

**Investigation into the death of a man, whilst a resident of
Ozanam House Approved Premises in Northumbria
Probation Area, in August 2009**

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

May 2010

This is a report of an investigation into the death of a man, who died at Ozanam House Approved Premises in August 2009. He had been at the hostel for less than three weeks.

I would like to extend my condolences to his family and to all those affected by his death. I would also like to apologise for the delay in issuing this report, and for any additional distress this may have caused.

One of my investigators was appointed to carry out my inquiries into the circumstances of his death. In addition, a clinical review was commissioned by Durham Primary Care Trust, who appointed the clinical reviewer to carry out the review. I am grateful for his timely contribution to the investigation. I am also grateful to the manager of Ozanam House and his staff for their co-operation and assistance and to staff at HMP Acklington who provided the records from the man's sentence.

The man was released on licence from Acklington to reside at Ozanam House for the rest of his sentence. Whilst at Acklington, he presented with a number of health problems, which continued when he arrived at the hostel. The night before he died, the man mentioned to staff that he would telephone for a doctor's appointment the next morning, as he had been feeling tired and unwell. The next morning, during a routine morning room check, staff discovered that the man appeared to have died. His death was confirmed by paramedics shortly afterwards.

I make two recommendations, one to Acklington concerning continuity of medical care, and the second to Ozanam House regarding checking residents.

The version of my report, published on my website, has been amended to remove the names of the woman/man who died and those of staff and prisoners involved in my investigation.

Jane Webb
Acting Prisons and Probation Ombudsman

April 2010

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SUMMARY

On 31 January 2008 the man was sentenced to three years imprisonment at Durham Crown Court. He initially went to HMP Holme House and then transferred to HMP Acklington.

Whilst in prison, he had a number of health problems and was seen frequently by medical staff in healthcare. He complained that he was unable to sleep at night but fell asleep during the day, had previously had depression and anxiety, had eczema and asthma and was suffering from hypertension (high blood pressure). It was also noted that he had learning disabilities.

On 31 July 2009, the man was released on licence from Acklington, to reside at Ozanam House Approved Premises. He arrived at Ozanam House later the same day. He underwent the usual, and very thorough, induction procedure for all new residents and registered with a local doctor. Throughout his time there he was prescribed trazodone (an antidepressant), a salbutamol inhaler for his asthma, paracetamol and E45 cream.

During his short stay at Ozanam House, staff noticed that he often fell asleep in the dining room and television room and complained that he was unable to sleep during the night. He also looked generally unwell and often appeared breathless. His weight caused concern and he agreed to take part in a healthy lifestyle programme to look at ways to eat more healthily and lose weight.

The night before he died, the man told staff that he wanted to book a doctor's appointment the next morning as he felt very tired and generally unwell. Staff agreed that he should ring the surgery the next morning. He spent some time playing dominos with a night care worker, before taking his medication as usual that night and retiring to his room.

At about 11.20pm, the project support worker at the hostel carried out the last room check of the night. She saw that the man was lying under the bed covers watching television when she entered his room. She said goodnight to him and, although she does not remember if he responded, she was confident that he was alright.

The next morning, the night worker carried out a room check at approximately 8.00am. When she knocked on the man's door, she received no response. She went into the room and found the man lying on his bed, on top on the covers. It was clear to her that he had died.

I make two recommendations. One concerns the continuity of medical care at Acklington and the other is about checking residents at Ozanam House.

THE INVESTIGATION PROCESS

1. One of my investigators was appointed to conduct this investigation after the office was notified of the man's death. She received all necessary paperwork shortly after the man died and visited Ozanam House on 10 November 2009 to conduct recorded interviews with staff.
2. Notices were issued to both residents and staff inviting anyone who had information regarding the man's death to make themselves known to my investigator. No further witnesses came forward.
3. One of my family liaison officers contacted the man's father to explain the role of the Prisons and Probation Ombudsman and offer the opportunity to participate in the investigation. The man's father said that, although he did not want to participate, he would like to receive the report in due course. He added that his son was happy at Ozanam House and was treated well there.
4. Durham Primary Care Trust (PCT) were commissioned to conduct a clinical review into the standard of care the man received. The clinical reviewer led the review.

OZANAM HOUSE

5. Ozanam House is an Approved Premises (Approved Premises were formerly known as a Bail Hostels). It provides an enhanced level of residential supervision in the community and aims to provide a supportive and structured living environment for offenders. Most residents are required to stay at Ozanam House as a condition of a court order or prison licence.
6. Ozanam House is located near the city centre of Newcastle-Upon-Tyne. It is managed by a senior probation officer, who is assisted by a deputy manager, key workers, support workers and night care workers.
7. Each resident is allocated a key worker who is their primary point of contact during their stay. They also assist residents to deal with practical issues such as housing. All residents are registered with a local doctor. A residents relationship with the doctor is completely independent from the hostel, and all consultations are confidential.
8. Whilst at Ozanam House, residents are required to pay rent and adhere to various rules and regulations. They include observing an overnight curfew between the hours of 11.00pm and 7.00am. During the day, residents are free to go out unaccompanied, without telling staff where they are going, although closed circuit television monitors their movements in and out of the building. Breakfast and dinner is provided for all residents. There are 25 rooms, one of which is a double room for two residents. Room checks are conducted each morning and evening, to check that residents are present and well.
9. Ozanam House has an established routine for inducting all new residents. The induction is carried out by a member of staff, during which they discuss the rules and expected behaviour for residents. Ozanam House has a strict policy on alcohol and drug use and the possession, or use of, these are strictly prohibited in the hostel or its grounds.
10. All residents are also informed about the rules regarding the use of prescription medication. All medication is kept in the staff office, and dispensed to residents at the designated time, with no medication kept in-possession. Regular reviews are carried out by staff to determine whether residents need a repeat prescription. Prescriptions are sent from the doctor's surgery to the local chemist, who delivers the medication directly to the hostel. Rooms are searched regularly and, although staff are not permitted to search individuals, they are able to search their property.
11. Since this investigation, a new Probation Instruction (PI 9/2009) regarding medication in approved premises has been issued. It sets out new arrangements for handling residents' medication and should enable most residents to be permitted to keep their own prescribed and 'over the counter' medication themselves. Staff are now expected to risk assess all residents and their medication before allowing them to keep it in their own possession.

Since this office began investigating deaths in Approved Premises there have two other deaths at Ozanam House.

HMP ACKLINGTON

12. HMP Acklington is a category C establishment in Northumberland. It was built on the site of a former RAF base and accommodates convicted male adults. About half the population are vulnerable and/or sex offender prisoners. The prison can hold a maximum of 871 prisoners. It provides employment in farms and gardens, education and a variety of workshops.
13. Acklington does not have 24 hour medical cover. Outside of the normal operating hours the prison relies on the services of an on call doctor, or, if necessary, the emergency services.

HMP HOLME HOUSE

14. Holme House is a category B prison for unconvicted, convicted and sentenced male adults. It opened in May 1992. The prison primarily serves communities of the Tees Valley, South West Durham, East Durham and North Yorkshire. It has a total of six residential units, known as houseblocks one to six. It has an operational capacity of 994.
15. North Tees Primary Care Trust are the providers of healthcare services at Holme House. There is an in patient unit with 28 beds and 24 hour nursing care. An out of hours doctor's service is covered by the prison doctor with help from an emergency out of hours doctor service.

KEY FINDINGS

16. On 31 January 2008, the man was sentenced to three years custody at Durham Crown Court. He was initially taken to Holme House prison, but transferred to Acklington prison on 11 June.
17. He had a medical examination when he arrived at Holme House. During this consultation it was established that he had been receiving zopiclone (an anti-depressant, used in this case to treat insomnia), co-codamol (a pain killer), and ventolin and beclometasone (to treat asthma). He also had been prescribed cream for eczema. His height, weight and blood pressure were measured and a referral made to a doctor because of concerns about his physical health. It was established that, although he had seen a psychiatrist in the past for depression and anxiety, he had no suicidal thoughts at that time.
18. Throughout his time at Holme House, the man was frequently prescribed paracetamol and E45 cream (for eczema), as well as occasional herbal sleeping tablets. He complained of being unable to sleep, of having inflamed lower limbs and headaches. On 20 March, medical staff noted in his records that the man was using too much paracetamol and they began to monitor his use. He said that he needed the painkillers for headaches and tension in his neck muscles. He also received a ventolin inhaler and a Clenil modulite inhaler (both are treatments for asthma).
19. On 30 May, the man told the doctor that he felt his current anti-depressant medication (trazodone) was not working. It was decided to reduce the dosage of trazodone and also prescribe paroxetine (another anti-depressant) to see whether this suited him better.
20. The man transferred to Acklington on 11 June 2008, and was located on the vulnerable prisoners unit. During a reception health assessment a number of tests were carried out, including a blood pressure reading, weight and height measurements, blood tests and peak flow (to measure the extent of his asthma). The assessor assessed that the man was not fit to attend the gym, but was fit for work. She also noted that the man had asthma, depression and anxiety attacks and was on medication for these.
21. Medical records show that the man was seen regularly by healthcare staff at Acklington for a number of reasons. He had dry, itchy skin on his legs, and had trouble sleeping, but said that trazodone made him sleepy. He was referred to a doctor, and the first doctor who saw him on 24 June. The doctor prescribed E45 cream, betamethasone cream, paracetamol tablets, E45 shower cream and amoxicillin (an antibiotic) capsules. The records do not explain why all of this medication was necessary.
22. Two days later, the man had a mental health assessment with a Registered Mental Nurse (RMN). It was noted that he presented himself well, maintained good eye contact and seemed relaxed. The only issue the man spoke about

was early waking in the morning. He said that he had a good appetite. The RMN suggested that more activity during the day would help him sleep, as he was not expending enough energy throughout the day. The nurse noted that there were some residual issues about the death of his mother, so she referred him to MIND, an external organisation which deals with mental health issues. She decided that no further input from the prison's mental health team would be required.

23. On 2 July, the man was seen by a nurse as he was still not sleeping and he felt he was becoming more depressed. He was seen by a second doctor a week later. The doctor noted that the man asked to hold his anti-depressants in his own possession as, at that time, he was given his daily dose at 4.00pm, felt drowsy an hour later, and then could not sleep at night. Instead he would keep his own medication and take it when it suited him rather than waiting for a member of healthcare to issue it. The doctor agreed to the request.
24. The man was seen again by the second doctor on 13 August after being referred by nursing staff. He admitted to taking double doses of the anti-depressants some nights to help him sleep. The doctor agreed to increase the dosage of the tablets, but no longer allowed the man to hold them in his possession.
25. There were no further entries in the medical record until 22 September, when he was seen by a Registered General Nurse (RGN). The man was referred by gym staff, although it is unclear why he was in the gym, as he had been assessed as being unfit to attend in June and there was no record of this being reviewed. However, gym staff were concerned about a high blood pressure reading when they carried out a blood pressure check. The RGN wrote that she would review this and carry out some blood tests for cholesterol (the tests were carried out on 29 September). The man told her of a family history of heart disease and hypertension.
26. The man saw the second prison doctor again on 1 October. His blood pressure was a little high and he was grossly overweight. It was decided that nursing staff would take some blood pressure readings over the next few weeks for a doctor to review, but that he would probably need some treatment. The man was also referred for remedial gym sessions. His blood pressure was taken five times before his next appointment with the doctor.
27. On 21 October, it was noted that the man had been falling asleep during education classes. He blamed this on his medication.
28. The man saw the second doctor again on 29 October. The doctor again noted his raised blood pressure, his weight and diagnosed essential hypertension (a type of high blood pressure which has no definable cause). He prescribed lisinopril tablets (to treat high blood pressure) and said that he would see the man again in a month. After a risk assessment, it was agreed he could keep these tablets in his possession.

29. On 9 December, the man attempted to collect the trazodone from healthcare. However, a new prescription was not due for another week so the nurse spoke to the third doctor. The doctor noted that the man could not now keep the trazodone in his possession. (It is not clear from the medical records when the decision made on 13 August not to allow him to keep his medication in his possession was reversed.)
30. Three days later, the second doctor noted that the man had been taking additional trazodone as he had been feeling down. The second doctor increased the dosage of trazodone to 200mg, but the man was still not permitted to keep the medication himself.
31. The man also saw a counsellor for MIND, later that day. The counsellor for MIND noted that he seemed low in mood, was not sleeping well and began a counselling session to talk about the loss of his mother.
32. The counsellor for MIND held a second counselling session with the man on 5 January 2009. Again, they discussed the loss of his mother and that he still felt a little low. (He saw the counsellor again on 30 January, 27 February, 19 March, 23 April but failed to attend an appointment on 4 June.)
33. The man attended the Sexual Offenders Treatment Programme (SOTP). A note made in his prison record, on 5 February, said that although the man was attending the course and participated fully, he struggled to stay awake as he said he was not sleeping well at night.
34. On 16 March, whilst collecting his medication at the treatment hatch, the man tried to take two additional tablets of trazodone. He was seen and challenged and the tablets were found in his hand. He told staff they must have 'slipped in there'. The man was reprimanded and it was noted that he needed close supervision at the treatment hatch in future.
35. The man saw the first doctor again on 5 June. Although a medication review was noted, there was no mention of the lisinopril tablets prescribed by the third doctor on 29 October. The second doctor prescribed co-amoxiclav tablets (an antibiotic) for a spreading rash on his abdomen, and an umbilical infection. The first doctor noted that the man was very overweight and they would discuss this once his other symptoms had settled down.
36. Between 9 June and 3 July, a number of blood tests, including fasting tests were carried out. On 3 July, the second doctor saw the man again. As he was due to transfer to Ozanam House in less than a month, the first doctor talked to him about the symptoms of diabetes and advised him to see his own doctor regarding his blood pressure, and for dietary advice, once he had arrived at Ozanam House.
37. The RGN saw the man on 8 July. She reviewed his asthma and noted that he had no attacks in the last year. His Body Mass Index was calculated at 49.2. (The BMI index is a measure of healthy body weight which compares height

and weight, the normal range being between 18.5 and 25.)..He was given advice about health education.

38. The last entry made in the medical records was on 30 July, the day before the man moved to Ozanam House. It was noted that he was medically fit for discharge and that he felt well.
39. The next day, he was released on licence to reside at Ozanam House. His sentence was due to expire on 30 January 2011.
40. The man arrived at Ozanam House at approximately 1.00pm. A risk assessment carried out on arrival noted that there were no concerns about him harming himself, although he was taking medication for depression. It was decided that staff should observe the man and note whether there were any signs of his mental health deteriorating. A referral form detailed the man's probation officer, his offence and the restrictions imposed on his and noted that he had learning disabilities.
41. The man was given a thorough induction where the rules and expectations of the hostel were explained to him, the terms of his licence were also explained and he was shown around the hostel. He was shown to room 12, which was a single room.
42. The man brought with him some paracetamol and trazodone tablets, prescribed by the prison doctor. He signed a drug treatment contract, which explained that all his medication was kept in a locked cabinet, would be signed for and taken in front of staff. A medication chart was opened for paracetamol, although it is not clear what this medication was for, and at 8.05pm the man took two tablets. (He took at least two tablets, often more, every day until he died.) He was also prescribed two 100mg of trazodone every day. (He also took these every day until he died.) That evening it was noted in the man's induction log that he had appeared to settle in well and played bingo with other residents.
43. The next day, the man left the hostel for a couple of hours during the day, and still seemed to be settling in well. An entry on 3 August noted that he did not seem to mix much with other residents. The same day, it was noted that he had an appointment to register with the local doctor at 3.10pm. He attended another doctor's appointment at 8.30am on 5 August.
44. Two days later, he had his first meeting with his key worker. The man's key worker was responsible for monitoring and supporting the man and liaising with police, probation and social services on his behalf. They spoke about his history of depression. He told her that he felt both physically and mentally well. He had felt depressed in prison, but was now looking forward to life again and having more contact with his family.
45. On 6 August, the man was prescribed a salbutamol inhaler for his asthma. (There is only one entry on the medication chart, indicating that the man used it once on 10 August.) On 6 August, he was also given E45 cream, which he

also only used once. Records showed that he had a doctor's appointment at 4.40pm on 10 August.

46. A note was made in the induction log on 11 August to say that the man fell asleep in the dining room. The medication chart showed that he had begun taking zopiclone on 11 August, prescribed by his new doctor. He took one every night (and six in total before he died).
47. Two days later, the man's key worker spoke to him about his clothes. He was wearing trousers that had a hole in the crotch, exposing his genital area. The man said he had money and agreed to purchase new trousers the next day. He also told his key worker that he had attended the Labour Club the night before and had four pints of beer.
48. At a meeting with his key worker the next day, the man said he slept better the night before, after being prescribed sleeping tablets. She helped the man complete an application for a grant to buy some new clothes, as he said he had gained weight in prison and had nothing to fit him. He told her that he had taken a walk around the city centre earlier that day, had no problems at Ozanam House. He had a season ticket for Newcastle United football club and intended to watch them play soon. He also said that he had been taking part in hostel activities such as bingo, quizzes and board games.
49. Later that day it was again noted that the man had fallen asleep in the dining room. The following evening he removed his tee shirt in the television room. A member of staff told him to put it back on, which he did after wiping sweat from his body. He fell asleep in the dining room again the next evening, at regular intervals. He told a member of staff that he felt ill. The project support worker at the hostel, whose responsibility included managing the residents) asked him to come to the staff office the next morning to make an appointment to see the doctor. The man said he would take part in the hostel's 'Healthy Ways' programme, to look at ways to improve his general health through a healthier lifestyle.
50. The final entries in the induction log were made by the project support worker at the hostel who wrote that on the evening of 16 August, whilst collecting his medication, the man asked if he could use the office telephone the next day to make a doctor's appointment. She asked if he was okay, and he replied that he was, but had been feeling tired. As he was panting, the project support worker asked whether his breathing was alright. The man said that it was and repeated that he just felt tired a lot of the time. They agreed that it would be best if the man saw a doctor the next day.
51. A second project support worker, added some additional information after the first project support worker's entry making her note after the man died. She said that on the evening of 16 August she overheard the man requesting a doctor's appointment and being told to come to the staff office first thing the next morning. She noted that on the Sunday evening the man participated in a quiz and spoke to her about the 'Healthy Ways' weekly meetings. The aim was for residents to support each other to try to eat more healthily and take

more exercise, with a view to losing weight. The man said he would give it a try. The second project support worker also said that, when he saw the doctor the next day, he should request a diet sheet to help him. She noted that the man did seem tired and a bit breathless at times. The second project worker saw the man later that evening when she gave him his medication in the office. She told him that the first 'Healthy Ways' programme would be at 6.15pm the next day, and he said he would be there. She reminded him that a doctor's appointment would be made the next morning. The man spent the rest of the evening around the hostel and playing dominoes with the night worker.

52. The first project support worker carried out a final room check at approximately 11.20pm. This is a check carried out every night, to ensure that all residents are okay. She recalled that the man was lying in bed, with the covers over him, watching television. She said during her interview that she called out goodnight to him, and, although she could not remember if he replied, knew that he was okay.
53. The next morning, the night worker began a morning room check at approximately 7.45am. When she arrived at the man's door, she knocked but did not get a response. She knocked again and then went into the room. The evening worker saw him lying at the end of the bed, with his head against the wall and one leg hanging over the edge. She said that he appeared to be clutching something and that she knew immediately (as she had previously been a nurse) that the man had died. The night worker called to another member of staff, (who was on duty and carrying out room checks as well), to stand by the door of the man's room and ran downstairs to alert a second member of staff (the night worker said she did not use her pager or personal alarm as she knew the second member of staff was in the office downstairs.)
54. When the evening worker and the second member of staff reached the man's room, the first member of staff was standing by the door. The second member of staff also said that the man looked as though he had died, his face appeared very blue in colour and his lips were almost purple. The second member of staff said that the man's limbs had stiffened and he was very cold to the touch as he felt for a pulse (both the evening member of staff and the second member of staff are qualified first-aiders).
55. The second member of staff recalled that the paramedics and police were called immediately, complying with the hostel procedures, but he could not remember who called them, or if indeed he did so himself. At approximately 8.00am, the hostel manager, arrived and was told there had been an 'incident'. He was directed to the man's room and found the second member of staff there. The second member of staff also checked the man for vital signs, but that he had died. The hostel manager also checked for a pulse, but found did not find one.
56. The second member of staff began to manage the other residents to prevent them from gathering around the man's room. The paramedics and police arrived very quickly. He accompanied them to the man's room and, after

carrying out checks, they agreed that he had died. The police checked the man's room, watched while the hostel manager sealed the man's possessions and stayed until the undertaker arrived to take the man to the mortuary. They then left to inform his family about what had happened.

57. The hostel manager held two residents' meetings to inform them what had happened to the man and check that they were okay. He told residents that anyone affected by his death could speak to a member of staff or, if they needed additional support, they could speak in confidence to a counsellor. The hostel manager also spoke to all the staff who were either on duty or knew the man, to check they were alright and offer time off if they needed it. Staff were reminded that they could talk to the hostel manager, or any member of staff, and counselling was available. The hostel manager was concerned for the night worker, and, as she decided to return to work the next night, he arranged for another member of staff to come in as additional support for her, although she had not requested this.
58. A post mortem was held later that day at the Royal Victoria Infirmary. The cause of the man's death was noted as congestive cardiac failure, due to ischaemic heart disease and asthma and chronic obstructive pulmonary disease.
59. The hostel manager contacted the man's father and invited him and the man's sister to visit the hostel and take any belongings they wanted from his room. He returned the man's money and valuables to him. Staff and residents contributed to a collection for the man, rather than send flowers to the funeral, and the man's sister decided where to donate the money. The hostel manager attended the man's funeral and wrote to his father afterwards.

ISSUES

Healthcare at HMP Acklington

60. On 29 October, the third doctor prescribed the man a month's lisinopril for high blood pressure and hypertension. Medical records at Acklington do not show whether this was reviewed or whether the man received more of this medication. The clinical reviewer, notes in his review that

“following the diagnosis and treatment of the man's hypertension by the third doctor on 29 October 2008, no review of the condition would seem to have occurred which would normally be nurse led in a community based practice.”

61. The clinical reviewer said it was not clear why the prescription of lisinopril is not recorded as having been continued. He adds that, although not directly relevant to the man's death, there is a link between congestive cardiac failure, ischaemic heart disease and hypertension. The clinical reviewer recommends that the monitoring and continued treatment of prisoners' blood pressure at Acklington should be addressed, perhaps by nurse led monitoring.

62. I agree that if there is a concern about a prisoner's health, whether regarding their blood pressure or any other condition, this should be monitored and followed up where necessary. I understand that the man did not always see the third doctor, but any of the other doctors should have reviewed his medical record to determine his health needs.

The Head of Healthcare should ensure that any concerns about a prisoner's health are noted and reviewed appropriately, that all healthcare staff check medical records before or during a consultation, and any necessary action taken.

Medication in approved premises

63. The hostel manager, spoke to my investigator about the national medication policy for Approved Premises, in particular about residents holding their own medication rather than going to the staff office and taking it in front of staff.

64. I have already explained that, since the man died, a new Probation Instruction (PI 9/2009) regarding medication in approved premises has been issued. It details the requirements for handling residents' medication in approved premises and should enable most residents to be permitted to keep their own prescribed and 'over the counter' medication in their rooms, or on their person. This will mean, however, that staff must risk assess all residents before allowing them to keep medication in possession. I hope this will alleviate some of the workload for approved premises staff and allow them to direct their resources elsewhere.

65. However, in the man's case, I think it unlikely that he would have been assessed as being suitable to hold his medication in possession at Ozanam

House. On the occasions he was permitted to do so in prison, he took more than the prescribed doses (especially of trazodone) and therefore had this facility withdrawn.

Checking residents

66. The night worker was the staff member who discovered the man on the morning he died. She received no response when she knocked on the door of his room, and, when she went inside the room she saw that he had died. The night worker used to be a nurse, which is how she said that she could tell immediately.
67. It would appear from the statements of other staff that the man appeared blue, his lips were purple, he was cold and stiff to the touch and a pulse could not be found, and that he had clearly died. I also understand that the night worker would not have expected to find a resident in this way and was shocked. She took action quickly to ensure the first member of staff stood by the door and found help from the second member of staff. However, I would suggest that, given that all staff at Ozanam House are first aid trained, as soon as she had called for assistance she should have immediately checked the man for any signs of life herself. Although it is very unlikely that she would have found any, this may not always be the case and immediate action is of paramount importance.

Any member of staff who finds a resident collapsed or unconscious should immediately check for signs of life. This would ensure that prompt and correct action follows.

CONCLUSION

68. The man appeared to be a generally unwell man, who had serious weight problems. Throughout his period of custody, he said that he had trouble sleeping, but continued to fall asleep for spells during the day and evening. He suffered from anxiety and depression, asthma and eczema and took a number of medications for these. He also took medication for hypertension for a month whilst at Acklington.
69. He was seen regularly by doctors and nursing staff whilst in prison and, once he arrived at Ozanam House, he registered with the local doctor, who he saw on at least two occasions in the 17 days he lived there. Staff at Ozanam House carried out a full and thorough induction for the man, managed his medication for him and had meetings with him when appropriate. Staff spent time playing board games with him and had persuaded him to join a 'Healthy Ways' programme which was due to begin the day after he died. They kept a close eye on him, especially in regard to his continual sleeping around the hostel.
70. The night before he died, the man complained of feeling tired and seemed unwell. He arranged to telephone for a doctor's appointment the next morning. He took his medication as usual before he retired to his room for the night. He was still alive at 11.20pm, when the last room check of the night was conducted. Another member of staff carrying out the morning room check the next morning found that the man had died.
71. I have found that, generally, the man was well cared for both in prison and at Ozanam House. However, the clinical reviewer has highlighted that procedures at Acklington need to be tightened to ensure that responsibility is taken for ensuring that prisoners' medical needs are fully met. I have also recommended that staff at Ozanam House are reminded of the need to check residents when they are found in a collapsed state, and not just rely on their instincts. This might not have made a difference for the man, but could be important for other residents in the future.

RECOMMENDATIONS

To HMP Acklington

1. The Head of Healthcare should ensure that any concerns about a prisoner's health are noted and reviewed appropriately, that all healthcare staff check medical records before or during a consultation, and any necessary action taken.

To Ozanam House

2. Any member of staff who finds a resident collapsed or unconscious should immediately check for signs of life. This would ensure that prompt and correct action follows.