National Offender
Management Service

Directorate of Probation
Room 1.15
Clive House
70 Petty France
London
SW1H 9EX

12 November 2015:

Mr Thomas Osborne
Senior Coroner for Milton Keynes
HM Coroner's Office
1 Saxon Gate East
Central Milton Keynes
MK9 3 EJ

Dear Mr Osborne,

LEE ANTHONY BODEN

Thank you for your Regulation 28 report, dated 29 September, which was sent to Colin Allars, Director of Probation, following the inquest into the death of Mr Lee Anthony Boden.

We are grateful for your comments and recommendations for improvement, which we have considered in detail. Your report identifies a series of issues, relating to communication, operational procedure and offender care, arising out of the evidence heard at the inquest. I explain below what action has been or is being taken in relation to each of the points you have raised.

The deceased was not informed of his intended placement in Milton Keynes until the day before his release

The decision to place Mr Boden in Approved Premises (AP) in Milton Keynes was taken at a late stage, in response to information received on 9 February that indicated a potential risk of harm to a victim. This necessitated a change of accommodation plan, to ensure that a protection plan was in place. No places were available at Approved Premises in Cheshire at this point and the place at the Milton Keynes premises was not confirmed until the day before Mr Boden was due to be released. We nevertheless accept that a greater focus on planning for Mr Boden's release, from an early stage, including better liaison with the Cheshire probation area, might have enabled him to be placed nearer to home. In addition, rather than relying on the prison to inform Mr Boden of the change of plan, It would have been preferable for his offender manager to make contact with him to explain the circumstances and to ensure he was aware what could be done to help him on his return to the community. Timeliness in developing release plans, and ensuring that service users are kept informed of changes, are learning points for the team and this will be addressed with managers and staff across the Buckinghamshire and Oxfordshire Local Delivery Unit.

The sudden arrival at the hostel would have increased his risk of using heroin

Drug use was discussed during Mr Boden's induction on arrival at the AP. I enclose a copy of the local guidance on managing vulnerable residents, which highlights the risk of drug overdose for those newly released from custody.

He had been in the bathroom for almost four hours before he was discovered

Measures are in place to assure, as far as possible, the well-being of residents at the AP. The regime includes two "walk-around" checks during the day (the last at 5.30pm), as well as a curfew check of all residents at 11pm. Residents with earlier curfews are checked at their curfew time (as was the case with Mr Boden) and those subject to self-harm monitoring procedures are checked in accordance with a monitoring schedule set out in their self-harm management plan.

Mr Boden had returned to the AP at 7pm for his curfew. He had a discussion with duty staff on his return and gave no sign of distress or other indication that his level of vulnerability had increased. The member of staff who spoke with him says that Mr Boden was pleased that he had succeeded in returning before his curfew and, while not happy about being at the AP, was positive about the prospect of discussing his situation with his offender manager the following Monday. The risk of overdose had been discussed with him at the induction interview. Both during his final weeks in custody, and again on release, Mr Boden had consistently stated that he was drug free and had no intention of using drugs. The Prisons & Parliamentary Ombudsman was satisfied that staff at the AP could not have anticipated Mr Boden's actions.

Having just been released from prison and being unable to return to his home, he should have been recognised as a vulnerable resident

Mr Boden's vulnerability was recognised, and his history of drug use was discussed with him at his induction meeting. Although there were no identified self-harm issues, it was decided to undertake overnight welfare checks.

There appears to be no protocol in place for continuing monitoring of new arrivals who remain vulnerable

The AP has a policy and procedures for assessing risk of self-harm and suicide and a system based on the Assessment, Care in Custody and Teamwork process (ACCT) for identifying those who require additional monitoring. In Mr Boden's case, an ACCT assessment was undertaken and overnight welfare checks were established as a result.

While both of the staff on duty were trained in first aid, neither had received specialist training in responding to a suspected drugs overdose. There is scope to explore additional training options, including the feasibility and desirability of staff administering heroin antagonists if residents are suspected of suffering from a drug overdose.

I hope that the information provided above and the actions to be taken forward provide the assurance you are seeking of the National Probation Service's commitment to addressing the issues you identified in your report.

Yours sincerely,

Richard Hughes.