

**Circumstances surrounding the death of a man
whilst resident in Approved Premises, in May 2006**

**REPORT BY THE PRISONS AND PROBATION OMBUDSMAN FOR
ENGLAND AND WALES**

OCTOBER 2006

This is a report into the death of a man at an Approved Premises in May 2006.

The man resided at the Approved Premises from 8 March 2005, initially as a condition of bail and then, from 8 April 2005, as a requirement of a Community Rehabilitation Order imposed by the Crown Court. He had complex needs, including mild learning difficulties, depression, anxiety, auditory hallucinations, a diagnosed personality disorder and a history of self-harm. He found independent living extremely difficult and was isolated from the community. However, over the course of his 14 month residency at the Approved Premises, his quality of life improved considerably and at the time of his death he was preparing for more independent accommodation. The support of the staff team at the Approved Premises engaged him so that he was able to develop many of the skills necessary to cope with everyday life.

The man died after apparently suffering a heart attack. Staff attended promptly and attempted to resuscitate him before he was taken to hospital by ambulance. Sadly, medical staff were unable to revive him and he was pronounced dead minutes after arriving at the Accident and Emergency Department.

This investigation has been undertaken by a member of my team. I would like to thank the Senior Probation Officer in charge of the Approved Premises and his staff for their co-operation and active participation.

Fatal incident investigations conducted by my office attempt, as far as possible, to address the concerns of family members and anyone to whom the person who died was close. Unfortunately, in this case, it has not been possible to identify the man's next-of-kin to offer them the opportunity to participate in the investigation. I therefore express my condolences to anyone who was close to him and hope that this report answers any questions they may have.

I make two recommendations as a result of my investigation, one of which reflects positively on the response of the staff team to his collapse. I also cite two examples of good practice, which I would like the National Probation Directorate to draw to the attention of other Approved Premises.

In sad circumstances, this is a report that reflects extremely well upon staff at the Approved Premises and upon the relevant Probation Area as a whole.

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Prisons and Probation Ombudsman

October 2006

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SUMMARY

1. The man appeared at the Magistrates' Court in February 2005 when he was bailed on the condition that he reside at an Approved Premises run by the National Probation Service. As there were no vacancies on the day, he did not take up residence until 8 March.
2. The man returned to court on 8 April, when he was sentenced for breaching a three year Community Rehabilitation Order imposed the previous year. The court imposed a concurrent two year Community Rehabilitation Order and stipulated that he was to reside at the Approved Premises for a further 12 months.
3. On 15 February 2006, the man informed his supervising probation officer that he was experiencing "shooting pains". A week later, he informed a member of hostel staff that he was suffering from pain and that he could not get his breath. The member of staff concerned made a doctor's appointment for the man which resulted in him being prescribed an inhaler. The diagnosis was apparently that he had a chest infection.
4. Throughout the night of 10 May, the man was heard coughing by staff. At 12.20pm on 11 May, he went as usual to the general office to collect his prescribed medication. He told a member of staff that he thought he might be getting another chest infection and asked the staff member to contact his doctor's surgery to bring his scheduled appointment forward.
5. At 12.50pm, the man was found on the stairs at the hostel, struggling for breath. An ambulance was called and arrived within six minutes. In the interim, he vomited and stopped breathing, and emergency resuscitation procedures were initiated by hostel staff.
6. The man was taken to hospital by ambulance but was pronounced dead shortly after his arrival. Subsequently efforts were made by both the Approve Premises and Her Majesty's Coroner to contact his family, but hitherto these have not been successful.

THE INVESTIGATION PROCESS

7. My investigator considered the man's probation records, including those held by the Approved Premises. The investigation was formally opened on 13 June 2006, when he met the Senior Probation Officer in charge of the hostel and interviewed three members of his team. He also interviewed a probation officer who supervised the man between 2002 and 2005 and knew him particularly well.
8. Prior to my investigator arriving at the hostel, notices were issued to staff and residents announcing the investigation and inviting anyone with information relevant to the man's death to make themselves known to the investigator. In the event, nobody came forward.
9. Investigations into all deaths conducted by my office attempt to address the concerns of the next-of-kin or other family members. Sadly, on this occasion it has not been possible for the Probation Service or, indeed, Her Majesty's Coroner, to identify and locate any next-of-kin. The investigation into the man's death was therefore conducted without the contribution of members of his family.
10. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of the investigation and to request a copy of the Post Mortem report. On this occasion, the Coroner has decided not to hold an inquest into the circumstances surrounding the death.

APPROVED PREMISES

11. The hostel is a 22-bed Approved Premises for adult men. It is staffed 24 hours a day by probation employees who provide support to residents and ensure their compliance with the hostel rules and licence and bail conditions. A system of curfew operates between 11.00pm and 6.00am, and residents have to agree to comply with this and the other rules of residence. The residents are on bail or convicted offenders, who live there as a condition of a court order or as a requirement of their release from custody.
12. All residents are registered with a local doctor. The hostel has recently entered into a new arrangement with the local Primary Care Trust which has meant that all the residents have had to register with a new surgery. Prescribed medication is stored in a locked cabinet located in the general office at the hostel, to which residents do not have access. They are dispensed by staff in accordance with the directions given on the label.
13. Staff at the hostel are trained in first aid. The training is delivered over a half a day by the relevant Probation Area. The hostel also has basic first aid equipment, including a resuscitation mask.
14. Each resident is allocated to a keyworker soon after their arrival, and this member of staff acts as their primary point of contact for sorting out practical issues. Regular keywork sessions, which take place approximately every ten days, give residents the opportunity to discuss their difficulties in depth. Although these sessions are not governed by a set agenda, issues such as benefits, health and move-on accommodation are routinely discussed.
15. The day-to-day regime at the hostel is relaxed, although all residents are expected to attend the daily morning meeting which commences at 9.00am. The meeting is chaired by a member of staff and acts as a forum for staff to pass on information to residents, such as details of appointments, activities available at the hostel on that day and menu options for the evening meal. Residents are expected to use their time at the Approved Premises productively, and are actively encouraged to pursue training and employment options.
16. The hostel is currently equipped with one cordless telephone which enables staff to move around the hostel when taking or receiving calls. It is also used by staff from visiting partnership agencies who do not have access to a room with a fixed landline.

KEY FINDINGS

17. After being discharged from hospital, the man appeared at the Magistrates' Court on 21 February 2005 for breaching the Community Rehabilitation Order imposed on 7 April 2004. At the hearing, the court decided to adjourn sentencing and grant bail on the condition that he reside at an Approved Premises. However, because there were no bed spaces available on the day, it was agreed that the bail condition would only become enforceable when a vacancy arose. On the same day, the man's supervising probation officer placed him on the Probation Area's suicide / self-harm register because of the suicide attempt that contributed to his period in hospital.
18. The man went to live at the hostel on 8 March. He received an induction that day, during the course of which he provided the hostel with the name of a next-of-kin to be contacted in an emergency. He did not provide a telephone number or an address. On 11 March, he participated in a joint meeting with hostel staff and his probation officer. His health needs, including his mental health needs, were discussed and a plan for managing these was drawn up. He was also allocated to a keyworker.
19. On 14 March, the man registered with the local doctor's surgery. The doctor informed the man that he would refer him to hospital for an x-ray on his hip and a brain scan, which was originally scheduled to take place at the time he was arrested.
20. On 8 April, the man returned to the Court to be sentenced for breaching his Community Rehabilitation Order. The court imposed a concurrent two-year Community Rehabilitation Order and stipulated that he was to reside at the hostel for a further 12 months.
21. Towards the end of April the deputy manager noticed that the man appeared to be anxious and low in mood. She spoke to him about this and he said he was concerned about outstanding matters that were being investigated by the police. He also disclosed that he was suffering from "intrusive thoughts" and said he found it hard to leave his room. The deputy manager made an appointment for the man to see the Community Psychiatric Nurse (CPN) responsible for hostel residents on 9 May.
22. After seeing the CPN on 9 May and being prescribed new medication, the man's emotional well-being improved noticeably and he was encouraged by staff to participate more fully in hostel life. He developed an interest in maintaining the garden and engaged positively with the hostel staff, who observed a tangible improvement in his physical appearance and mental state. On 15 June, he was removed from the Probation Area's suicide / self-harm register as it was felt that he no longer posed a danger to himself. He had been on the register for almost four months.

23. On 12 August, the man saw the Community Psychiatric Nurse again. She informed him that the psychiatrist responsible for his care had increased the dosage of his Promazine medication. This came about in response to the man's complaint at an earlier appointment that he was suffering from panic attacks. He was seen again by the Community Psychiatric Nurse on 23 August, when she observed a marked improvement in his mental state.
24. In late September, the man became increasingly troubled by auditory hallucinations. However, by talking about his worries with hostel staff and his Community Psychiatric Nurse, he was able to get the voices under control. By early October, he had overcome the problem and he enjoyed good health for the remainder of the year.
25. On 15 February 2006, the man informed his supervising probation officer that he was experiencing "shooting pains". He told the probation officer that he would go to his doctor the following day, although I have not been able to ascertain from the records whether he did so.
26. On 21 February, the man informed a member of hostel staff that he was suffering from pain and that he could not get his breath. A doctor's appointment was made for him which resulted in him being prescribed an inhaler. He informed his keyworker during their meeting, on 24 February that the doctor had told him he had a chest infection.
27. On 27 February, the man was visited at the hostel by his probation officer. He informed her that he was experiencing "digestive problems and pain" and had an appointment with his doctor later in the day. I have not been able to confirm whether he attended this appointment or, if he did go, whether he informed hostel staff of the doctor's opinion of what was wrong with him.
28. In the early hours of 13 March, the man mentioned to the night staff that he had had a very disturbed night because of aches and pains. The night worker made an entry in the man's record of contact that a doctor's appointment should be made. Unfortunately, I have not been able to establish whether an appointment was made.
29. Throughout the night of 10 May, the man was heard coughing by the waking night staff. By 9.00am on 11 May, he had failed to attend the daily morning meeting, although this was not particularly unusual. The probation service officer went to the man's bedroom to remind him that the meeting was about to start, and he went a few minutes later. Around 9.15am, after the meeting had finished, the man had a discussion with the deputy manager, during the course of which he mentioned that his trousers felt tight. He also reported feeling "unwell".
30. At 12.20pm, the man went to the general office as usual to collect his prescribed medication. Whilst the probation service officer sorted out the

medication, the man talked to his keyworker who was also in the general office, about how much weight he had gained since coming to the hostel. According to the keyworker, the man discussed the issue in a light-hearted manner and he joked that it was the fine food at the hostel that had made him put on weight. During the course of this conversation, the keyworker observed that the man's lips looked off colour. She asked him whether he felt okay. He said that he had had a panic attack earlier because he thought he had lost his wallet. He told her that he went outside to get some fresh air and felt a little better as a result. He did, however, say that he thought he might be getting a chest infection again. He asked his keyworker whether she could try to arrange for his doctor's appointment on 16 May to be brought forward so he could be seen sooner. She told him that she would call the doctor's surgery after lunch to find out whether any earlier appointments were available.

31. At 12.50pm the hostel manager was in his office when he heard a voice calling for help. He went to investigate and saw the man at the top of the stairs on the first floor landing. The man said, "Help, I can't breathe". The manager observed that the man looked pale, and then he started to collapse. The manager asked the man whether he had taken anything but he did not reply. The manager left the man to go to the general office where he told the keyworker to call an ambulance. He immediately returned to the man and was joined by the probation service officer. Together they started calling out to the man in an attempt to establish whether he was still conscious.
32. On the manager's instruction, the probation service officer took the man's pulse and found that it was faint. He was still breathing but his breaths were very shallow. On the advice of the keyworker who telephoned the emergency services operator, the man was manoeuvred onto his back.
33. Moments later, the man appeared to stop breathing. The manager and probation service officer attempted to move the man into the recovery position. Whilst they were doing this, he vomited, losing fluids through his mouth and nose.
34. At this point, the deputy manager arrived at the landing having been alerted by the keyworker. She saw that the man had vomited which she thought was a sign of organ failure. She realised that Cardio Pulmonary Resuscitation (CPR) needed to be started immediately and, with the manager's assistance, turned the man onto his back. Using a resuscitation mask that the probation service officer had collected from the general office, the deputy manager commenced mouth-to-mouth resuscitation whilst the manager began chest compressions.
35. Whilst the manager, the probation service manager and the deputy manager attended to the man, the keyworker called the emergency services from the landline telephone in the general office. The emergency services operator asked the keyworker a number of

questions about the man's condition, none of which she could answer without first running to the stairs leading to the first floor landing and addressing the same questions to the manager and probation service officer. She then returned to the general office where she relayed news of the man's condition to the operator. Over the course of the next few minutes this happened on numerous occasions. In the end, the keyworker used her personal mobile telephone so that she could keep the operator informed of the man's condition from the staircase.

36. At 12.56pm, a paramedic arrived at the Approved Premises. After assessing the situation, the paramedic encouraged the deputy manager and the manager to carry on doing CPR whilst he prepared his equipment. He described to them how many breaths should be given and how forceful the chest compressions should be, and then administered an adrenaline injection.
37. Within minutes, an ambulance with more two paramedics arrived at the hostel. They asked the manager and deputy manager to carry on administering CPR whilst they prepared their equipment. They then took over administering CPR and placed the man in a wheelchair. Whilst he was being moved, he vomited again. The three paramedics placed him in the back of the ambulance where they continued to work on him. After five minutes, the ambulance left the premises and made its way to hospital on a blue emergency light.
38. The keyworker and the deputy manager followed the ambulance to the hospital in the latter's car. Whilst the deputy manager parked the car, the keyworker went to the Accident and Emergency Department to explain who she was. After a short while, she was taken through to the lounge and told that the man had been pronounced dead. She was joined shortly afterwards by the deputy manager who telephoned the manager to inform him of the sad news.
39. The manager contacted the Probation Area headquarters to inform them of the man's death. Within minutes, both the Area Manager and Director of Interventions arrived at the Approved Premises and they helped to maintain the hostel regime whilst also providing direct support for staff and residents. This is an example of good practice and shows that the Probation Area's senior management team was sensitive to the impact of the man's death on both hostel staff and residents.
40. At 4.00pm, staff convened an emergency meeting with the residents. During the meeting they acknowledged that everyone had been and would be affected by the man's death, and residents were asked to be respectful to one another in the weeks to come. Similar meetings took place on 12 May and 15 May. Residents known to be particularly vulnerable were spoken to individually and offered support. Both staff and residents were offered 'Critical Incident' counselling by a specialist external agency, and many took advantage of this service.

41. After the man's death, it became apparent that the details of his next-of-kin were insufficient. The keyworker subsequently spent considerable time going through probation records and the man's belongings to try to identify his relatives. Unfortunately her efforts were unsuccessful and it has not been possible for the hostel or the Coroner to contact anyone. Responsibility for arranging the man's funeral has now been assumed by the local Social Services.

ISSUES

Response to the man's collapse

42. It is a medical fact that a rapid response to cardiac arrest significantly increases the likelihood of a heart attack victim surviving. When the heart stops, the absence of oxygenated blood can cause irreparable brain damage in only a few minutes and death invariably occurs within ten minutes. The response time is therefore critical.
43. In this case, the manager reached the man within seconds of him crying out for help. The first thing he did when he discovered the man was in distress was to get one of his colleagues to call an ambulance. He then returned to the man and with the probation service officer, carried out basic observations of his pulse and breathing. As the man was breathing and had a pulse, there was no reason for emergency resuscitation to be started. It only became necessary when he vomited and stopped breathing, and was commenced by the manager and his deputy when the latter arrived moments later.
44. On the basis of the evidence available there is nothing to suggest that the response to the man's situation was anything other than very prompt. There was very little more that hostel staff could have done in an effort to revive him.

Staff involved should be commended by the Chief Officer of the Probation Area for their efforts to resuscitate the man.

Exchanging information with the ambulance service

45. The manager's first action after discovering the man on the first floor landing was to go to the general office and instruct the keyworker to call an ambulance. The keyworker, entirely understandably, made the call from the nearest telephone to hand, the fixed landline in the office. When she got through to the emergency services operator, she was asked a number of questions about the man's condition, none of which she could answer straightaway because she could not see him.
46. This resulted in a situation where the keyworker had to run between the general office and the stairs to the first floor landing, relaying messages between the emergency services operator and the hostel staff attending to the man. It would have been preferable if she had been able to speak to the operator whilst observing what was going on. However, the cordless telephone was in the basement at the time, being used by a partnership worker from the local college. In the end, she resorted to using her personal mobile telephone to speak to the emergency services operator.
47. As a result of the events leading up to the man's death, the hostel is currently reviewing the access to the cordless telephone and considering

whether another should be acquired. I have been assured by the management team at the hostel that the review will ensure that the same problems would not be encountered in the event of another medical emergency. Consequently, I refrain from making a recommendation on this matter.

Records of next-of-kin

48. When new residents arrive at the hostel, they are routinely asked to provide the name of their next-of-kin to be contacted in the event of an emergency. In this case, the man gave the name of a family member but did not provide contact details. After he died, strenuous efforts were made by hostel staff, particularly his keyworker, to locate his relatives. This meticulous work proved to be futile and, at the time of writing, no member of the man's family has been informed of his death.
49. Prior to the man's death, it appears that next-of-kin information was collected but little thought given to its practical application. The need to have on file accurate, up-to-date next-of-kin information that is readily accessible at times of crisis is self-evident.
50. I therefore approve of the steps already taken by the Approved Premises to review the effectiveness of their procedures for recording next-of-kin details. I suggest that a new system should include a mechanism for reviewing the information held on file.

The Approved Premises should maintain accurate and up to date records of residents' next of kin and their contact details. The information should be reviewed every six months.

The support offered to staff and residents after the man's death

51. After news of the man's death was received at the hostel, the manager passed the information to senior managers at the Probation Area headquarters. Shortly afterwards, the Area Manager and Director of Interventions arrived at the hostel to provide practical support to the staff team by relieving them of many of their day-to-day duties. This helped those staff members involved in attempting to revive the man to come to terms with what they had witnessed, and also gave them the space to talk to each other without the burden of more routine, everyday tasks. In addition, every member of staff was offered grief counselling.
52. During the afternoon of 11 May, the manager, deputy manager and keyworker called a meeting to talk with the resident group about what had happened and its impact on everyone at the hostel. Residents were asked to show consideration for each other and to be respectful to the man's memory. All the residents were offered the use of a specialist counselling service, whilst residents known to be particularly vulnerable were spoken to individually to check that they were alright. Subsequent resident meetings conducted by the deputy manager on 12 May and 15

May reiterated the message of compassion and mutual respect. It is difficult to believe that these matters could have been handled with greater sensitivity or professionalism, and I commend the staff concerned in the highest terms.

The emotional support offered to residents following the man's death is an example of good practice.

53. The fact that two senior managers interrupted their day-to-day schedules, at short notice, to attend the hostel and provide practical assistance to their frontline colleagues sent a clear message to the hostel staff that they did not have to deal with the man's death alone. This in turn helped the staff team to support the resident group, with whom they work on a daily basis and with whom they have particularly close professional relationships. The hands on leadership displayed in the hours after the man's death helped ensure that it did not have a negative impact on the positive staff-resident relationships at the hostel.

The practical support demonstrated by senior managers for the staff team at the Approved Premises is an example of good practice.

RECOMMENDATIONS

1. **Staff at the hostel should be commended by the Chief Officer of the Probation Area, for their efforts to resuscitate the man**

In the Probation Area's formal response to this report, I have been assured that the Chief Officer will write to the named members of staff and praise them for their actions.

2. **The Approved Premises should maintain accurate and up to date records of residents' next of kin and their contact details. The information should be reviewed every six months.**

The Probation Area's formal response to this report confirms that this recommendation has been implemented by all seven Approved Premises within their area.

Good practice

3. The emotional support offered to residents following the man's death is an example of good practice.
4. The practical support demonstrated by senior managers for the staff team at the Approved Premises is an example of good practice.