

**Investigation into the death of a prisoner at an Approved Premises in the
Thames Valley Probation Area in November 2004**

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

October 2005

This is the report of an investigation into the circumstances of the death of a prisoner. The man who died was a resident at an Approved Premises which is managed by the Thames Valley Probation Area.

The man was aged 61 when he died at the hostel in November 2004. The post mortem report states that he died from ischaemic heart disease and chronic artery atherosclerosis. The Coroner has decided that there will not be an inquest into the man's death.

Since 1 April 2004, my office has been responsible for investigating all deaths of Approved Premises residents, including those due to natural causes. One of my investigators conducted the investigation. Although no formal statements needed to be taken, I am grateful for the assistance and co-operation that she received from staff at the approved premises including the hostel's General Practitioner.

During the course of this investigation, the man's brother, with whom he was in touch infrequently, was contacted by one of my family liaison officers. There were no issues that the man's brother thought I should explore.

As this report shows, the man required a lot of help from staff at the hostel as he did not have the necessary life skills to look after himself adequately. It is evident that hostel staff, and his supervising probation officer, worked very diligently with the man and supported him in many ways. Whilst robustly monitoring and challenging any offending risk, they also engaged positively and thoughtfully with him. They provided a kindly and supportive environment for the man during the last months of his life.

This investigation has highlighted the good practice shown to the man by a number of probation staff. I commend them for that. I make two recommendations.

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Prisons and Probation Ombudsman

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Summary

The man who died was released from HMP Bullingdon on 2 August 2004, his non-parole release date. He was to be supervised on licence until 2 December 2004. Given that he was going to be homeless on release, and considered to present a degree of risk, a place was found for him at the Approved Premises. The man had a borderline learning disability and struggled to cope with the demands of day-to-day living.

On 9 August, following a referral from the G.P. who serves the hostel, the man attended the emergency surgical unit at a hospital in Oxford. He had been experiencing severe pain in his right leg. Hospital staff wanted to admit him overnight for further tests. The man, who was very fearful of hospitals and medical treatment, declined to be admitted and discharged himself.

Despite being diagnosed with a blocked artery on 8 September, the man refused to undergo an operation to remove the blockage. All attempts to persuade him to do so, or even to attend hospital for the necessary pre-operation tests, were resisted.

He collapsed and died at the hostel in early November 2004. Following a post-mortem, the cause of death was given as ischaemic heart disease and chronic artery atherosclerosis.

The investigation found members of staff at the Approved Premises, and his probation officer, gave a high level of care to the man who died. Staff and residents at the hostel were distressed and saddened by his death. The report makes one recommendation in relation to record keeping and one designed to draw the good practice to wider attention.

Background information

Approved Premises, Oxford

Approved Premises, formerly known as Probation & 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 persons granted bail in criminal proceedings and in connection with the supervision and rehabilitation of persons 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.

The Approved Premises in Oxford can accommodate 18 male offenders, aged 18 and over, in a 12 room hostel. There are an additional six rooms in two self-catering units. Residents are provided with breakfast and evening meal daily.

The hostel operates a keyworker system, with one member of staff taking a particular interest in each individual resident. The hostel manager is a Senior Probation Officer (SPO) and the deputy is a probation officer. There are five assistant wardens who staff the front office, run projects, and work overnight on a rota basis. Two staff sleep in the hostel overnight.

At the time of the man's death, staff members had been employed at the hostel for some time and were familiar with the residents. The hostel made only limited use of agency staff.

A curfew operates from 11:00 pm until 6:00 am and there are daily morning meetings at 10am. The hostel staff run a daily log book for recording day to day events and individual case records. There are regular staff meetings.

Residents are referred to a local surgery if they need to see a doctor.

Events leading up to the death of the man

The man who died was visited on a number of occasions by his probation officer whilst in custody and a referral was made to the Approved Premises. Upon his release on 2 August 2004, he was collected from Bullingdon by his probation officer and taken in person to the hostel. He arrived there with no personal possessions and staff immediately applied for a grant for clothing via the Probation Trust.

Prior to the man's release, his probation officer had started to make referrals in relation to his long-term housing needs. There was a concern that he might be vulnerable to bullying at the hostel and staff monitored him closely.

Throughout his stay at the hostel, the man presented with a variety of problems as he struggled to manage the demands of day-to-day living. Staff helped with all these problems as well as managing his risk factors in relation to offending. He took inadequate care of himself and staff were concerned about his unhealthy eating habits.

On 9 August, the man collapsed in the hostel and his leg went numb. An appointment was made with the General Practitioner who serves the hostel, that afternoon. The G.P referred the man immediately to the surgical assessment unit at the hospital.

He was seen at the hospital and staff wanted him to stay overnight for further tests. However, he became agitated and discharged himself against medical advice at 7:00 pm. The man returned again to the hospital at 10:00 pm saying he needed money for a taxi. Hostel staff had earlier contacted the hospital as they were concerned that they had not heard from him. The man returned to the hostel that evening. Hostel staff were told that, should he experience further problems, they should immediately phone for an ambulance. The man expressed to staff his extreme fear of doctors, hospitals and any kind of medical treatment.

On 10 August, the G.P contacted the hostel to say that the man would need treatment for his leg. On 12 August, he was found crying outside the hostel due to the pain he felt in the leg. The man went to see the doctor on 13 August. Neither hostel records nor his individual case file indicate what the outcome of this appointment was.

At a keyworking session, on 15 August, he spoke again about his fear of hospitals. Concern was also expressed about the man's poor eating habits and that he appeared to be suffering from incontinence. Staff liaised with the GP and a referral to the Community Assessment Team was completed.

During a keyworking session on 1 September, the man continued to maintain that he would not agree to an operation. By now he was walking with the aid

of a stick. His keyworker tried to persuade him to have an assessment to find out what the problem was. On 8 September, the man and a member of the hostel staff attended an appointment at the Vascular Clinic at the hospital. He agreed to return for a scan on 15 September. A blockage was found and the man was told that he would have to have an operation to remove it. He remained adamant that he would not have an operation.

On 21 September, staff at the hostel became aware that the man was taking additional aspirin on top of the aspirin prescribed to him. Staff immediately contacted the G.P who advised that he should not take any more that evening. Staff continued to monitor the man's use of medication.

On 9 October, the man became distressed after receiving a letter outlining the results of his scan. They had found a blocked artery which would require him to have a local anaesthetic to have the artery stretched. The man needed to be admitted as a day patient. After considerable persuasion, he finally agreed to attend the hospital to speak with the author of the letter to discuss the procedure. However, on 12 October, he received a further letter to say that he would need to go for some tests prior to the operation. The man refused to go and the hospital was telephoned and told to put the appointment on hold.

At his following keyworking session on 13 October, his keyworker again tried to explain to him the consequences of not having the operation. Again, the man refused to consider it. On 15 October, he agreed to attend a podiatry appointment with a member of staff. Hostel records indicate that it was a struggle for the nurse to provide any treatment for his foot. At a keyworking session on 23 October, he would not talk about his leg.

The man was visited by his probation officer on 3 November and records indicate that he said his leg was not hurting as much and he was not limping so badly.

Events on the day he died and thereafter

As was usual, the man was in and out of the front office at the hostel all afternoon the day he died. At 7:20 pm, he was in the office talking to the two assistant wardens on duty that night staff. The man mentioned that he was feeling better and was walking without the aid of his stick. He left the office to go into the communal pool room.

At 7:30 pm, another resident came into the office and said that the man had collapsed. Both assistant wardens immediately went to the room where they found him unconscious on the floor. One of the assistants went to telephone an ambulance and the other made sure that the man's airways were clear and placed him in the recovery position. Two ambulance crews arrived within ten minutes and assessed that the man was still breathing but that his pulse was very faint. Despite resuscitation attempts, he was pronounced dead at 8:13 pm.

The hostel manager also arrived quickly. Given that the man had died in a public area of the hostel, residents had been around and had been aware of what had happened. The manager undertook a full debriefing of staff and residents and remained with staff on duty until the following day.

Many of the staff from the hostel attended the man's funeral along with a number of residents, who had also made a collection. Flowers were sent by the Thames Valley Probation Area.

Conclusions and Recommendations

Some events of significance were not always recorded in the man's individual case records. However, judged overall, I have been very impressed by the care, compassion and professionalism shown by the staff who were responsible for the man who died. It was evident to my investigator that the man was very liked, and that staff at the hostel had done all that they could to support the man during the last months of his life.

I am also struck by the quality of contact offered by the man's probation officer while he was in prison and the fact that he was taken in person to the hostel on his release.

I make two recommendations:

The hostel manager should remind all staff that significant events should be transferred from the day to day log and recorded in the individual case records.

A copy of this report should be drawn to the attention of the man's probation officer, to the staff at the hostel, and to the members of the Thames Valley Probation Board.