

**INVESTIGATION INTO THE CIRCUMSTANCES SURROUNDING
THE DEATH OF A MAN AT AN APPROVED PREMISES
IN APRIL 2004**

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

December 2004

CONTENTS

**Part One Introduction by the Prisons and Probation
 Ombudsman, Stephen Shaw CBE**

Summary

Investigation methodology

Approved Premises

Events prior to the man's death

Discovery of the man's death

Post Mortem and Toxicology

Emergent issues

Clinical review

Observations

Recommendations

Introduction by the Prisons and Probation Ombudsman, Stephen Shaw CBE

This is the report of an investigation into the circumstances surrounding the death of a man at an Approved Premises during April 2004.

The investigation was conducted according to the terms of a protocol agreed between my office and the National Probation Service which came into effect on 1 April 2004. In keeping with that protocol, my own investigator was assisted by a representative of the Probation Service. My thanks go to him for the policy advice he offered during the course of the investigation and for the support he gave my investigator during interviews with Approved Premises staff. In my judgement the staff at the Approved Premises acquitted themselves admirably in preparing quickly and comprehensively for an investigative process that was entirely new to them.

My investigator met with members of the deceased's family who expressed a number of concerns about the management of his healthcare both at Acklington prison and at the Approved Premises. These concerns are addressed in the main body of my report.

I commissioned an independent clinical review of the management of the man's healthcare while he was at the Approved Premises. This was led by a representative of the local Primary Care Trust.

SUMMARY

The man had been serving a seven year prison sentence at Acklington Prison in the North East of England, when, on 3 December 2003 he was released on parole with a condition that he should reside at the Approved Premises until the expiry of his licence in June 2006. He was found dead in his bed at approximately 8:10am on 6 April 2004 by a member of staff. He was 51 years old when he died.

He was described by staff as a model resident. He was unemployed and spent as much time as possible in the company of his partner who lives quite near the premises. About a week before he died he had been assessed as suitable for allocation to a cluster Approved Premises where he would have enjoyed more autonomy in his daily life.

The man had been prescribed medication by his local GP for a range of ailments. He had never displayed any signs of serious illness or distress whilst at the Approved Premises.

On the eve of his death, the man had returned to the premises, as usual, at about 10:30 pm and had gone straight to his room. During the night, he had visited the toilet twice and returned to his bed. When the night duty staff did not see him at the usual time the following morning they checked his room and, just after 8am, found him apparently dead in his bed. An ambulance was called and paramedics confirmed death at the scene.

A Post Mortem examination was carried out on 8 April 2004. Its conclusion was that the man died from cardiac dysrhythmia which in turn was due to coronary artery thrombosis together with carcinoma of the lung.

I have drawn the conclusion that the man was appropriately cared for by the staff at the Approved Premises who could not have predicted or prevented his untimely death.

At Section 11, I make one observation and, at Section 12, three recommendations.

INVESTIGATION METHODOLOGY

My investigation, and that of the PCT, examined:

- (1) the extent to which the medical authorities at HMP Acklington passed information about the man's medical condition to the Approved Premises.
- (2) the manner in which his healthcare needs were met while he was a resident of the hostel.
- (3) the procedures for the administration of prescribed medication to him and to the residents in general.
- (4) the means by which staff who manage Probation Approved Premises might have better access into the rooms of residents who are unwell.

In keeping with the protocol agreed between my office and the National Probation Service, the investigation was opened jointly on 15 April 2004 by my investigator and by a representative of the Probation Service.

The Approved Premises Manager and her staff produced the man's case file and a number of associated documents for scrutiny.

My investigator contacted the Coroner's Officer to brief her on the nature and scope of my investigation and requested a copy of the Post Mortem report.

Notices were issued to the staff and to the residents of the Approved Premises.

A number of staff were formally interviewed.

A meeting with the man's three brothers took place on 23 April 2004. My investigator explained the purpose and process of the investigation, and also asked the family if they had any concerns or questions they would like the investigation to explore and address where possible.

I commissioned an independent clinical review of the management of the man's healthcare. This was led by a representative of the Primary Care Trust.

THE APPROVED PREMISES

At the time of the investigation, the hostel was run by a manager, deputy manager, four assistants, three part time support workers and a senior clerical assistant.

At least two members of staff must remain on duty in the premises at any given time. The two night duty staff must remain awake between 5pm and 1am but thereafter they are permitted to sleep until 7am when their shift continues into the daytime. Residents are normally required to report back to the premises before 11pm and to be in their rooms by midnight. A bank of CCTV cameras observes movements 24 hours a day. There is a local policy that all Approved Premises assistants, support workers and administration staff are trained in first aid. Although there is no guarantee that a trained first-aider is always available on duty, the two staff on duty at the time of the man's death were both first-aid trained.

On 5 and 6 April 2004 there were 14 residents in the premises and on 15 April 2004, the day the investigation began, there were 16 residents.

A local GP is assigned to the Approved Premises and residents are obliged to register with that practice as a condition of their residency.

My investigator found the premises clean and well managed by a caring and dedicated staff. Good staff/resident relations were evident.

EVENTS PRIOR TO THE MAN'S DEATH

The man was released on licence from Acklington Prison on 3 December 2003 with a condition that he should reside at the Approved Premises. He had previously been interviewed at Acklington by the Approved Premises deputy manager as part of the normal referral procedure. No concerns about his medical condition were brought to the deputy manager's attention by officials at Acklington.

The man arrived at the Approved Premises on 3 December in the company of his Probation Officer. As part of his induction process the man was required to register with a local GP whose practice is affiliated to the Approved Premises. He co-operated with this requirement. He was in possession of a computer printout containing details of his medical condition which he claimed were given by healthcare staff at Acklington. This was to be passed to his local GP. The man mentioned to the Approved Premises staff that he was suffering from ischaemic heart disease. Staff were not in a position to verify this but were aware that he had been prescribed a variety of tablets which needed to be administered to him in the Approved Premises on a daily basis.

On Friday 12 December, the man wrote to his Probation Officer to confirm that he was willing to undertake relevant offending behaviour programmes.

He mentioned in his letter that there were “a few health issues” about which he was concerned but which would not in his view prevent him from completing the courses deemed necessary.

The man had rarely been employed and soon after his arrival at the hostel he quickly settled into a routine of leaving at about 7:30am to spend the day with his partner who lives in sheltered accommodation not far from the Approved Premises. He normally returned at about 10:30pm each night, seven days a week, and would invariably go straight to his room without having any contact with other residents. As a consequence, he was not well known to the manager or to the deputy manager (whose working hours were from 9am until 5pm) or to some of the other residents. Even the member of staff appointed as his key worker commented that aside from his weekly meetings with his client they otherwise had little contact. Although the man’s Approved Premises file records that on occasions he would return slightly drunk from his days out, he was nevertheless regarded by staff as a compliant resident. Shortly before he died the man had been assessed as suitable for allocation to the 'cluster' premises, a facility linked to, but separate from this Approved Premises, in which residents are given more autonomy as they prepare for final release into the community.

The man was routinely prescribed medication by his GP for hypertension, arthritis, dyspepsia, ischaemic heart disease (for which he was under investigation) and depression, and included :

Bendrofluazide
Aspirin
Felodipine
GTN spray
Simvastatin
Isosorbide mononitrate
Co-codamol
Lansoprazole
Lofepamine
Atenolol

In keeping with normal practice, the man’s prescriptions were faxed from the surgery to a local pharmacist where the drugs were made up and sent to the Approved Premises for administration according to the GP's instructions. Staff kept his prescribed drugs in a secure cupboard and normally administered them to him on a daily basis. However, a week before he died, a decision was made to allow him to keep a week's supply of drugs in his possession. My investigator was told that this decision was made in the context of the fact that the man was shortly to move to the cluster Approved Premises where any residents under medication would normally collect a week's supply of drugs the medical centre. There seemed to be a difference of opinion between the managers as to whether this decision was appropriate. I question the wisdom of this decision and consider it further below.

Approved Premises staff keep a daily log of residents' movements. The only events of note recorded in respect of the man were those occasions when he occasionally returned at night smelling of alcohol or appearing to be drunk.

On Monday 5 April 2004, the man left the premises at approximately 8am to spend the day with his partner. He returned at approximately 10:30pm. A member of staff on duty that night reports that she opened the front door to let the man in and that she spoke to him briefly. According to her, he appeared to be in good spirits and did not complain of feeling unwell. He went, as usual, straight to his room. The other member of staff on duty at the time reported that he had heard the man get up in the middle of the night to go to the toilet. This is borne out by CCTV footage which shows that he left his room once at 1:23am and again at 1:55am.

THE DISCOVERY OF THE MAN'S DEATH

At approximately 8:10am the next day, an Approved Premises support worker, concerned that he had not seen the man, entered his room and found him apparently dead in his bed. He described him as lying in his bed facing upwards as if he were asleep. There were no signs of life. The member of staff nevertheless attempted to get a response from him, but was unsuccessful. He could find no pulse and noticed that the man's arms were stiff. The member of staff called for a colleague to come to the room. When she arrived, she also tried to get a response but failed. Both members of staff were sure that the man had been dead for some time. An ambulance was called at about 8:15am and arrived at about 8:25am. Paramedics straightaway declared the man dead. No resuscitation was attempted by staff or paramedics. This was appropriate in the circumstances.

The CCTV equipment shows no evidence of any intrusion into the man's room by anyone during the night before he was found dead. The first member of staff on the scene had found the man's door locked and had to use a pass-key to gain entry. The police and paramedics who attended the scene have confirmed that there were no suspicious circumstances.

POST MORTEM AND TOXICOLOGY

A Post Mortem examination of the man's body was conducted at the mortuary of the local hospital on 8 April 2004. This concluded that the cause of death was cardiac dysrhythmia due to coronary artery thrombosis together with carcinoma of the lung.

A toxicology report was submitted to the Coroner separately. This report reveals no toxicological abnormalities.

EMERGENT ISSUES

1. The following issues were of concern to my investigator:

- It appeared that there was no hand-over of medical information between healthcare staff at Acklington and either the Approved Premises staff or the GP assigned to the premises when the man was released on licence from prison on 3 December 2003. The man was given a medical-in-confidence computer printout showing his medical history on leaving Acklington. He passed this on to the GP practice when he registered for the first time.
- About a week before he died, he was given a week's supply of medication, which, if taken inappropriately, might have had an adverse effect on his health. There is no evidence that this was done on the basis of a risk assessment.
- If the man experienced any warning at all of his heart attack and had wished to call for help his ability to do so would have been severely restricted by the absence of any personal alarm system.

2. Issues of concern to the man's family.

My investigator met with the man's three brothers at a Probation Office on 23 April 2004 to brief them on the nature and scope of the investigation and to invite them to raise any issues of concern. Whilst the family were, in general terms, content with the manner in which the Prison and Probation Services had treated their brother, they were confused as to whether he did or did not have ischaemic heart disease. The family gave my investigator a copy of a form Med 3, signed and issued to him by a doctor on 23 March 2004, in which she advised him that he should refrain from work for four weeks, quoting ischaemic heart disease as the reason. However, one of the man's brothers informed my investigator that on 8 April 2004 he was told that the Coroner's Officer had been informed by a consultant that the man had not been suffering from ischaemic heart disease. The family specifically asked my investigator to look into this apparent confusion. They were particularly alarmed at the possibility that their brother might have been taking tablets for a condition that he did not have.

My investigator made a number of attempts to contact the man's partner by telephone but was unsuccessful.

3. These issues are considered at paragraphs below.

CLINICAL REVIEW

My investigator asked the Primary Care Trust to carry out a clinical review of the management of the man's healthcare relating to his time as an Approved Premises resident, taking into account his own concerns and those of the family. The PCT was asked to provide answers to the following specific questions (the PCT's responses are shown in italics) :

- **Did HMP Acklington provide any background medical information to his new GP practice?**

When the man registered with the practice, he brought with him a computer printout of his recent medical notes. It is unclear whether he obtained this from HMP Acklington or from the medical practice in question.

- **There is some confusion as to what medical condition he was suffering from prior to his death. Please provide medical details.**

The man was suffering from hypertension, asthma and generalised osteoarthritis. He also declared a history of ischaemic heart disease for which he was under investigation at hospital. Whilst in prison he had had a myocardial perfusion scan. We eventually obtained the results on 24 March by telephone. The myocardial perfusion scan results were normal, implying that he did not have ischaemic heart disease.

- **It is not clear what information was passed from HMP Acklington to the GP or to the Approved Premises on 3 December 2003 about the man's medical condition**

The only medical information received was as described in point 1.

- **It is not clear for what condition the medication prescribed to the man was needed**

The man was taking medication for hypertension, arthritis, dyspepsia, ischaemic heart disease and depression. (Bendrofluozide, aspirin, felodipine, GTN spray, simvastatin, isosorbide mononitrate, co-codamol, lansoprazole, lofepramine, atenolol).

- **Did the man have responsibility for managing his own medication and what are the procedures for prescribing, dispensing and administering medication?**

Our current procedure, when patients register with this practice, and are residing at the Approved Premises is that, should they require medication, a prescription is printed and sent directly from the GP surgery to the local chemist who then dispense the medication to the Approved Premises. Our understanding is that the Approved Premises staff then give the medication to the patient at the time it is due.

It is unfortunate that these responses were submitted by the man's own GP at the local practice rather than by an independent source. It is also understood that the PCT did not communicate with anyone at Acklington as part of the clinical review.

OBSERVATION

The presence or absence of Ischaemic Heart Disease

The anxiety experienced by the man and his brothers about the question of whether he was suffering from Ischaemic Heart Disease (IHD) is understandable. It became clear during my investigation that the man was under medical investigation for IHD and underwent a myocardial perfusion scan while still at Acklington prison. The results of this scan were not received by the GP until 24 March 2004, approximately two weeks before the man died. He was prescribed medication for IHD until the scan results showed that he did not have the disease. The Post Mortem examination confirmed that that he did not die of IHD. The date of the receipt of the scan result explains why the GP advised the man on 23 March to refrain from work because of IHD. The medication was withdrawn after the scan results were received.

I offer no criticism in respect of the management of this aspect of the man's healthcare

12. RECOMMENDATIONS (NATIONAL)

Recommendation 1: Sharing of medical-in-confidence information

On 26 July 2004, my investigator spoke to the current healthcare manager at HM Prison Acklington, to seek his views about the systems in place for the communication of medical-in-confidence information between the prison and Probation Approved Premises or the designated General Practice surgery.

My investigator was told that prisoners who are released from Acklington at the end of their sentence are indeed given a computer print-out showing details of their medical history. The healthcare manager emphasised that this is a medical-in-confidence document which is given to the prisoner (who is, in effect, a patient in the community) to hand to his GP on release. Because it is a confidential document it should not be given to any member of staff in the Approved Premises at which the prisoner is to reside.

The opinions independently volunteered by the healthcare manager were in keeping with those expressed by the man's GP.

A policy should be developed to ensure that appropriate information is shared between agencies to maximise the health and social care of persons in Approved Premises in accordance with the Social Exclusion Policy. (A protocol is in place in the Prison Service – see paras 4.11 and 5 of Prison Service Information and Practice 1/2002, Guidance on the protection and use of confidential health information in prisons and inter-agency information sharing.)

(At the fact check stage of this investigation, the National Probation Department indicated this was an issue they did wish to take forward with the Prison Service and Department of Health. However, there was a concern – which I understand – that they did not want Approved Premises staff to be taking on responsibilities outwith their remit and training.)

Recommendation 2: The issue of a week's supply of prescribed medication

Although my investigator was concerned about a possible link between the man's death and the fact that he had been issued with a week's supply of drugs only a week before he died, the Post Mortem and toxicology reports rule out any such link. Although patients in the community at large bear the ultimate responsibility for administering prescribed drugs in the quantity and at the frequency advised by the prescribing doctor, those in Approved Premises attract a duty of care by the staff. The responsibility for the correct administration of prescribed drugs is thus shared between the Approved Premises staff and the resident. Particular care must always be taken by staff in the administration of prescribed drugs to any resident who may, for example, be suffering from an illness such as depression.

The National Probation Service should consider whether it needs to issue guidelines to the staff of Approved Premises regarding the administration of prescribed medications, in particular whether some form of risk assessment should be conducted before any resident is issued with more than one day's supply of prescribed drugs.

(I understand that the National Probation Service issued Probation Circular 33/2004 on this subject on 8 June and that further guidance will be issued in due course.)

Recommendation 3: The absence of any personal alarm system for residents

The man was found dead in his bed in the room allocated to him. The door was locked from the inside. Although staff are able to enter locked rooms using a pass key, those residents who become critically ill behind the locked door of their room may not be able to alert staff or other residents of their need for assistance.

The National Probation Service should consider whether some form of personal alarm system should be made available either in residents'

bedrooms or for residents to wear about their body, or an emergency call-bell system as used in sheltered accommodation.

(At the fact check stage, the National Probation Department indicated that they had considered personal alarms as I had requested but did not believe making a personal alarm available to all residents would be appropriate. There were concerns as to cost and to the possible misuse of alarms by residents. Be that as it may, it seems to me that providing alarms for those most at risk is something that may well have merit in individual cases.)

Stephen Shaw CBE
Prisons and Probation Ombudsman for England and Wales

25 November 2004