

**Investigation into the circumstances surrounding the
death of a man at an Approved Premises in the South
Wales Probation Area in September 2008**

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

January 2009

This is the report of an investigation into the circumstances surrounding the death of a resident at an approved premises in the South Wales Probation Area. The man died in his room on 12 September 2008. The cause of his death was recorded as cardiomegaly (enlargement of the heart due to heart failure). I offer my sincere sympathy and condolences to the man's family for their loss, as I do to all of those who have been affected by his passing.

The investigation was carried out on my behalf by my colleague. I would like to thank the deputy manager of the approved premises for his assistance in liaising with my investigator. I would also like to thank all of his colleagues for their full and ready co-operation with the investigation.

The man died suddenly and unexpectedly. My report makes two recommendations – one of which is that all staff at the approved premises are trained in basic first aid in line with national guidelines.

Stephen Shaw CBE
Prisons and Probation Ombudsman

January 2009

CONTENTS

Summary	4
The investigation process	5
The approved premises	7
Key findings	8
Issues	12
Recommendations	18

SUMMARY

The man arrived at the approved premises on 20 June 2008, following his release from prison that day. This was the first time that he had lived in an approved premises. The man's stay at the hostel began three weeks earlier than was initially expected. This was because the Parole Board had instructed that the man be released from prison early, as his recall to custody following an earlier release on licence in March 2008 was technically unlawful.

The man found it difficult to settle at the approved premises, and initially refused to co-operate with key work sessions (one to one meetings with a designated member of staff to discuss any issues in depth). However, he established some rapport with his key worker and began to settle into hostel life, spending a lot of time working in the garden. He still had some bad days though and did not get on with every member of staff. The man also raised concerns about the standard of accommodation that had been arranged for him to live in when he left the approved premises, and refused to accept it. Instead, he found private accommodation himself and was able to put a deposit down on a small house. The man was due to move in on 7 October.

A fellow resident said that he saw the man looking unwell on the night of 11 September (although examination of hostel records indicates that the resident may have meant 10 September). Nevertheless, the man did not report any illness to hostel staff. Indeed, he was seen regularly by staff on 11 September and no concerns were noted.

At around 8.20am on 12 September, a fellow resident went to the man's room to speak to him. He ran straight back down to the main office and reported that the man had fainted. Two members of staff, including the deputy manager, ran up to the man's room. They found him semi-conscious and with laboured breathing, and called an ambulance immediately.

The paramedics arrived at around 8.30am, shortly after the man's condition had deteriorated. They attempted to resuscitate him but were unsuccessful. The man's death was pronounced at 9.00am.

My investigation found that not all staff at the approved premises are trained in basic first aid, which is not in line with instructions provided in Probation Circular 35/2006. I have recommended that the Chief Officer addresses this and considers the benefits of training all staff in cardio-pulmonary resuscitation. I make a further recommendation regarding the support available to staff who are affected by the death of a resident.

THE INVESTIGATION PROCESS

1. The investigation was opened on 15 September 2008, when my investigator issued notices announcing the investigation to staff and residents. The notices included an invitation to those who wished to submit information relating to the man's death to make themselves known. One resident came forward as a result.
2. My investigator visited the approved premises on 18 September. During his visit he was shown around the hostel, including the room where the man lived. He was also given copies of all documentation relating to the man. My investigator returned on 1 October when he interviewed three members of staff and two residents, including the one who had responded to the notices.
3. One of my family liaison officers contacted the man's second wife and his brother to inform them of the investigation. My investigator and my family liaison officer subsequently visited the man's brother on 23 October. At the meeting, the man's brother raised the following issues that he wished the investigation to address:
 - The man had told him that he could not get his medication when he was in prison.
 - The man was concerned that all prescribed medication was held in the office at the approved premises, which meant that residents could not obtain their medication quickly.
 - The man had difficulty finding accommodation to live in when he left the approved premises, and was offered a bedsit that was unsuitable.

THE APPROVED PREMISES

4. The purpose of an approved premises is to provide an advanced level of residential supervision in the community, alongside a supportive and structured environment. Whilst residents have to comply with their individual licence or bail conditions, curfews, and the hostel's house rules, they are essentially free to come and go from the building. All residents at this approved premises are subject to a curfew at night.
5. The approved premises at which the man died is one of 101 approved premises in England and Wales. It accommodates up to 26 residents in a mixture of single and shared rooms. The hostel is staffed 24 hours a day by probation employees, whose role is to provide support and to ensure that the rules and licence or bail conditions are complied with. Following a recent restructuring, the two hostels in the South Wales area share a manager who divides her time between the premises. Each hostel has a deputy manager who is based there permanently.
6. All residents are allocated a key worker. Regular key work sessions take place, giving the resident the opportunity to raise and discuss any issues or difficulties in depth. Some residents will also attend offender management meetings or appointments with external staff in the probation area.
7. Residents are required to register with a doctor at a local surgery during their stay. All prescription medication is collected by hostel staff and logged and stored at the front office. Residents collect their medication from the office during the day and must sign to confirm the type and quantity on each occasion. A pilot scheme was recently run in which residents of selected approved premises held their own prescription medication in possession. This pilot was a success and the scheme is due to be rolled out nationally.
8. Each resident is responsible for their own health. If they require a consultation with a doctor or visit to hospital then, unless it is an emergency, the onus is on the resident to arrange the appointment and transport. There are identified staff who are trained in first aid and cardio-pulmonary resuscitation (CPR).
9. This is the first death to have occurred at the approved premises since April 2004, when I began investigating all deaths in approved premises in England and Wales. There have been no deaths at the other approved premises in the South Wales Probation Area.

KEY FINDINGS

10. The man was initially scheduled for release on 11 July, and plans were made for him to take a place at the approved premises. However, the Parole Board ordered his release on licence on 20 June after discovering that his recall to custody in March 2008 was unlawful. This was because the man's first offence for which he was convicted was committed before 1999 and the recall should therefore have been conducted through the Courts. As a result, the man moved into the approved premises on 20 June. During his time at the hostel the man did a lot of work in the garden, which he apparently enjoyed.
11. The conditions of the man's licence included an initial curfew of 8.00pm to 10.00am and the requirement to sign in four times a day, every two hours from 12 noon to 6.00pm. Other conditions instructed the man not to live in a house where there were children under the age of 18 (a breach of which had resulted in his recall on 15 March) and to engage in offence based programmes.
12. The man arrived at the approved premises on 20 June 2008. He was given an induction to the hostel by his key worker. The man's key worker explained the conditions of his licence to him, including those set out in paragraph 11. The man told his key worker that he would not be engaging in key work sessions as he "doesn't want anyone to know anything about him". The man's key worker informed him that he was expected to engage and that his place at the hostel might be withdrawn if he did not.
13. The following day, the man's key worker completed a hostel supervision plan for the man. She noted that he suffered from high cholesterol, high blood pressure, arthritis and an underactive thyroid. The key worker also noted the medication that the man was taking as levothyroxine (for an underactive thyroid), simvastatin (to lower cholesterol) and metoprolol (for high blood pressure). It was also noted that an area of South Wales had responsibility for accommodating the man in future and that he had completed the necessary housing forms.
14. Two days later, on 23 June, the man was visited at the approved premises by his offender manager. They had a meeting together with an approved premises officer, who was standing in for the man's key worker whilst she was on leave. At the start of the meeting, the man spoke of his anger about his recall to prison. As the meeting progressed, however, he calmed down and agreed to concentrate his thoughts on the future. The group discussed how the man would go about registering with a doctor and sorting out his state benefits.
15. At his next meeting with his offender manager, a week later, the man was much calmer. He was still slightly opposed to doing one to one work with his key worker, but said that he liked his key worker. The man's offender manager therefore hoped that he would be able to engage with her. It

16. Following the man's offender manager's next visit, on 10 July, the man's signing times were relaxed to three times a day, at 1.00pm, 4.00pm and 7.00pm. His curfew remained the same. At his next key work session with the man's key worker, five days later, the man was noted to be settled and relaxed at the hostel. He was also getting on well with the other residents. These sentiments were repeated at the man's next key work session, on 25 July, when it was also noted that he was spending a lot of time working in the hostel garden. The man added that he sometimes forgot to sign in, and was reminded by his key worker to do his best with this.
17. On 5 August, following a meeting of the Multi-Agency Public Protection Arrangements (MAPPA, a panel led by the police, probation and prison services, with co-operation from other agencies such as social services, that meets to assess and manage those deemed to be a high risk to the public), the man's curfew was relaxed by an hour and was now 9.00pm to 10.00am. He was also now only required to sign in once a day, at 4.00pm. Two days later the man visited the local probation office, where he was seen by an offender manager who was covering the man's offender manager's leave. The man was angry about an incident in the previous week when he had not signed in on time, apparently because he was delayed by traffic. He complained about the bureaucracy of having to sign in and said that he was being victimised by a particular member of staff. A note by the man's key worker later that day indicated that the man had become more isolated and introverted following this incident.
18. At a key work review on 10 August, his key worker noted that the man was still isolated and not socialising with other residents. He explained that this was because of the argument he had had about failing to sign in on time.
19. The following week, at a MAPPA meeting on 19 August, it was noted that the man now presented no management problems. It was agreed to issue him with a '28 days notice to quit' the approved premises, as he was close to finding housing in an area of South Wales. The man subsequently visited a property on 22 August. (This was the eighth property that the local Public Protection Unit had assessed for the man. None of the previous seven had been deemed suitable for him.)
20. After the man had viewed the property, he told his offender manager that he was going to refuse it. He said that it was too small, with a communal kitchen and bathroom and shared bills. The man was warned that this would be the only property that he was offered and that there was a danger that he would be homeless when he left the approved premises if he was unable to arrange something himself. Nevertheless, the man was adamant that he did not want to take the property.

21. On 26 August, the man's requirement to sign in at 4.00pm was removed. He was now free to come and go as he pleased during the day, but was still subject to curfew at night.
22. At the beginning of September, the man was assigned a new offender manager as the previous offender manager had taken up a new job. He met his new offender manager at her office on 3 September. The man said that he still had not found any accommodation and would rather go back to prison than live in the property he had recently viewed.
23. The man met his new offender manager again six days later. He said that he had now put down a deposit on an address, although the offender manager expressed concern that he might not be able to afford the rent. As the property was not available until 7 October, the deputy manager of the approved premises agreed to extend the man's stay until that time.
24. In the hostel logbook on 10 September it was recorded that the man went out for a drink that night and that he had "no problems". On 11 September, the man was signed out of the hostel on two occasions. In the morning he went out at 10.25am and returned at 11.20am. Then, in the afternoon, he left at 3.33pm and returned at 4.45pm. This second occasion was just after he had collected his medication from the office at 3.30pm. Hostel staff did not know where the man went on either of these occasions, although his brother later told my family liaison officer that the man was in a pub with him.
25. At 5.30pm, a relief worker made an entry in the hostel logbook saying "seen [the man] regularly through the day, seemed in a very good mood". A curfew check is undertaken each night at around 11.00pm. On the night of 11 September, a tick was put next to the man's name after the check, indicating that he was in the hostel and had no problems.
26. The following morning, at around 8.15am, a resident who was due to leave the hostel that day approached the deputy manager and asked if it would be possible to get a lift to his new house. The deputy manager said that hostel staff would not be able to help him, but suggested that the resident might ask the man for a lift, as he owned a car. The resident therefore went to knock on the man's door at around 8.20am.
27. Shortly afterwards, the resident ran down to the office and said that the man had fainted. The deputy manager and a relief worker ran up to the man's room and entered. They found the man sitting on the floor between his bed and the door. The deputy manager described his condition as follows:

"He was sitting partially upright, eyes open, mouth open and moaning ... his breathing was laboured but he was breathing."
28. The deputy manager asked an approved premises officer to call an ambulance, which he did immediately. Prior to the paramedics arriving,

29. At around 8.30am the paramedics arrived. At their request, the relief worker helped to lay the man on the floor. The paramedics then began cardio-pulmonary resuscitation (CPR). Sadly, they were unable to revive the man. He was pronounced dead by the paramedics at 9.00am. A post mortem report gave the cause of death as cardiomegaly (enlargement of the heart due to heart failure).

30. Shortly afterwards, the deputy manager gathered the other residents in the games room to inform them of the man's death. The news was broken to his next of kin by South Wales Police. The man's ex-wife and sons visited the hostel on 15 September to see where he lived and to collect his belongings. A card of condolence was arranged and was handed to the man's family by a resident with whom he had been friends.

ISSUES

The man's recall to custody

31. The man was initially released on licence on 1 February 2008. He was recalled to custody on 15 March as he had broken a condition of his licence that stated that he was not permitted to live with children under the age of 18. The man was due for release from prison on 11 July. However, his release was ordered by the Parole Board on 20 June after his recall was found to have been unlawful. This was because the earliest offence for which the man was convicted was committed before 30 September 1998, which meant that his recall should have been processed through the Courts. The man had been due to take a place at the approved premises on 11 July but, following the Parole Board's decision, he moved there three weeks early.
32. The decision to recall is initially made by the supervising offender manager in conjunction with their line manager. A recall report is then completed by the offender manager and signed by their line manager and the assistant chief officer. This is faxed to the Public Protection Casework Section (PPCS, then the Release and Recall Section) of the Ministry of Justice, who will make the final decision on the recall within 24 hours (unless it is an emergency recall, in which case a decision is made within two hours).
33. At the time of his death, the man's offender manager had only been responsible for his supervision for around two weeks and had not therefore been involved in his recall to custody. She told my investigator that it was rare for a recall to have to go through the Courts and that she had never experienced such a case.
34. Each case in which an individual has been recalled to custody is subsequently reviewed by the Parole Board. The aim of the review is to determine whether the decision to recall the prisoner was justified. It was at his Parole Board review that the mistake in his recall was determined and the man's release from custody was ordered.
35. Given the particular condition of his licence that the man had breached, it would be a surprise if the Court had not agreed to his recall to custody had the recall been processed correctly. Nevertheless, it is self-evidently worrying that an individual can be recalled to custody unlawfully, albeit because of a technicality. Whilst I do not make a formal recommendation, the chief officer will wish to remind staff of the importance of ensuring that recalls to custody are processed correctly. I have also sent a copy of my report to PPCS for their information.
36. PPCS provided the following response to my draft report:

"Clearly it is regrettable that the recall was processed incorrectly, but it is equally likely that the officer dealing with the recall in PPCS was

unaware of the date of the earliest offence, and there are only a handful of long serving offenders currently in the system to whom this would apply. It would be worth however, in pointing this out to PPCS staff afresh just to remind them that there may be the odd occasion when this issue does arise, and they should be mindful of the importance of the cut off date.”

37. The South Wales Probation Trust also provided the following response:

“Guidance will be issued to ensure that careful scrutiny is given to conviction dates when licence revocations are being considered in future.”

Medication

38. The man’s brother told my investigator that the man had said that he could not always obtain his medication when he was in prison. Following his conviction in March 2007, the man spent time in HMP Swansea, HMP Parc and HMP Usk. Since I began investigating all deaths in custody in England and Wales in April 2004, I have completed a number of reports at these three establishments. In one of these investigations, following the death of a prisoner at Parc in November 2005, I recommended that a comprehensive review of medicines management be undertaken at the prison. This recommendation was accepted and a review, including the recruitment of a full time pharmacist, took place in January 2006. I have not subsequently raised the issue of medicines management in any of my investigations at Parc, Swansea or Usk.

39. The man had been resident at the approved premises for just under three months at the time of his death. I have not been provided with any details of the medication that the man apparently did not receive in prison, or an indication of when this might have happened or at which prison or prisons. Given the time that has elapsed since any missed medication, I do not consider that this would have had a bearing on the man’s death and so I have not investigated the matter further.

40. The man was also concerned that his brother could not access his medication easily at the approved premises, as it was stored in the office. Probation Circular 33/2004 provides the current guidance on the handling of medication of residents of approved premises. It provides the following instruction:

“As a general rule, residents of Approved Premises are not permitted to keep their own prescribed medication in their rooms or on their persons ... whenever a person becomes resident of Approved Premises they must agree to hand over their medication to a supervisory member of staff for safe-keeping.”

41. These guidelines are in place for the protection of staff and residents. Restricting the access of residents to prescribed medication is designed to

42. A pilot scheme was recently run in which residents of selected approved premises held their own prescription medication in possession. This pilot was a success and the scheme is due to be rolled out nationally.

Housing

43. The man's brother told my investigator that the man had struggled to find accommodation to move into on leaving the approved premises. He said that the man was offered a place in a bedsit, but turned it down as he did not consider it to be suitable.

44. From his arrival at the approved premises on 20 June, the man's future accommodation was a regular topic of discussion. It was raised in his hostel supervision plan on 21 June, when his key worker noted that an area of South Wales was responsible for accommodating the man.

45. A total of eight different properties were recommended by the area's Housing Advice Centre. However, the first seven of these were rejected by the local Public Protection Unit as unsuitable. There were concerns for the man's safety in several areas. He had previously been forced to move house during his release on licence in February 2008, due to being the target of anti-social behaviour.

46. There were also complications in the housing process because the man owned a property with his ex-wife. It was not therefore initially certain that he would qualify for a council property. Moreover, the man was unable to move into this house due to the incidents in February. He also expressed a desire to live away from this and a neighbouring town, which narrowed his options further.

47. A property was eventually found that was deemed to be suitable by all parties. However, the man inspected it on 22 August but was unimpressed and turned it down. He said that the property was too small, with a communal kitchen and bathroom and shared bills. Despite being warned that this was the only property that would be offered to him, the man said that he would rather return to prison than live there.

48. The man's offender manager described the process of finding accommodation as a "struggle". There were a number of barriers in place and it took around two months for a property to be found. It is unfortunate that the man did not consider this accommodation to be suitable. However, he was able to find a property himself and put a deposit down on it prior to his death.

Issues raised by a fellow resident

49. A fellow resident of the approved premises said that he saw the man on a High Street, around a two minute walk from the hostel, at around 7.00pm on the evening before he died. The resident recalled that the man was on his way to a local pub but that he did not look the same as normal. He asked the man how he was feeling, to which the man replied, "I'm alright, just feeling a bit rough, I'll soldier on". The man joked that the evening meal they had eaten at the hostel might have been the cause, saying, "I don't think the curry did me any good".
50. The hostel records for 11 September, the night before the man died, show that he returned to the premises at around 4.45pm and did not leave again that night. Staff were confident that he could not have left the building without being signed in and out, as the entrance can only be opened by a button pushed by a member of staff in the office. The records for the previous evening, however, show that the man had been to the pub that night. It is possible that the resident has confused which night he saw the man on the High Street.
51. At no time after the evening of 10 September did the man indicate to any member of staff at the approved premises that he might be ill. A relief worker, commented that he had seen the man several times on 11 September and that he "seemed in a very good mood". Moreover, if the man had been feeling unwell then, unless it was an emergency, the onus would have been on him to arrange a medical consultation.

Response when the man collapsed

52. The man was attended to by the deputy manager and a relief worker, when he was taken ill on 12 September. When the alarm was raised they checked on the man promptly and called an ambulance immediately. Until the arrival of the paramedics they monitored the man's condition and tried to make him comfortable and to communicate with him.
53. Shortly before the ambulance crew arrived, the man's condition deteriorated. His breathing became more laboured and his pulse faint. However, as he was still breathing and the deterioration was just as the paramedics were arriving, the staff did not begin cardio-pulmonary resuscitation (CPR).
54. Whilst the relief worker was recently trained in first aid, including CPR, the deputy manager is not trained. Not all staff at the approved premises are trained. Instead, there are nominated first aiders whose assistance can be called upon when necessary.
55. Probation Circular 35/2006 provides guidance on preventing deaths of approved premises residents. It gives the following instruction:

“Probation areas should refer to the Health and Safety Risk Assessment ‘Approved Premises Management Guidance’ which has been circulated to Areas and is available on EPIC [the Probation Service intranet]. This states that ‘all supervisory staff must be trained, as a minimum, in basic first aid’.”

56. In the man’s case it was not necessary for staff to commence CPR as he was still breathing when the paramedics arrived. However, there could be other occasions in which the intervention of staff might be required. In such circumstances, the skills of properly trained and qualified staff may be the difference between life and death.

The Chief Officer should ensure that all staff are trained in basic first aid, as required by Probation Circular 35/2006. Consideration should be given to training all staff in CPR.

57. There are currently no defibrillators at the approved premises. Such devices are now widely installed in public places like shopping centres and railway stations. They can give automated instructions to the resuscitator on how to treat a patient, with little prior training required. Following the death of a hostel resident in May 2008, I recommended that the National Offender Management Service should review the costs and benefits of providing defibrillators in all approved premises. This recommendation was accepted in October 2008 and I do not repeat it here.

Support to staff following the man’s death

58. Following the man’s death, the relief worker was offered the opportunity to go home for the remainder of the day by the deputy manager, which he accepted. The relief worker told my investigator that he was very happy with the support that he received.
59. The deputy manager, on the other hand, felt that he did not receive suitable support from his superiors. Whilst he was happy to receive informal support from his colleagues at the approved premises, the deputy manager felt that the contact he had with the assistant chief officer was concerned more with events over the weekend following the man’s death. He also felt that the contact he had with the director of operations might have been better if it had been earlier and over the telephone rather than on email.
60. The officer, who contacted the emergency services when the man collapsed, was sadly told of a family bereavement on the same morning that the man died. Whilst he said that he had little to do with looking after the man when he collapsed, the approved premises officer felt that as he was associated with two deaths on the same day it would have been nice for someone to have contacted him to see how he was.

61. Probation Circular 35/2006 says that, “following a sudden death Probation Areas should consider providing support to residents and staff”. I consider it essential that staff are provided with proper support following a death in a hostel. Not least, this is part of the employer’s duty of care to its staff. Unfortunately, the hostel manager was on leave at the time of the man’s death. Had she not been, she might have been able to bridge the divide between staff at the approved premises and area management.

The Chief Officer should review arrangements for supporting staff following the death of an Approved Premises resident.

RECOMMENDATIONS

1. The Chief Officer should ensure that all staff are trained in basic first aid, as required by Probation Circular 35/2006. Consideration should be given to training all staff in CPR.

Accepted – additionally, the four the approved premises staff who were not first aid trained had been identified before The man's death, and arrangements had been made for them to attend the same four day course as their colleagues. This training will take place in the early New Year.

2. The Chief Officer should review arrangements for supporting staff following the death of an Approved Premises resident.

Accepted – the South Wales Probation Trust will re-visit its arrangements for providing support to staff in circumstances such as this and guidance will be revised, promptly, if required.