Circumstances surrounding the death of a man, on 3 August 2004, at an Approved Premises under the management of the Probation Service.

Report by the Prisons and Probation Ombudsman for England and Wales

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INTRODUCTION

This is a report of my investigation into the death, apparently from natural causes, of a man. He was a resident of an Approved Premises, on life licence following his conviction and life sentence for murder in 1967.

The purpose of my investigation was to establish the circumstances and events surrounding his death, including the quality of care provided by the Probation Service. I also wanted to find out whether there were any lessons to be learned about operational methods, policy, practice or management arrangements that might help prevent such occurrences in the future.

A member of staff from my office carried out the investigation with the co-operation of the Probation Area. I am grateful for all the assistance that my Investigator received from the Manager and members of staff at the Approved Premises.

A key part of the investigation was to make sure that the family had the opportunity to raise any concerns they had about his death. My investigator was able to speak to the brother in law, on the telephone. I am most grateful to him for having this conversation at what must have been a very difficult and distressing time for both himself and his wife (the man's sister).

The man's sister wrote a letter to the Coroner about her brother's eldest son. She said that, on attempting to contact him, it was found that he had in fact sadly died with his own son five years previously in a car accident.

I offer the man's sister and her family my sincere condolences. It does seem, however, that the last few months of the man's life at the hostel were tranquil, and that he was well respected. I hope that this provides some comfort.

STEPHEN SHAW CBE
PRISONS AND PROBATION OMBUDSMAN

SUMMARY

The man died of a heart attack at the Approved Premises on 3 August 2004. During his stay at the premises he was perceived as a quiet and resourceful man, and was well respected by other residents. He abided by the hostel rules.

He did not present with any serious medical complaints either at North Sea Camp prison or at the Approved Premises. He visited his GP only once while at the hostel, on 3 March 2004, complaining of a chesty cough for which he was treated.

The night hostel assistant at the hostel recalled that, when the man was checked at 11pm curfew on the night of 2 August, he was in good spirits. Sadly, when he was next checked, at around 6am on 3 August, he had passed away.

My investigation has identified two areas where procedures for dealing with fatal incidents could be improved. My recommendations can be found in Part 3.

CONDUCT OF THE INVESTIGATION

My Investigator conducted formal interviews with two members of the hostel staff. The interviews were not tape-recorded but the Investigating Officer's notes have been agreed, and signed by the interviewees.

Another member of probation staff, the man's Probation Officer, met with the investigator and a note of the meeting was agreed.

The Investigator also examined a variety of documents readily provided by the Probation Area. She spoke on the telephone to the man's GP who provided details of treatment he had provided to him which he confirmed in writing in a letter to the Coroner.

A clinical review of the healthcare provided to the man while at North Sea Camp prison and at the Approved Premsises was arranged by the Director of Nursing/Clinical Governance, Primary Care Trust (PCT). The review was undertaken by a doctor, GP Clinical Governance lead for the PCT. The review concluded that there was no indication of sudden death from any particular existing illness but did not fully assess the medical care received by the man.

An inquest, with a jury, was held on 4 October 2004 and delivered a verdict of death from natural causes (myocardial infarction).

PART ONE

Background information

Section 1 – The man

The man was born in Glasgow on 21 May 1939. He was 65 years of age when he died on 3 August 2004 at the Approved Premises. He had been twice married, but it seems that both relationships ended in divorce. He had five sons and three daughters, aged between 49 and 24 years. He had a history of heavy alcohol consumption.

On 10 September 1967, he was convicted of murder and sentenced to life imprisonment. On 6 April 1979 he was first released on life licence, but he was recalled on 15 February 1980 following concerns about his potential for violence. On 26 November 1982 he was again released on life licence, but on 12 June 1995 the licence was revoked for a second time following various incidents concerning alcohol and potential violence. He did not return to prison, and remained unlawfully at large until January 2001, when he was rearrested, and admitted to HMP Pentonville. He remained there until 18 February 2002, when he was transferred to HMP North Sea Camp.

During 2003 he spent five periods of temporary home leave at the Approved Premises. This is usual for someone who has spent a considerable length of time in prison. These stays went well, and on 9 February 2004 he was released from North Sea Camp prison on life licence, with a condition of residence at the Approved Premises.

The man's key worker at the hostel, his probation officer and the hostel manager, all described him as being very resourceful and having a positive influence on other residents through sharing the benefits of his life experience. He was perceived as a quiet resident, respected by the other occupants and abided by hostel rules. He did not present any management problems. His probation officer was, at the time of the man's death, trying to arrange suitable accommodation for him to move into from the hostel. The man was looking forward to being settled in his own accommodation outside the hostel. Suitable accommodation was in fact identified shortly after his death.

Section 2 – The Approved Premises

Probation Approved Premises, formerly known as Probation and Bail Hostels, are approved by the Secretary of State, within Section 9 of the Criminal Justice and Court Services Act 2000. Their purpose is to provide accommodation for people granted bail in criminal proceedings and in connection with the supervision and rehabilitation of people convicted of offences. Hostels can provide a supportive, structured environment in the community for high risk and difficult to manage offenders. The supervision of offenders accommodated in Approved Premises is governed by the National Standards for the Supervision of Offenders.

Approved Premises operate on each day of the year with 24 hour staff cover on a rota basis. The hostel is a large house on a busy road. The hostel has 41 places and is managed by a senior probation officer. There is a deputy manager and a team of nine staff members, responsible for the daily management of residents.

The premises accommodates two categories of residents: those on life licence (such as the man) and those granted bail in criminal proceedings.

The accommodation comprises a mixture of single bedrooms and six self-contained flats, for which residents are required to pay rent. The self-contained flats each house two residents with separate bedrooms and shared kitchen and bathroom facilities.

All residents must be in the hostel between the hours of 11.00pm and 6.00am the next morning unless a court has imposed an alternative curfew.

Night cover at the hostel is provided by two night hostel assistants. An assistant manager, who sleeps on the premises, is on duty throughout the night.

A Basic Skills tutor attends the hostel one day a week, and a Community Psychiatric Nurse (CPN) attends one morning a week. The hostel has links with an organization which helps residents to find employment. It works with partners as part of the Criminal Justice Intervention Programme, which aims to provide individual tailored solutions for drug misusing offenders with the aim of getting them out of crime and into treatment.

Residents are allocated key workers who are expected to meet with them regularly, to identify any issues of concern on a day to day basis and to assist where possible. There is also an expectation that information will be shared regularly with probation officers in the field, who are responsible for case management.

PART TWO

Events leading to the man's death

Section 1 – The man's time at the Approved Premises

On 9 February 2004, the man arrived at the Approved Premises and received a full induction. This included the provision of health and safety information, expectations of behaviour and details of the hostel rules. He was required, like most residents, to be present at the hostel between the hours of 11.00pm and 6.00am the next morning.

The man was allocated a key worker and a probation officer, with whom he kept in regular contact.

He gave the hostel details of his eldest son, as his next of kin, and also details of his sister. He told his key worker that he was not in touch with his family, although on 27 February 2004 he said that he missed his children and might contact them at a later stage. On 29 July 2004 the man's key worker noted that one of the man's sons had come to visit him but he was not at the hostel. The note says that the man said that he did not want contact with this son anyway as he was taking drugs. The hostel manager thought that he might have met one of his sons shortly before 3 August, although this cannot be confirmed by hostel staff or by the official visitors signing in book at the premises.

Hostel records indicate that the man appeared settled and was coping very well. On 18 May 2004, he moved to one of the self-contained flats.

During the man's time at North Sea camp prison, the only ailment he reported was hemorrhoids, for which he had medication.

The man continued to report few health problems while at the Approved Premises. The notes of his key worker describe his health as follows:

> 18 February 2004: Health 'No problems apart from haemorrhoids.'
> 27 February 2004: Health 'Has a problem with ears which have swollen up. Doctors appointment requested for this afternoon.'

On 3 March 2004 the man visited the hostel GP, with whom he registered temporarily for three months. This is not unusual with hostel residents as they do not reside permanently at the hostel. While at the surgery, the man completed a medical history form, which did not indicate any adverse medical problems. The doctor treated him for a chesty cough and an infected cyst on his chest wall, prescribing cough medicine and cream.

The notes of the man's key worker continue to show no major concerns about his health:

18 April 2004: Health 'No problem apart from chest, throat a bit blocked. He will take the bike to use it for exercising.'
1 May 2004: Health: 'No problems. Had diarrhoea because he ate seafood but he is better now.'
5 June 2004: Health 'No problems. He told me that he still drinks but can control it very well.'
29 July 2004: Health 'No problems with his health. He told me that the only problem was occasional colds with the change of temperature in the winter. Otherwise he said that he was enjoying the sun and going for walks in the park. He still drinks the occasional beer in the pub with his friends but comes straight back to the hostel.'

The night hostel assistant recalled that he had distributed some medication to the man but he could not recall the date or the details of the medication or what ailments he was suffering from. The hostel no longer had any record of any medication.

While at the hostel, as part of his supervision plan, the man was referred to Crossroads, an alcohol counselling organisation, for counselling about alcohol abuse. There is a record of sessions he attended on 17 March 2004, 31 March 2004 and 28 April 2004. He was also required to fill in an alcohol monitoring sheet. There were no serious concerns about his alcohol consumption during this period, or any incidents of violence.

Section Two – What occurred on 3 August 2004

On 2 August 2004 the man was checked at the 11pm curfew and the night hostel assistant recalled that he was in good spirits. Shortly after 6am the next morning, the night hostel assistant went to the man's room at Flat C to conduct a routine morning curfew check. The man was not in his room so the night hostel assistant began a room search. He eventually found him in the bathroom, lying on the floor, slumped against the door. He formed the opinion that he was dead. He then called the man's flatmate who declined to enter the bathroom. He immediately called the night security guard and then went quickly to phone the Assistant Manager on night duty, at around 6:21. He told the Assistant Manager to come downstairs as there had been an incident. The Assistant Manager arrived downstairs and made his way with the night hostel assistant to Flat C. He entered the flat and made his way upstairs to the bathroom. He could only open the door by about two feet as the man was lying on the bathroom floor, with his body against the door. At about 6:32 he called an ambulance. When the paramedics arrived, they confirmed that the man was dead, and called his GP. At 7:20am two police officers arrived and examined the scene, and were subsequently joined by their sergeant. It is not clear which member of staff contacted the police. The man's GP, arrived at around 8:07am. Shortly after 8:10 he confirmed his death. The police officers left around 8:40.

The Assistant Manager completed an Incident Report after the incident.

The night hostel assistant, who was first on the scene, said in interview that he did not know of any formal procedures to follow after a death in an Approved Premises. He did not complete an incident report but made notes.

The Hostel Manager told my Investigator that deaths and other incidents are dealt with by staff at the level of Assistant Manager and above. These staff are aware of Probation Circular 40/2004 (Strategy for preventing sudden deaths in Approved Premises – Annex C- What to do in the event of an incident of significant self-harm or a fatality), but other staff would not necessarily be aware of the circular.

The police notified the man's next of kin of his death. There is no clear direction in Probation Circular 40/2004 Annex C about whether the hostel should be in contact with the next of kin. This is an issue that has been carefully considered in the Prison Service and would benefit from new thinking in a Probation or NOMS context.

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PART THREE

Consideration and conclusions

It is my role to consider the adequacy of care provided for this man at the Approved Premises. In doing so, I have also considered whether hostel procedures were clear to staff and in line with the requirements for all such hostels as defined in the Approved Premises Handbook.

The handbook requires residents to be registered with a GP. The Approved Premises complied with this requirement by identifying a GP who was willing to take all the residents of the hostel. It appears that this man received appropriate care from the GP.

Members of staff at the Approved Premises work hard to ensure that residents are treated as individuals with care and consideration. I am satisfied that the overall quality of care provided by the hostel to him was good. There was no evidence to indicate that his sad death could have been prevented by changes in either management procedures or policy.

That said, the Night Hostel Assistant was first on the scene after the incident on 3 August 2004 but he was not aware of any formal procedures for dealing with such an incident. It was not appropriate to try and involve a resident in the incident, and the Assistant Manager should have been alerted immediately to the nature and location of the incident. This would have made no difference in this man's case, but the consequences in other circumstances could have been more serious.

I recommend that the Approved Premises ensure all staff are aware of Probation Circular 40/2004 (Strategy for Preventing Sudden Deaths in Approved Premises). This will ensure they are better prepared to deal with such incidents.

I am also concerned that the Approved Premises was not able to produce records of what medication had been issued to this man.

I recommend that the Approved Premises review arrangements for keeping records of medication it issues.

RECOMMENDATIONS:

Local:
I recommend that the Approved Premises ensure all staff are aware of Probation Circular 40/2004 (Strategy for Preventing Sudden Deaths in Approved Premises), in particular Annex C. This will ensure they are better prepared to deal with such incidents.

Local:
I recommend that the Approved Premises review arrangements for keeping records of medication it issues.

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PRISONS AND PROBATION OMBUDSMAN

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