# Investigation into the circumstances surrounding the death of a man, a resident of an Approved Premises in the West Midlands Probation Area, in December 2008

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

## January 2010

Final Report: Date: 29.01.10

This is the report of an investigation into the circumstances surrounding the death of a resident of an Approved Premises, who died on 3 December 2008. The cause of death was recorded as cerebral oedema and obstructive hydrocephalus which occurred after the man suffered a heart attack whilst in hospital. He had been taken to the hospital by his family because he was not feeling well, and whilst there he collapsed with a heart attack. Complications resulted from attempts to revive the man, and he was moved to an intensive care unit on a ventilating system. He deteriorated over the next two days and he died with his family around him on 3 December.

I would like to extend my condolences to the man's family and friends for their loss.

This investigation was carried out by one of my colleagues. No clinical review or post mortem was carried out because the man died whilst a resident in Approved Premises and was under the care of doctors in a hospital.

I would like to thank the manager and the staff of the Approved Premises for the assistance they have given to my colleague.

The man was overweight, and I have uncovered nothing in this investigation to suggest that his death could reasonably have been anticipated by the Approved Premises, or that the actions and decisions of staff were in any way inappropriate. Indeed, it is clear that those staff were shocked and saddened by his passing. Nevertheless, this investigation does offer an opportunity to the West Midlands Probation Area to review the staffing make-up at the Approved Premises given its specialist function and the vulnerability of its residents. I make two recommendations to this end, and one focussing on the issue of staff support.

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

**Stephen Shaw CBE**
**Prisons and Probation Ombudsman** **January 2010**

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## SUMMARY

The man was arrested in February 2000 and was sentenced to four years imprisonment plus five years extended licence by a Crown Court in November 2001. Whilst in custody, the man's mental health deteriorated and in June 2003 he was sectioned under the Mental Health Act. He was sent to a local Mental Health Clinic, where he was looked after by the secure mental health services. He was released from the Mental Health Clinic on 14 June 2006 to live with his parents, but was still the subject of the extended licence until it was due to expire in June 2009.

When the man who is the subject of this report arrived at his parents' home, it was discovered by his probation officer that the victim of his crimes had moved to within a few yards of the man's address. It was therefore considered that he should be moved, on a temporary basis, to an Approved Premises.

This temporary move proved to be anything but temporary as he remained there for the next two and a half years. This was of such concern to the man's family that they requested a Judicial Review of the way he had been treated by his Probation Area. This was set for October 2008 but, before the court hearing, the family and the Probation Service agreed to an independent review by another probation area. The reviewer reported in November and recommended that the man should have a phased return to the community, initially to supervised accommodation, but moving to supported housing near his family home by June 2009.

The man who died was a man who needed a lot of support from both his family and probation staff. It was this need for supervision, coupled with his mental health needs, that made it difficult to accommodate both the man's and his family's needs whilst managing the risk of re-offending.

The man had occasional episodes of illness that required attention from the local emergency services or local hospital. He collapsed and was admitted to hospital on 4 February 2008, 13 March 2008, and again on 27 November. On 1 December whilst with his family, he complained of feeling unwell, and they took him to hospital. Whilst there he suffered a heart attack and subsequent brain damage. He was put on to a ventilator and admitted to the Intensive Therapy Unit, but died two days later. His family were at his bedside.

## THE INVESTIGATION PROCESS

1. My investigator visited the Approved Premises on 5 December 2008. He was given access to the man's records and shown around the Approved Premises. He met the manager and spoke informally to a number of staff who were on duty at the time. Notices of my investigation for staff and residents were sent the following week with a request to ensure they were displayed prominently. No staff or residents asked to speak to my investigator as a result of these notices.

2. No clinical review was requested for the man as he had died whilst in hospital, under the care of a local GP. The coroner also felt it was not necessary for a full inquest before a jury as he was not resident in a prison and had died of natural causes. A copy of my report will nonetheless be sent to the coroner. At the time of issuing the draft report it was not thought that a post mortem had been performed on the man. This proved to be erroneous and I subsequently became aware that the family had asked for a private post mortem. The post mortem report concludes that cause of death was

    > 'undoubtedly acute hydrocephalus causing severe increase in intracranial pressure, on a background of chronic hydrocephalus, both attributable to intermittent obstruction of CSF [cerebrospinal fluid] flow by a tumour consistent with a colloid cyst of the third ventricle.'

3. One of my family liaison officers contacted the man's family solicitor, on 19 December as this was the method of contact requested by the family. The Family Liaison Officer explained the investigation procedure in her letter to the solicitor and invited him to ask the family to raise any concerns or comments they might have. The family's main concern was how the man was dealt with in respect of his licence arrangements. They also had concerns that the hostel focussed on his mental health needs and less so on his more general health. They felt they could have looked after him better at home.

4. The investigator made a further visit to the Approved Premises on 12 December and interviewed the manager and deputy manager together with a member of the night staff. It was evident to the investigator that staff were badly affected by the death of the man, and he asked if there had been any staff support after his death. The investigator was told that there had not been anything constructive up to that point. He therefore telephoned the Probation Service who rectified this situation immediately.

5. The investigator obtained a short report on the man's medical condition from the local GP. He also wrote to the consultant psychiatrist responsible for the man who had died, requesting detail of physical examinations undertaken whilst he was at the mental health clinic.

## THE APPROVED PREMISES

6. The Approved Premises is deemed a specialist Approved Premises for mentally disordered offenders. It is staffed 24 hours a day. Although the staff are not nurses or mental health professionals, they are very experienced in managing and caring for offenders with mental health problems.

7. The Approved Premises is an old Victorian style house. It accommodates 20 men over the age of 18 in single occupancy rooms. There are two resident's lounges, a games room, resident's laundry, kitchen and dining room. Staff and residents are supported by mental health professionals from a local mental health clinic, a medium secure forensic psychiatric unit.

8. The mental health clinic's team provide assessment of each resident's mental health, and ongoing advice regarding the resident's mental health management. Residents who are originally from the local area are the responsibility of the clinic even after they leave the Approved Premises. Residents from out of area have their mental health needs looked after by their local psychiatric team when they leave the Approved Premises. The physical health needs of residents are overseen by the local GP at the local General Practice.

9. Multi-Agency Public Protection Panels (MAPPP) manage the risk an offender may pose to the public upon their release from custody under arrangements known as MAPPA (Multi-Agency Public Protection Arrangements). The panels consist of local agencies (police, prison, probation, social services, health and other agencies as required). Level 1 represents low risk and Level 3 represents very high risk. The man who died was deemed to be a Level 2 risk which meant that he was thought to be a potentially high risk to the public requiring multiple agencies to consider what they would do to minimise that risk (Level 1 allows for a single agency to manage the risk posed).

10. Approved Premises are not inspected in the same way as prisons. The Approved Premises referred to in this report was last reviewed in 1998 by Her Majesty's Inspectorate of Probation. They described the Approved Premises as demonstrating, 'that it was possible to accommodate mentally disordered offenders, many of whom had committed serious offences and who exhibited significantly disturbed behaviour, in a specialist approved probation and bail hostel.' The thematic review 'Probation Hostels: Control, Help and Change', published in 2008, says that generally:

    > 'Funding levels for hostels were no longer sufficient to support the required development of a hostel regime with a full programme of purposeful activity and probation areas with hostels had had to invest significant amounts from their main service budgets to make up for the shortfall in the central grant. This had been sufficient to ensure appropriate restrictive measures were in place everywhere.'

    Although it should be noted this extract from the Probation Inspectorate's report does not specifically refer to the Approved Premises referred to in this

report, it is a feature of this report into the death of the man, that there is concern at the level of resources available to the hostel to discharge its responsibilities, especially bearing in mind the specialist nature of the Approved Premises.

11. There have been two previous deaths at the Approved Premises since I was given responsibility for investigating all deaths of residents of Approved Premises in 2004. The circumstances of the man's death bore no similarities to either of my earlier investigations.

## KEY FINDINGS

12. As noted above, the man who died was sentenced to four years imprisonment at a Crown Court in November 2001. He was sent to HMP Birmingham where he remained until he was sectioned under section 47/49 of the Mental Health Act (1983) on 13 June 2003. (Section 47 of the Act refers to transferring a prisoner to a hospital for treatment of a mental health condition and section 49 restricts the patient from being discharged without the Secretary of State's permission.) On 14 February 2004, he was formally released from custody, but he remained in hospital on a section order under the Mental Health Act and on licence from his sentence by the court.

13. On 6 June 2006, the man was discharged from hospital to live with his parents, but he was still on licence in respect of his original conviction. One of the conditions set by the West Midlands Probation Area was that he should visit his offender manager when he was told to do so. (An offender manager is the probation officer with overall responsibility for an offender. They assess an offender's risks and needs; plan how their sentence will be organised; decide what interventions are needed; review the offender's progress against that plan; and adjust the plan in the light of changing circumstances.) The man's first appointment was scheduled for 8 June and he kept the appointment. However the man's offender manager had been made aware that the victim of his crimes had moved house and now lived very near his place of residence – his parents' house. This caused concern for all parties, including the man who died as he had allegedly been threatened by the victim's boyfriend. The offender manager therefore felt obliged to find alternative emergency accommodation for him. In view of concerns about his mental health, it was decided that a safe place for him would be an Approved Premises.

14. The man's parents took him to the Approved Premises on 8 June 2006, but expressed concern that he was in breach of his licence conditions by having to stay there. It was explained to the family by the manager of the Approved Premises, that the offender manager had the right to alter licence conditions and he had done this through the proper system. It was also explained that this was expected to be an emergency placement until something more suitable could be found for him.

15. When the man arrived at the Approved Premises, a community psychiatric nurse from the mental health clinic was contacted. She was able to give some background information to the staff at the Approved Premises, regarding his mental health history. She also made arrangements for his prescribed medicines to be taken to the hostel.

16. The man's psychiatrist from the mental health clinic also went to the Approved Premises on the evening of 8 June to see him. He emphasised to the man that he (the man) must keep to the hostel rules, and abide by any curfew that the hostel or his offender manager imposed. This curfew was initially set at 24 hours. That meant that he could not leave the hostel for any reason. The man's daily contact sheet (a hostel record of each individual resident's daily

occurrences) shows that his psychiatrist was concerned that he had not fully understood that he might have to go back to prison if he breached his new licence conditions.

17. The man's mother visited her son at the Approved Premises on 10 June. She found it difficult to accept that she could not simply walk in and see her son. Staff had to spend some time with her explaining that he was at the Approved Premises under licence conditions and on a 24 hour curfew. Some time after the man's mother had left; the man asked if he could have some money for a pizza order. This was refused, but he placed the order by telephone anyway. When it was delivered, he had no money to pay for the order and the delivery man took the pizza away. Other residents were reported to be concerned that this might jeopardise the arrangement they had with the pizza company.

18. On 12 June, the man's mother again came to visit her son. Neither the man nor his mother could understand why he was still being kept at the Approved Premises. The man's mother suggested that, if her son could not live with her and her husband, then he might be able to stay with his sister. It was believed by staff at the hostel that this was being explored as a possibility by his offender manager, but had not been approved at that time.

19. The man continued to be a resident of the hostel under the tight restriction of not being allowed out of the premises at any time. On 22 June, staff asked the offender manager if the man might be allowed out. The entry in the record says that 'they were not keen', which seems to be a reference to the offender manager although the entry in the record does not say. There was concern that he would go back to his home address, even if he was accompanied by his parents, and there was now an exclusion order on his licence banning him from being in that area.

20. On 23 June there was email contact between staff at the Approved Premises and the mans offender manager asking if there was any progress on moving him. The offender manager made arrangements to come and visit the man at the hostel. He said in his email that he was hoping to sort out some funding so that he could be moved out of the area.

21. There is no entry in the records to confirm that the offender manager visited the man on Monday 26 June, but on 28 June the records say that he was allowed to leave the hostel, under the supervision of his parents, for two hours a day to visit a park just a short distance from the Approved Premises. This arrangement was to help the man get some fresh air and exercise and to encourage contact with his family.

22. Despite attempts to find the man alternative accommodation, nothing positive materialised for him. On 9 August, his solicitors informed the Approved Premises that they would be seeking a Judicial Review of his case as they felt the Probation Area had mishandled his care.

23. A probation officer visited the Approved Premises on 11 August 2006 and met with the man and his family. She told them that it had been agreed his curfew

was to be relaxed. He was to be allowed out of the hostel on Mondays, Tuesdays and Fridays between the hours of 10.00am and 2.00pm and he could continue to have two hours on the other days of the week to go to the local park. The man and his family were reminded of the importance of the exclusion zone – the areas that he was not allowed to go to.

24. From the records it is not completely clear when, but the two alternative options where the man might live failed to materialise. The report by an Assistant Chief Officer of Gwent Probation says that for reasons that are unclear no alternative accommodation was found for the man. (As noted earlier, the report by the Assistant Chief Officer was provided as part of an agreement between the West Midlands Probation Area and the man's solicitors in respect of the Judicial Review proceedings.) In his review, the assistant Chief Officer talks about one of the alternative accommodation options. The alternative accommodation option is a 14 bed registered care home for people with mental health problems. It provides 24-hour staffing to help residents live comfortable and fulfilling lives. The home consists of a 10 bedded main unit with 4 separate self contained flats next door. Another accommodation alternative was being looked at in August 2006; however, neither hostel was able to provide accommodation in the end.

25. Throughout the rest of 2006 and 2007, the man settled into a routine of being supported by his family and various offender managers, as well as the staff of the Approved Premises. He needed quite a lot of support and encouragement, in particular relating to his personal hygiene and daily activities. He could not exercise choice very well, needing to have things explained to him over and over again. He also displayed occasional signs of hearing and responding to voices in his head, for which he was under the care of his psychiatrist from the local mental health unit, a community psychiatric nurse (CPN) ensured the man's medication was brought to the Approved Premises on regular occasions and would also act as link nurse for the man's mental health needs.

26. The man's visits to his local GP were for problems of a routine nature throughout this time, and his GP's main concern was about his obesity. His GP was encouraging him to take more exercise and eat less, both of which he found hard to do.

27. The man was reviewed by the local mental health clinic psychiatric team on 27 June, 31 July and 19 November 2007 and was judged by his psychiatrist to be stable on the medication prescribed.

28. On 30 November, the man had a flu jab at the GP surgery. He also had a check-up of his asthma condition.

29. In the keywork session report for week commencing 20 December 2007, it is reported that there is nothing identified for the man by way of alternative accommodation, or plans for moving him on. The entry says, 'SB [a reference perhaps to his probation officer] took the issue to MAPPA but unfortunately

there is no funding.  Has spoken to Mr B about the matter.'  (Mr B is an Assistant Chief Officer in West Midlands Probation.)

30. At Christmas 2007, the man who died received permission to stay away from the hostel overnight with his sister.

31. On 3 January 2008, the man had some blood tests for kidney and thyroid functions.  These were found to be normal.

32. The man who died was supported by his family throughout his stay at the Approved Premises.  After his family had taken him to see his GP on 4 February 2008, he returned to the hostel and vomited, complaining of chest pain and headache.  Staff at the Approved Premises monitored him every half an hour.  They described his breathing as sharp and his pulse as being slow.  At 8.25pm, the man was found collapsed on the floor.  Staff put him into the recovery position and called an ambulance.  When paramedics arrived they gave him oxygen and did an ECG (an electrical tracing of his heart's activity).  Because of his size, the paramedic crew required extra help from residents to lift him into the ambulance.  He was taken to the local hospital, and then discharged from the hospital later that night with a diagnosis of having had a possible fit.

33. The man's CPN took him to see his GP on 5 February.  His GP observed that he had problems with his right eye, noting that his eyes were 'crossed' according to the entry in the events record.  His GP expected this to correct itself within two weeks, but said if it did not he would refer the man to a neurologist.  The CPN also asked that the consultant psychiatrist review the man in one month's time (3 March).  The GP reported to my investigator that the man's eye problem resolved itself by 7 February, and there was therefore no need to refer him to a neurologist.

34. On 15 February, the man's mother noticed that he was waiting in the queue for dinner and objected to him being given food.  She said that he always had dinner with the family, but it appears that he was having another evening meal when he returned to the hostel.  She asked staff to refuse to give him this evening meal.

35. A Care Programme Approach (CPA) meeting was held on 3 March.  It was felt that overall the man who died was doing well, but that realistically he was going to remain at the Approved Premises until he could return home.  The consultant psychiatrist reported that there was no money available to move him on as the opportunity to access funding had been missed.  The consultant psychiatrist said that he thought the man was quite stable mentally and 'as good as he can be due to supervision/care by MHT [Mental Health Team]'.  His next CPA meeting was set for 1 October.

36. Whilst visiting his family on 13 March, the man began to vomit and became unsteady on his feet.  His family brought him back to the Approved Premises where staff called for an ambulance.  The man was taken to the local hospital.

He stayed in overnight, and was discharged to his home the following day having been diagnosed with possible gastroenteritis.

37. The man's father accompanied him to the GP's surgery on 20 March. His GP explained to the two men that some of his unsteadiness, loss of consciousness and vomiting might be due to him being too vigorous in his exercises. He was advised to take things more gently, perhaps just walking for the time being. His GP told him that he was most likely suffering the effects of a virus. The GP also undertook more blood tests and an ECG, both of which were normal.

38. Until September, the man who died appears to have been fairly stable as regards his mental health care. He was prescribed medication by his consultant psychiatrist, and his family and staff at the Approved Premises made sure he took his tablets regularly as prescribed by the MHT. However, in late September, his mental capacity started to show signs of deteriorating. He would occasionally soil himself, he began to suffer dizzy spells and he was often drowsy. The MHT adjusted his medication by reducing the dose of his antipsychotic tablets (Clozapine). The man also went to see his GP on 23 September to check if there was anything else causing his illnesses. His GP concluded that nothing else was wrong with him, other than he needed to lose weight and he had a mental health problem.

39. On 26 September the man went to see his GP with his mother and sister. They were concerned that since his medication had been altered he was getting more 'turns' when he got up. They thought his behaviour had become rather irrational and he was salivating more. They were also concerned about his noisy breathing and snoring at night.

40. On 29 September, the man was seen by hostel staff to be trying to hide his medication in his hands, rather than taking his tablets as prescribed. When staff challenged him, he took the tablets properly. Later that day, he went to the hostel office and asked if he could have his tablets again. He was seen to be very unsteady on his feet and had difficulty walking. Staff explained that he had already received his medication.

41. The man went again to see his GP, accompanied by his sister who wanted to know more about his condition. His GP explained that it was long term and that he would likely need medication on a daily basis indefinitely. The GP also explained that his noisy breathing and heavy snoring were essentially due to his being overweight. His GP referred him to the weight management nurse at surgery. According to his GP's records, he did not see him again.

42. In early October 2008, the man started to show other signs of mental deterioration. He started to talk to inanimate objects and to himself. He was also seen to be taking food from serving bowls at the hostel with his fingers. Other residents complained about how unhygienic this was for them.

43. When the man's family brought him back to the Approved Premises on 3 October, he was sweating profusely. Shortly after this he vomited in the

hostel office and complained of feeling unwell and being in pain (although the entry in his case records does not describe where he was having pain). Staff encouraged him to go to hospital, but it is not clear from the record whether he actually went.

44. On 8 October, the man's medication was reduced by a further 25mgs a day. That same day, his MAPPA risk level was increased to level 2.

45. The man who died was scheduled to go to the High Court in London for his Judicial Review hearing on 21 and 22 October. His solicitors asked if permission would be granted for him to stay overnight in London, outside of his curfew times. Permission for this was granted on 20 October. The man also asked for home leave for the festival of Diwali (in late October), but permission for this was refused. As I have said above, it later proved unnecessary for the man to travel to London as agreement had been reached between his solicitors and West Midlands Probation to hold an independent review into his care conducted by the Assistant Chief Officer.

46. Entries in the man's case record notes say that on 21 October he was seen talking to himself in the television room at the Approved Premises. Aside from this report, he seemed to be relatively settled throughout the rest of October and November. He was visited and interviewed by the Assistant Chief Officer on 4 November, but for most of the time his day consisted of going out with his family.

47. Evening duty staff noticed on 23 November that the man's door was ajar. When they went in to see him, he complained of having heartburn. He was given some milk, but then said he could not breathe. Staff advised that he sit up and cough to clear his chest, which he did to good effect. The staff reported in the daily contact sheet that he described the pain in his chest as 'like a tarantula or crab in his chest, creeping. Is this a repeat of his past medical condition, asthma, or is it the onset of a cold/virus or simply heart burn?' The staff monitored him over the next few hours, when he was seen to be asleep and snoring.

48. The man collapsed outside the games room in the Approved Premises on 27 November. He was put into the recovery position for a short while, but he insisted on sitting up in a chair. When he was in the chair, he complained of being hungry and was given a cheese sandwich. Staff contacted the local hospital by telephone, who advised they ring for the emergency services. Paramedics arrived at 10.07pm and checked his blood pressure and temperature (BP 143/88 [very slightly raised], temperature 'up a bit'). The paramedics gave him some paracetamol and advised he should go to bed. He did, and staff checked on him throughout the night. The record also indicates that staff called the out of hours doctor, who confirmed the advice of the paramedics.

49. The following day, the man's family were asked to take him to hospital with a copy of the paramedics' report from the previous evening. They did that, and

returned after two hours with a diagnosis of a chest infection. There is no record of any treatment being prescribed.

50. On 29 November, 30 November and 1 December, the case record notes all say that the man who died left the hostel with his father and that there were no issues or problems (save for a small argument between the two men about the man getting out of bed on time).

51. At 8.15pm on 1 December, the man's sister telephoned the Approved Premises to advise staff that he had been unwell and they had taken him to the local hospital. Later that evening a doctor from the hospital confirmed that the man was being kept in overnight.

52. The next morning, staff at the local hospital reported that the man was in a critical condition, having suffered a cardiac arrest during the night and was now located on the Critical Care Unit. Although medical staff at the hospital managed to resuscitate him at the time of his cardiac arrest, he had suffered massive brain damage and was not expected to survive.

53. At about 5.00am on the morning of 3 December, the man's life support machine was turned off. His family were with him at the time.

## ISSUES

54. The family's main concern centres around the change of licence conditions that required the man who died to reside at the Approved Premises, as opposed to being able to live at home. They also feel that the Approved Premises concentrated on the man's mental health problems, rather than any physical ill health issues he may have had.

55. From the very early days of the man's admission to the Approved Premises, it is clear that his family wanted him at home and had, in fact, been expecting him to live with them on his discharge from the mental health clinic. The unfortunate turn of events (the close proximity of the victim of the man's crime) made this impossible. The matter was of such grave concern to the family that they asked for, and were granted, a Judicial Review of his care by West Midlands Probation Area.

56. Shortly before the matter was to be heard in court, agreement was reached between West Midlands and solicitors acting for the man who died so that an independent review by the Assistant Chief Officer from Gwent Probation Area was undertaken. This resulted in a three stage plan that would have seen the man released from the Approved Premises to take up assisted residence somewhere suitable in the West Midlands. This plan was due to start in December 2008 but had not been implemented by the time of his death.

57. The inclusion in the plan of partnership working with mental health services, coupled with the ongoing support felt appropriate for the man by the mental health team, reflects his mental health needs. The mental health clinic team gave consistent support to the man throughout his time at the Approved Premises. The man's CPN, was available for advice to staff at the Approved Premises, and she was responsible for ensuring that his medication was always available for him. Without this support, he might well have relapsed into poor mental health and required readmission to hospital.

58. That having been said, one of the factors that has struck me is the lack of on-site clinical support. It is true that members of the mental health teams from the mental health clinic visited the man at the Approved Premises. Indeed, on the first night he arrived at the Approved Premises, the consultant psychiatrist visited personally to ensure that he understood the importance of abiding by his new licence conditions. However, in view of the serious health conditions that are present in residents of the Approved Premises where this man resided, it surprises me that there are no qualified nursing staff on the full time staff at the Approved Premises. Furthermore, it appears that at night time only two members of staff are on duty throughout the night. This can make it next to impossible for a resident to be accompanied by anyone other than a family member, or another resident, should they need to go to hospital. Indeed, even during the day this can prove difficult to arrange. In view of the vulnerability of the residents at this particular Approved Premises, I find this difficult to understand.

**West Midlands Probation Area should undertake a needs led assessment of the staffing levels at the Approved Premises, to include provision of sufficient staff in emergency situations.**

**West Midlands Probation Area should undertake a needs led assessment of the staffing skill mix at the Approved Premises, to include consideration of provision of specialist staff, such as nursing staff, on site.**

59. When my investigator visited on 12 December 2008, staff at the Approved Premises were quite clearly still affected by the man's death. He enquired if there were any staff support systems in place for such traumatic events. The staff at Approved Premises all said they knew they could call on outside counselling support, but thought this was something the manager had to organise. My investigator made enquiries of senior staff at West Midlands Probation Area and they responded very positively to the suggestion that staff at the Approved Premises needed support at this time. Despite their prompt response I feel it necessary to make a recommendation regarding staff support.

**West Midlands Probation Area should review procedures for supporting staff following any serious incident.**

60. The other concern of the man's family is that too much emphasis was placed on his mental health needs and not sufficient on his more general health. My own judgment is that the Approved Premises did all that they could have been expected to have done as regards his physical health needs. He was registered with a local GP and remained under his care throughout his time at the Approved Premises. The man was also reviewed on a number of occasions by the local acute hospital.

61. The man was last seen by his GP on 1 October 2008. According to hostel records, he was taken ill on no fewer than four occasions up to but not including his final admission to hospital. He was seen and treated by emergency services, and each time he was returned to the care of the hostel. It does not appear that any attempt was made to either take the man, or encourage his family to take him, to his GP during this time. However, I do not believe that this had a direct bearing on his death.

62. The man was a vulnerable man because of his inability to care for himself and comprehend even the simplest instructions. He required almost constant supervision, which he received from his family and the staff at the Approved Premises. He was under the care of the mental health services and a local GP. His weight was a constant problem which he found difficult to manage himself. Those around him tried hard to reinforce the GP's message that he needed to lose weight. Although he was getting some exercise and people around him were trying to discourage him from over-eating, he still managed to eat more than was healthy for him. This must have had an effect on his heart.

63. When the man became unwell on 1 December, he was admitted to the local hospital but suffered a heart attack there. Despite the best efforts of NHS staff, he did not recover from his heart attack and he died with his family around him on 3 December.

64. The questions I raise in this report about staffing at the Approved Premises are not directly linked to the man's death, which was from natural causes and could not have been prevented by the hostel. Nevertheless, I have concluded that there is a need to look at the resourcing of the Approved Premises given its specialist function. Vulnerable individuals like the man who died need services above and beyond those that might reasonably be expected to be made available for offenders living in the wider community.

## RECOMMENDATIONS

West Midlands Probation Area responded to each of the recommendations as follows:

West Midlands Probation Area should undertake a needs led assessment of the staffing levels at the Approved Premises, to include provision of sufficient staff in emergency situations.

This recommendation is partially accepted. There is no funding available to increase overall staffing levels at the approved premises, nor do we believe that the circumstances of the man's death support the case for more staff. However, the idea of introducing arrangements for emergency staff cover to be available for escorting people to hospital is an interesting one worthy of further consideration. There would be some cost implications, but they might be manageable within existing resources. We will do some work, therefore, to consider the financial viability of any such arrangements and how they might work across the seven Approved Premises in the West Midlands. Any learning accrued from that exercise will be fed back to PPU (NOMS) in order to inform other providers.

West Midlands Probation Area should undertake a needs led assessment of the staffing skill mix at the Approved Premises, to include consideration of provision of specialist staff, such as nursing staff, on site.

This recommendation is not accepted. The report notes that hostel staff did all that could be expected of them in respect of meeting the man's physical health needs, but concludes that nursing staff may be needed on site. This seems to imply that in general the physical health needs of the Approved Premises' residents may be greater than those of residents in other Approved Premises. This is an unproven contention. As the recent HMIP Thematic Inspection Report noted, the shifting profile of the Approved Premises population - notably in relation to age - may give cause to consider afresh how best to meet the health care needs of that group, but that would apply across the estate. This is a national issue that carries significant cost implications. More recently, the Bradley Report made some observations about the management of mentally disordered offenders within accommodation such as the Approved Premises. The report did not recommend the provision of on-site physical health care services as a matter of course, though did suggest that PCTs should consider commissioning specialised offender mental health and learning disability services. This proposal will doubtless be considered as part of the Government's response to Bradley. It seems unlikely that local PCTs would fund nursing provision in individual Approved Premises in the absence of national direction or guidance.

West Midlands Probation Area should review procedures for supporting staff following any serious incident.

This recommendation is accepted. Whilst the Area does have well-established provision for offering support to staff following a serious or potentially traumatic incident, it is of concern that staff were not automatically directed toward that

provision in the wake of the man's death. At the very least it may be that managers and staff need to be reminded of the provision, its purpose and the mechanisms by which it can be accessed.

**West Midlands Probation Area Comments on other matters**

*The absence of a clinical review*

There has recently been a PPO investigation into the death of a resident at another approved premise. These were not dissimilar circumstances in which there were ongoing health problems and intermittent admissions to hospital. In that investigation a clinical review was ordered to run alongside the main investigation. This was completed by a senior professional within the local NHS Trust. It was found to be invaluable in terms of their review of the health services provided within and outside the hostel environment, and their judgements as to the adequacy of that provision. The lessons learnt from this clinical review might have been mirrored in the man's case, and it is unclear why the decision was taken not to undertake such a review in this case. The result is that the focus is primarily on the hostel setting.

*Access to suitable supported move-on accommodation*

This was a crucial issue in the man's case. There is some lack of clarity regarding Mental Health Trust responsibility for move-on in cases where the offender's continuing health needs are paramount. It would be valuable for this to be defined. Whilst locally the availability of suitable accommodation is a matter for the Supporting People Commissioning Body (and its successor under the LAAs), there may be merit in liaison at national level between DH and the Government Dept now responsible for post-SP arrangements.

The man's family commented on the draft report as follows:

## Family issues and concerns:

The cause of death recorded on the death certificate was cerebral oedema and obstructive hydrocephalus which occurred gradually over many months. It did not happen over night. He had been taken to the hospital because he was not feeling well, and whilst waiting to be seen he collapsed with a heart attack. Complications resulted from attempts to revive him, and he was moved to an intensive care unit on a ventilating system. His breathing was through a ventilating machine, and his family was told that he was extremely ill. Hospital staff did not think he would recover as his brain had died during the heart attack due to the extremely extensive swelling in his brain.

Contrary to the draft report which says a post mortem was not carried out, the family obtained a post mortem of their own as they were so shocked and saddened by his death. The post mortem on the brain was carried out by a doctor, who specialises in neurological post mortems at a local hospital. At a meeting with him afterwards, he told the family that had the tumour been found and removed, our relative would not have died.

Our relative's initial collapse in February 2008 caused concern for his family and gradually his condition seemed to be getting worse in that he always seemed lethargic and extremely drowsy. When staff at the approved premises were told about this by the family, they were told to inform the psychiatric team from the mental health clinic. The family did this at the six monthly review of his care in June 2008. The consultant psychiatrist, community psychiatric nurse and the social worker were present at this meeting. Our relative spent most of the meeting asleep, but his family stressed that his condition was deteriorating. The psychiatric team agreed to arrange for a brain scan and do a 'full MOT' on him. The family feel there were a lot of words and no action that came out of this meeting as no scans or further checks were made concerning his sudden collapses in February and March (where he was taken to the hospital but it does not appear any details were sought from the psychiatric team).

Throughout the year, his condition continued to get worse – he always seemed to be over sedated. Communication of the family's concerns to the consultant psychiatrist did not seem to be listened to. His medication was increased which caused him to loose control of his bowels. The family feel that the consultant psychiatrist did not do anything about this, nor did he follow up with his promised further checks and scans, despite many please for help from the family.

The staff at the approved premises acknowledged that he was a vulnerable person who needed more support than most people. He was not able to communicate his health problems or his feelings of being unwell. It was therefore for the doctors and psychiatrists to do checks and find out what his problems were. Our relative did not deserve to die so suddenly having the illness that he did. He was neglected and did not get the medical help that he needed to prevent his death. The brain tumour did not occur overnight but was gradual. Tests and scans would have detected the growth and it was without doubt the job of the medical team to do those checks. However, on 2 December 2008 it all proved too late and he died after suffering a massive heart attack. Although his heart was working with the aid of a ventilator, his brain had died due to the extreme swelling within and he could not be saved.