

**Investigation into the circumstances surrounding the  
death of a resident  
at an Approved Premises in the West Yorkshire Probation  
Area in May 2007**

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

**October 2007**

This is the report of an investigation into the death of a man at an Approved Premises in the West Yorkshire Probation Area in May 2007. He had been at the hostel for more than 12 months when he died of natural causes. The man, who was well liked by staff and residents, was 51 years old.

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. In this case the man's family had no specific concerns about the circumstances of his death. However, I hope that this report answers any questions they may have. I offer them my sincere condolences for their loss.

The investigation was undertaken on my behalf by a member of my team. I would like to express my thanks to the manager of the hostel and her staff for the help my investigator received.

Simply stated, the circumstances of the man's death were as follows. Just after midday on 12 May 2007, he collapsed on the first floor hallway of the hostel. Another resident found him and alerted a member of staff who, in turn, responded quickly and found him to be unconscious. An ambulance was called and emergency resuscitation (CPR) started. This continued for fifteen minutes until the ambulance arrived and paramedics took over. The paramedics treated the man for almost half an hour before taking him to a local hospital. He died soon afterwards.

I understand that the man enjoyed working in the hostel garden. It is therefore fitting that, since his death, a number of plants have been planted there in his memory. The money to buy the trees was collected by the residents of the hostel, who were shocked by his death. In the days before he died, the man had visited the local shops and attended a probation appointment, and it would seem that his collapse came without warning. Certainly my investigator has found no evidence to suggest that his death could have been predicted or, indeed, prevented.

I make one recommendation relating to first aid training. I also comment on the good practice demonstrated by the hostel staff.

**Stephen Shaw CBE**  
**Prisons and Probation Ombudsman**

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## **SUMMARY**

The man who is the subject of this report was released from prison on 5 May 2006 having served more than nine years of a 14 year sentence. One condition of his release was that he reside at an Approved Premises. Upon his arrival he disclosed he had been diagnosed with a heart murmur and was currently applying cream to treat athlete's foot.

Soon after his arrival, the man was allocated to a keyworker who met him on a regular basis throughout his time at the hostel. During a meeting three days later, the man said he was trying to come to terms with being released. However, he soon settled in and joined the hostel's gardening party, a group of volunteers who tend the property's flowers and shrubs. He would continue to be active until his death, regularly going for walks in the local area. In April 2007, he made two job applications. The man had no contact with his family throughout his time at the approved premises.

On 12 May 2007, the man collapsed in the first floor corridor of the hostel. He was found by a fellow resident, who asked him whether he was alright. The man did not respond, so the resident ran downstairs to alert staff. A male residential officer (RO) responded immediately and found that the man was unconscious but breathing. He put him in the recovery position, before going downstairs to instruct his female colleague to call for an ambulance. He then returned upstairs. The man stopped breathing just seconds afterwards.

The RO immediately realised that cardio pulmonary resuscitation (CPR) needed to be started. He moved the man onto his back and started giving emergency breaths and administering chest compressions. As his colleague is not trained in first aid or CPR, the RO continued unaided for 15 minutes before the ambulance crew arrived and took over.

The paramedics worked on the man at the hostel for more than 25 minutes before taking him to hospital on a blue light. Sadly, the medical staff were unable to revive him and he was pronounced dead shortly after his arrival. Hospital staff telephoned the hostel to say that the man had died and hostel staff passed on the news to the other residents.

The residents of the hostel subsequently held a collection and the money raised was used to buy a number of plants for the garden. The man's family were traced by the Coroner and subsequently attended his funeral.

## **THE INVESTIGATION PROCESS**

1. My investigator considered the man's probation records before formally opening the investigation on 7 August 2007.
2. Prior to my investigator arriving at the approved premises, notices were issued to staff and residents announcing the investigation and inviting anyone who had information relevant to the man's death to make themselves known to the investigator. Three members of hostel staff and one resident were formally interviewed. My investigator also spoke to the hostel manager.
3. 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. Upon completion, this report will be sent to the Coroner to assist him in his enquiries.

## THE APPROVED PREMISES

4. Approved Premises (formerly known as probation and bail hostels) are approved by the Secretary of State to accommodate sentenced offenders 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. They operate on each day of the year with 24-hour staff cover.
5. The Approved Premises in this case is a 22-bed hostel for men, located on the outskirts of Bradford. It is one of four Approved Premises operated by the West Yorkshire Probation Area. It is managed by a Senior Probation Officer who has overall responsibility for the running of the hostel. There is also a deputy manager who is responsible for the day-to-day management of residents and for making decisions about enforcement. The 'frontline' team is made up of four residential officers and three assistant residential officers. The services of relief staff are also drawn upon to cover staff sickness, training and annual leave. Staff are trained in risk management and emergency first aid, but are not trained to do nursing tasks.
6. The hostel has an admissions policy based on assessment of risk. In recent years, the resident profile has changed significantly with prolific lower risk offenders being superseded by individuals convicted of more serious violent or dangerous offences. The hostel now takes fewer people coming straight from court, and the majority of residents are required to stay at the Approved Premises as conditions of a court order or a licence on release from prison.
7. Each resident is allocated a keyworker soon after his arrival, and this member of staff acts as their primary point of contact for sorting out practical issues. Regular keywork sessions 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.
8. The hostel has close links with local health services, and all residents are registered with a general practitioner (GP) located about half a mile from the premises. West Yorkshire Probation Area pays the surgery to deliver an enhanced service, which ensures that residents get same day appointments when required.
9. Residents are required to pay rent and abide by the rules and regulations of the hostel, including observing a strict overnight curfew between 11.00pm and 6.00am. When residents are subject to statutory supervision, pertinent information is shared regularly with field probation officers who act as case managers.
10. The hostel has a Closed Circuit Television (CCTV) system to maintain the security of the premises and help ensure the safety of residents and staff. The CCTV system has 12 cameras displaying events on three screens simultaneously. The screens and recording equipment are located in the hostel

office. Each screen can be adjusted to display one large image, four medium-sized images or nine small images. The system is manually operated by staff, meaning certain areas of the hostel can be seen in more detail. Communal areas such as the lounge are generally displayed on the large image screen, whilst the rest of the hostel is displayed on the less detailed screens. Staff are expected to look at the screens regularly, but no one is required to watch them continuously. In practice, the system is used more often at night, when only two members of staff are on duty, one of whom is asleep and only there in case of emergencies. The system is also used when staff carry out searches of residents' rooms.

11. All bar one of the permanent members of hostel staff are trained in first aid. Some relief staff are also trained in first aid, but others are not.

#### *Release on Licence*

12. All prisoners sentenced to more than 12 months' imprisonment are released on licence, which means they are supervised by the Probation Service until the licence expiry date. In general terms, the expiry date falls threequarters of the way through a released prisoner's sentence. There are standard conditions for all licences, which include:

- keeping in touch with the probation officer in accordance with any instructions that may be given
- residing at an address approved by the supervising officer
- only undertaking approved work
- not travelling outside the United Kingdom
- being well behaved, not committing any offence and not doing anything that could undermine the purposes of supervision, which are to protect the public, prevent re-offending and help successful resettlement into the community.

Further conditions can be added by the Secretary of State if they are deemed necessary to manage a person's risk.

## KEY FINDINGS

13. The man who died was released from HMP Doncaster on the morning of 5 May 2006. A condition of his licence was that he reside at an Approved Premises in West Yorkshire. He arrived there shortly after 1.00pm. At 6.30pm, he received a formal induction to the hostel, during the course of which a 'Doctor's Information' form was completed. The man disclosed that he had previously been diagnosed with a heart murmur and had had rheumatic fever. He also said that he regularly applied a medicated cream to treat athlete's foot. No other health conditions were noted. The man also said that his next of kin was his mother, but he did not know her address or telephone number.
14. On 8 May, the man had his first keywork session. The man told his keyworker that he was still coming to terms with being released from prison and revealed that he suffered from panic attacks when in crowded public spaces. Nothing else of significance was recorded in the man's notes, and subsequent entries made by the keyworker show that the man soon settled in to life at the hostel. In early June, he started a gardening course and he would continue to enjoy this activity right up until his death.
15. On 29 November, the man told the hostel manager that he was not feeling well. He said he was suffering with toothache. My investigator has been unable to establish whether anything was done about this, although no further mention of it is made in the man's records.
16. In mid-April 2007, the man who is the subject of this report completed and sent off two job applications with the help of hostel staff. One was for a position in a bakery, the other for a factory operative post in a kitchen supply business.
17. Three weeks later, on 9 May, the man attended a probation groupwork session. He made a couple of noteworthy contributions to the session and it was recorded by one of the group facilitators that he was feeling 'quite happy'. No reference was made to any health difficulties.
18. On 11 May, the man attended an appointment with his probation officer. They discussed his plans for moving on into more independent accommodation, given that he had been at the approved premises for more than a year and had established himself in the community. Again, no reference was made to the man experiencing any health problems.
19. The following day (12 May) was a Saturday. At weekends, the hostel operates a reduced regime and only two members of staff are on duty. At 9.30am a female relief assistant residential officer (ARO) at the hostel started her shift. She received a handover from the 'waking night' staff, whose shift was due to finish. The departing member of staff did not pass on any information of note about the man who later died, and the relief ARO told my investigator that the hostel was "quiet" that morning. At 11.00am, the relief ARO was joined by a male relief residential officer (RO), and he too received a handover.

20. Shortly after 11.00am, the man came to the office and asked to speak to the RO. The man told the RO that he was annoyed because another resident had said that he [the man] had not done his chores the previous evening. The man told the RO that he was unhappy about this because he was trying his best. As the man was getting agitated, the RO suggested that they continue discussing the matter in the back garden, which they did.
21. The RO told my investigator that, during the course of this brief interaction, the man's appearance was normal. He was not struggling for breath and gave no indication that he felt unwell. After the man had been reassured about the efforts he was making around the hostel, the RO carried on with his normal duties while the man remained in the garden.
22. Around 12.00pm, a resident at the hostel was eating lunch in the hostel dining room when the chef asked "where's [the man who later died], has anyone seen him?" The resident told my investigator that it was unusual for the man to miss his lunch. The chef therefore put a meal aside for him, despite the fact that he had not made a request in advance.
23. After finishing his lunch, the resident made his way upstairs to his room on the first floor. As he got to the landing he found the man collapsed in the hallway opposite the toilet. He approached him and repeatedly asked him if he was alright. He received no response. The resident ran down to the staff office and said to the RO, "come quick." He told the RO that he had found the man on the first floor corridor. The RO immediately made his way upstairs followed by the resident.
24. The RO got to the man and carried out a brief examination. He found that the man was breathing, but unconscious. He put him in the recovery position before running downstairs to tell the ARO to ring for an ambulance. He then returned upstairs. Almost immediately, the man stopped breathing and his face went a bluish colour.
25. The RO immediately recognised that emergency resuscitation was needed. He turned the man onto his back and started administering cardio pulmonary resuscitation (CPR), giving two breaths for every 30 chest compressions. (This is the correct ratio.) He also told the resident, who was still on the landing, to pass on information to the ARO who was speaking to the emergency services.
26. After a while, the RO started to tire. He asked the resident whether he could assist, but the resident said that he was reluctant to do so because he had not had any training. The RO therefore continued to carry out CPR alone.
27. After calling the emergency services, the ARO contacted the West Yorkshire Approved Premises duty manager to tell them what was going on. By chance, the duty manager that weekend was the deputy manager at the hostel. The ARO told the deputy manager what had happened and said that everything was under control. She told him he did not need to come to the hostel, but he chose to do so anyway. The ARO then went upstairs to see if she could help the RO, but as she is not trained in first aid or CPR there was little she could do.

28. About ten minutes after calling 999, the ARO became concerned that an ambulance had still not arrived. She therefore returned to the office to contact the emergency services again. Whilst on the phone she heard an emergency services' siren and terminated the call. However, the vehicle went straight past the hostel.
29. In the meantime, the RO continued to administer CPR. In total, he worked on the man for about 15 minutes. He told my investigator that the man showed no signs of improvement at any point.
30. A couple of minutes after the first emergency services vehicle had gone past the hostel, an ambulance arrived at the approved premises. The paramedics made their way to the first floor corridor and identified that the RO was extremely fatigued. They assumed responsibility for giving CPR and continued to do so for more than 25 minutes. During this time, the RO, the ARO and the resident helped the paramedics by retrieving essential equipment from the ambulance.
31. Around 1.00pm, the ambulance crew took the man downstairs in a chair and put him in the ambulance. The ambulance left the premises on a blue light and made its way to hospital.
32. Minutes after the ambulance left the hostel, the deputy manager arrived. He spoke to the staff and observed that the RO looked extremely tired as a result of his attempts to resuscitate the man. The deputy manager asked the RO whether he wanted to go home or go for a walk to clear his head, but he declined.
33. A short while later, the ARO took a call from the hospital. She was told that the man had died. She passed on the news to her colleagues and the deputy manager told the resident in private. The deputy manager and his colleagues then told the other residents, all of whom were offered support. As the man had not provided the hostel or his supervising officer with contact details of his next of kin, staff were unable to pass on the news of his death to any family or loved ones.
34. As per the local protocol for dealing with the death of a hostel resident, staff called the police. They attended and carried out a search of the man's bedroom, finding a suspicious looking bottle of cloudy liquid. The officers told the deputy manager that they suspected the liquid was 'hooch', a rudimentary alcoholic drink made by mixing yeast, sugar and fruit. The deputy manager told my investigator that the man was not really a drinker and he thought he was holding the hooch for another resident. For the record, the Coroner has told my investigator in correspondence that the man's death was 'perfectly natural'.
35. In the days after the man's death, residents undertook a collection and raised enough money to buy a number of trees and shrubs for the hostel garden. These have been planted in the man's memory.

36. The Coroner subsequently traced the man's next of kin and they attended his funeral. A number of staff and a resident at the hostel told my investigator they were disappointed they were not made aware of the funeral, as they would have liked to have paid their respects.

## ISSUES

### *The man's collapse and the response to it*

37. After the resident found the man collapsed on the first floor corridor he immediately alerted staff, who responded as quickly as possible. The RO assessed the man's condition and realised that it was serious. He instructed his colleague to contact the emergency services and then started CPR when the man stopped breathing. He continued CPR for about 15 minutes, delivering two breaths for every 30 chest compressions as per current guidelines. The ambulance then arrived and the paramedics assumed responsibility for the man, spending some 25 minutes delivering life saving treatment at the hostel before leaving for the local hospital.
38. Whilst the attempts to revive the man were sadly unsuccessful, I was pleased to find out that the response to his collapse was both prompt and professional. The RO quickly realised that the man's condition was grave and took appropriate action, delivering CPR unaided for a considerable amount of time. I do not underestimate the physical and emotional demands that this presented, and offer my personal commendation of his actions. Whilst the ARO and resident played a lesser role in treating the man, their actions in summoning the emergency services and assisting the paramedics also warrant recognition.

### **The RO, ARO and resident should be formally commended by the Chief Officer for the role they played in trying to revive the man.**

39. After the hostel had been informed of the man's death on the afternoon of 12 May, staff followed the local protocol for dealing with the death of a resident. The police were contacted and they carried out a search of the man's room. The deputy manager also watched a recording of the hostel Closed Circuit Television (CCTV) footage in order to find out what had happened earlier in the day. He told my investigator that the footage covering the first floor corridor shows there was a seven minute lapse between the man collapsing and being found by the resident. The deputy manager said he was concerned by the delay.
40. However, closer inspection of the CCTV footage reveals that, after the man collapsed, he was barely noticeable at the bottom of the screen. The deputy manager expressed the view that staff would only have noticed something was wrong if they had been specifically watching the appropriate screen at the moment the man collapsed. He told my investigator that staff rarely have the time to watch the CCTV screens this closely.
41. Given that the CCTV system has three screens displaying up to nine camera angles simultaneously, and that staff are unlikely to be watching any of the screens at a given moment in time, it is not surprising that neither the RO nor the ARO noticed anything was wrong. It would be unreasonable to level any criticism at them whatsoever for failing to see that on the CCTV that the man had collapsed. When the man's situation was brought to their attention, they acted swiftly, competently and compassionately.

### ***First aid training***

42. I was pleased to find out that all bar one of the permanent members of staff at the hostel are trained in first aid. As the untrained staff member is a manager who usually works during the daytime, this means he is almost always on duty with a frontline colleague who is trained.
43. However, it would appear that the training amongst the pool of relief staff is a bit more patchy. By chance, the RO had attended a first aid refresher course the day before the man collapsed, but my understanding is that this was arranged through his permanent employer and not West Yorkshire Probation Area. Given that relief staff are sometimes paired up to cover shifts outside of office hours, for example at weekends, there are times when no one trained in first aid is supervising residents.
44. Whilst acknowledging the practical difficulties involved in such an arrangement, best practice suggests that a trained first aider should be on site at all times. This can be achieved by either modifying the staff rota or, preferably, ensuring that relief staff are trained in first aid.

**West Yorkshire Probation Area should consider training all Approved Premises staff, including relief workers, in first aid and emergency resuscitation.**

In its response to the draft version of this report, West Yorkshire Probation Area accepted this recommendation and has arranged for all relief staff to be trained in first aid.

## **RECOMMENDATIONS AND GOOD PRACTICE**

West Yorkshire Probation Area should consider training all Approved Premises staff, including relief workers, in first aid and emergency resuscitation.

The RO, ARO and resident should be formally commended by the Chief Officer for the role they played in trying to revive the man.