variously described by staff who saw him over the next couple of days as "a bit dazed", out of breath, hot and perspiring. These symptoms were put down to different reasons such as not having yet taken his methadone, the effect of his mental health medication or because he had recently suffered a chest infection.

It was confirmed that Mr A took his methadone

<sup>4</sup><http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2012/06/1.-NOMS-review-of-unclassified-deaths-between-2010-and-2011.pdf>

at the chemist on the day before his death and took his prescribed medication under supervision on his return to the premises. That night the member of staff conducting the well-being checks heard Mr A snoring heavily. When he did not appear in the morning, a member of staff found him unresponsive. Resuscitation proved unsuccessful.

The post mortem report concluded that Mr A 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. It was concluded that the combined effects were likely to have caused Mr A's respiratory system to fail.

The investigation report does not speculate on the findings of the post mortem though it is noteworthy that the level of methadone in Mr A's system was above that anticipated. It was confirmed that his methadone prescription was taken in front of the chemist so it is unclear how the level of methadone in his system was higher than his prescription and what single impact this had on his untimely death.

### **Case Study 2**

Mr B was resident in an approved premises for a number of months following his release from prison. He had a long history of drug use and was on a supervised methadone maintenance programme. He also took prescribed medication for lung disease, high blood pressure and a back complaint. This was kept by staff and issued under supervised self-administration. Approved premises staff were often concerned about Mr B's welfare as he regularly appeared over-sedated. On a number of occasions Mr B was found in possession of medication that was not prescribed to him (which was against the rules of residence). Staff appropriately raised their

concerns with his doctor, the drug team and his offender supervisor.

On the night of his death, staff were concerned that Mr B seemed unsteady on his feet and intoxicated. They suggested that the out of hours doctor be called but Mr B refused. Staff checked Mr B during the night and noted he was asleep in his chair (a regular habit). When Mr B did not appear the next morning staff checked and found him still in his chair, unconscious. Attempts at resuscitation failed. Toxicology analysis found high levels of a number of substances in Mr B's system including methadone, diazepam and nordiazepam. It was concluded that Mr B's death was caused by the high levels of these drugs in his system (all of which can affect breathing) combined with patchy bronchopneumonia (a complication of methadone treatment).

The investigation found that staff had tried to educate Mr B about the risks of taking illicit drugs and unprescribed medication. We were concerned to find though that on one occasion Mr B did not hand in his prescribed methadone, as he was required to do, and that staff did not appear to be aware of this omission. Methadone is generally given to residents under supervision at the local pharmacy on Monday to Saturday, with Sunday's dose given a day early to be handed to staff at the premises and taken under supervision the next day.

Our investigation revealed that staff at the local pharmacy were aware that individuals appeared to exchange or sell their prescribed medication outside the pharmacy door. There is a trade in many prescribed drugs in the search for a 'high', not least when taken with other medications. The toxicology report following Mr B's death indicated that he had high levels of methadone, diazepam and nordiazepam in his system indicating that they had been taken not long before his death. The level of methadone

was consistent with that found in patients on methadone maintenance therapy, but neither diazepam nor nordiazepam were prescribed to Mr B.

We recommended in this case that the approved premises make arrangements with their local pharmacies for prescribed medication to be collected by or delivered direct to the premises so that residents did not need to be relied upon to hand over their medication and to minimise the opportunity for trading. This is already a national requirement in line with the guidance in Probation Instruction 09/2009.

We found evidence of a similar misuse of prescription drugs and methadone in two further death investigations in this same period. While not believed to have contributed to the cause of death in these cases, the investigations highlight the prevalence of the trade in prescribed drugs and methadone among approved premises residents with a history of drug abuse and the consequent difficulties for staff in managing the problem.

Approved premises staff routinely test residents for the use of drugs (if they have a history of drug abuse) and drug workers are clear with residents about the reduction of tolerance levels following a period in custody and the hazards this poses. However, it is unclear from

***The Prisons and Probation  
Ombudsman's vision is:***

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

our investigations whether staff and residents are fully aware of the dangers of drug toxicity and the risks of mixing illicit and prescribed drugs especially when prescribed dosage is exceeded. We do not yet know the extent of the danger posed by mixing drugs, but have good reason to be concerned by the number of deaths that show evidence of drug toxicity as an exacerbating factor.

## Lessons learnt

### Lesson 1

**Staff and residents to be made aware of the dangers of:**

#### *Methadone toxicity*

It is absorbed into the system slowly, can affect breathing and is especially toxic at night.

#### *Mixed drug toxicity*

The combination of prescription and illicit drugs especially when dosage is exceeded and/or diverted medication is taken in combination.

### Lesson 2

**Approved premises to make arrangements for prescription drugs to be delivered by or collected from their local pharmacies.**

**To ensure medication is not kept in possession in contravention of the risk assessment and to reduce the opportunity for the trade in prescription drugs.**

## Contact us

Prisons & Probation Ombudsman's Office  
3rd Floor Ashley House  
2 Monck Street  
London SW1P 2BQ  
Telephone: 020 7035 2876  
Fax: 020 7035 2860

**Bulletins available online at [www.ppo.gov.uk](http://www.ppo.gov.uk)  
Please e-mail [PPOComms@ppo.gsi.gov.uk](mailto:PPOComms@ppo.gsi.gov.uk) to join our mailing list.**

<sup>5</sup> Regular use of heroin leads to an increased tolerance to the drug. If it is not used for a period of time the user's tolerance level drops. There is a serious risk of overdose if the user attempts to consume previous amounts.