

Investigation into the circumstances surrounding the death of a
man at a hostel in the Greater Manchester Probation Area

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

July 2006

The man at the centre of this report died in his room at a hostel in the Greater Manchester Probation Area, apparently as a result of Dihydrocodeine toxicity. He was 38 years old and had been released from prison at 4:00pm the previous afternoon with a quantity of prescription medication, including DF118 (Dihydrocodeine). He arrived at the hostel at 10:25pm that evening.

The loss of any family member is distressing, but especially so in the circumstances described in this report. My investigators and I offer our sincere condolences to the man's family and friends.

One of my investigators, assisted by another, carried out this investigation. I wish to thank the manager of this Approved Premises for making the necessary facilities and information available to them. I am also grateful to the Governor and staff at the prison.

In the course of the investigation, I asked for a clinical review to be carried out into the care and treatment received by the man whilst in custody. I am grateful to the Assistant Director of Quality and Nursing, Norwich Primary Care Trust (PCT), for her assistance.

My report – a copy of which should be shared with the NOMS Safer Custody Group because of the implications for the Prison Service – makes a total of eight recommendations, six of which come from the Clinical Review. I have been particularly pleased to commend a Community Psychiatric Nurse based at the hostel for her efforts to resuscitate the man. Her efforts in very trying circumstances were a credit to her dedication and professionalism.

Stephen Shaw CBE
Prisons and Probation Ombudsman

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Summary

1. The man was due to be released on licence from HMP Norwich on 15 November 2005, with a condition that he lived at a hostel in the Greater Manchester Probation Area. This hostel is situated near Manchester, and is approximately 213 miles from Norwich. Due to the distance involved, the man would have been expected to arrive sometime in the early afternoon. However, on 14 November, the Deputy Manager at the hostel received a telephone call from the probation office in Atherton (Wigan) informing him that the man had been given a day back on his sentence and that the re-calculation of his release date meant that he was to be released that day. Later that afternoon, a further telephone call was received by the Deputy Manager from the Duty Officer at Atherton saying that the man had been released at 4:00pm and was making his way to the hostel that evening. Staff at the hostel were concerned at the lateness of this release from prison, as they were not certain that the man would arrive before the curfew time of 11:00pm. In the event, he arrived at 10:25pm.
2. On his release from Norwich prison, the man was given a rail warrant to purchase a one way rail ticket to Manchester and sufficient cash to purchase a public transport ticket onwards. It is believed that he travelled to the hostel via Manchester Piccadilly Railway Station and public transport, but this cannot be confirmed.
3. The man had a number of medical problems, including a diagnosis that he was schizophrenic. He had also developed deep vein thrombosis which required him to take medication on a daily basis to control the symptoms. At the request of the Community Psychiatric Nurse (CPN) based at the hostel, he was released from prison with sufficient prescribed medication to last him one week. This was because the man would not be placed onto a local GP list for some days and would therefore be unable to access prescribed medication.
4. A condition of residence at the hostel is that residents are required to hand in all medication to the staff. They in turn store the medication in individual lockers until dispensed. On arrival, the man refused to hand over his medication to the night staff and became aggressive. Due to staffing levels being at their lowest, they decided not to challenge him that evening preferring to deal with the matter the following morning.
5. On 15 November, the man left the hostel early in the morning and told the staff that he was going to see his son. He returned in the afternoon, along with three visitors, and became aggressive when told that he could not take his visitors to his room. He was seen to be swaying and looking intoxicated, and due to his aggressive behaviour the hostel manager began procedures to revoke his licence.
6. The man's visitors left the building at approximately 3:00pm. Because he was experiencing difficulty in finding his way back to his bedroom, a member of staff accompanied him.

7. At approximately 4:20pm the hostel manager received confirmation from the Home Office, Licence Recall Section, advising him that the man's licence had been revoked and that the police would be instructed to re-arrest the man and return him to custody.
8. At about the same time, whilst carrying out a routine check of the building, a member of staff entered the man's bedroom and found him unconscious on his bed. Resuscitation procedures were started and emergency paramedic assistance requested. Regrettably, the paramedics were unable to resuscitate the man and pronounced him dead at 5:00pm.

Conduct of the Investigation

9. Once my office had been notified of the man's death, the investigation was allocated to one of my senior investigating officers, another investigator assisted.
10. The senior investigator opened the investigation at the hostel on 21 November, where he met and received a briefing from the hostel manager. During the opening meeting, he visited the room where the man had been found and familiarised himself with the premises.
11. The hostel manager made a number of documents relating to the man available to my investigator. These were kept secure pending the investigation interviews commencing on 12 December. A number of hostel staff were interviewed, plus the Community Psychiatric Nurse (CPN) and a visiting psychiatrist. The investigator also met a number of residents who had asked to see him. They assisted by providing their own observations of the man's behaviour during his short time at the hostel.
12. The Assistant Director of Quality and Nursing at Norwich PCT was asked to undertake a clinical review into the care and treatment the man received whilst in prison custody and to report her findings to my investigator. The man's prison medical records and other medical documents held by the CPN were forwarded to this Assistant Director.
13. As the man had been released from HMP Norwich on the day prior to his death, it was necessary for the investigator to visit the prison. On 10 January 2006, the investigator held a meeting at the prison with the Assistant Director to discuss the clinical review. He also met with a seconded prison Probation Officer, prison Executive Officer and Segregation Unit staff. Once he had completed his investigation work at Norwich, he and his assistant met with the Governor and briefed him about what had been identified.
14. One of my Family Liaison Officers (FLOs) contacted a member of the man's family and explained my role in investigating the circumstances of his death. The man's next of kin did not raise any concerns regarding the care and treatment the man had received, and believed he might have died as a result of deep vein thrombosis (DVT) which he was aware had been diagnosed. The man's family said they had been looked after well by staff at the hostel when they went to collect his property.

HMP Norwich

15. Norwich prison holds convicted and remand prisoners, including adults and young offenders. It is designated as a local prison and serves the courts of East Anglia. The Certified Normal Accommodation is 591, and the jail has an Operational Capacity (total crowded capacity) of 823.
16. A car park and road divide the prison. The majority of the population is accommodated in the main prison complex. The other section of the prison accommodates young offenders and the Healthcare Centre, which also includes a dedicated elderly prisoner unit. The Healthcare Centre has outpatient facilities, as well as in-patient beds for prisoners with physical health problems and severe and enduring mental health needs.

Multi Agency Public Protection Arrangements

17. Multi Agency Public Protection Arrangements (MAPPA) are procedures designed to manage high-risk offenders in the community. There are three levels of MAPPA:

Level three

Anyone subject to level three is considered as being the highest risk case, where more than one agency will take responsible for the management of the person concerned.

Level two

As with level three, anyone who has been identified as falling into the level two heading would be managed by more than one agency, very often limited to Probation and the Police. However, it is possible to involve more agencies if the circumstances warrant it.

Level one

An offender on level one MAPPA is normally managed by a single agency; this is the lowest monitoring procedure available under the MAPPA system.

18. In addition to the requirements of MAPPA, HMP Norwich has introduced a filter group into their procedures. The group initially considers all cases where the nature of offending or custodial behaviour gives cause for concerns regarding public protection. A multi disciplinary group, comprising the Seconded Prison Senior Probation Officer (Chair), Public Protection Clerk, Senior Officer responsible for Observation Classification Allocation and Sentence Management, the Security Manager, Healthcare representative and drugs worker, meets to discuss all cases.
19. Any prisoner identified as falling into the category of MAPPA level one is automatically filtered out of the meeting. All others are considered to determine whether they should be placed in level two or three. Once the filter

group has made its decision, the names of anyone considered are passed to the Inter Departmental Risk Management Team (IDRMT), chaired by the Head of Resettlement. In addition to those attending the filter group, the prisoner's personal officer attends. The purpose of the IDRMT is to carry out a further risk assessment and decide on the appropriate level of MAPPA.

20. Although MAPPA arrangements at Norwich are well embedded, it was evident to my investigator that a number of core groups of staff were not attending the meetings on a regular basis. He raised this with the manager responsible for MAPPA, and she was able to assure him that she was addressing the problem with those concerned. The Governor also gave an assurance that the lack of attendance was being dealt with.
21. Norwich has developed strong links with the Strategic Management Board for the county, and now holds the county MAPPA meetings at the prison. This is good evidence of the Governor's commitment to MAPPA and the links that he is developing.

Calculation of Sentence

22. Once someone has been sentenced to a period of imprisonment, a suitably qualified person calculates the date of release. As the calculation is frequently complicated, it is quite often allocated to a manager in the prison's Discipline Office. When the calculation has been undertaken, the dates of release are confirmed to the prisoner and entered onto the prisoner record. Fourteen days prior to release, a further check of the calculation is carried out and, providing there are no discrepancies, the prisoner is released on the scheduled date. Changes to the original release date can take place throughout the sentence (these could be as a result of appeal against length of sentence, or time identified as police custody time).
23. At Norwich, any change to the calculation of release date is carried out within 48 hours of the prison being notified. However, Prison Service Standard 56 "Sentence Calculation" under the heading "Re-calculations and changes to release dates", gives the following instructions: *Any re-calculation following adjudication, or changes to a prisoner's release date for any other reason, are carried out and notified to the prisoner within one working day.*

Segregation

24. Prisoners may be segregated under Prison Rule 45 for reasons of Good Order or Discipline (GOOD) when there are reasonable grounds for believing that their behaviour is likely to be so disruptive that keeping the prisoner on ordinary location is unsafe. In all cases of segregation under GOOD, the Governor can authorise the prisoner's segregation for a period not exceeding 72 hours. After this time, a Segregation Review Board must re-consider the segregation and either approve the decision to continue segregation or consider a phased return to normal location. If continued segregation is recommended, a member of the Independent Monitoring Board (IMB) must

sign the GOOD document and note that they either agree or disagree with the decision.

The Hostel in the Greater Manchester Probation Area

25. Approved Premises, formally 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 an enhanced level of residential supervision in the community as well as a supportive and structured environment.
26. This hostel is a 29 bed building, owned and managed by the National Probation Service. It is situated approximately six miles from Manchester City Centre.
27. The hostel was built in the 1960s as a children's home, but was purchased in the 1970s by the Probation Service, and is one of seven Approved Premises in Greater Manchester. Six of the premises accommodate adult males, whilst the remaining building accommodates females.
28. The resident group at the hostel consists of males aged 18 years and over and comprises those on bail, those subject to Community Orders, and offenders subject to a licence having been released from the custodial element of a prison sentence. Offenders in the latter category currently make up approximately 70 per cent of the population.
29. The majority of the accommodation is single rooms, but there are two double rooms. Additionally, there are facilities for physically disabled residents.
30. Approved Premises offer a way of managing offenders, assessed as being of high risk, in the community. This hostel works very closely with other agencies and organisations such as the police and local community drug teams. Each resident is subject to conditions within their court order or licence which enable staff to monitor and manage their behaviour. The enforcement of order and licence conditions is of paramount importance in order to protect the public. Residents are also subject to rules which include a curfew from 11.00pm to 7.00am. If a resident breaches the rules, action could be taken to withdraw the bed space. Enforcement action would also be taken, as the offender would then be unable to comply with the residence condition which is part of the court order and licence
31. The hostel offers a programme of rehabilitation which consists of work on offending behaviour, education and a full range of other purposeful activities. Each resident is assigned to a Key Worker. Those subject to statutory supervision by the Probation Service (i.e. all licences and those subject to Community Orders) will also have regular meetings with their Probation Officers and other staff in their home districts. They may also be required to be involved in accredited offending behaviour programmes, as well as other interventions designed to tackle their behaviour.
32. The staffing profile at the hostel is made up of one Senior Probation Officer, one Probation Officer, four Assistant Managers, two Weekend Supervisors, five Night Supervisors and one Hostel Administration Officer. There is always

a minimum of two staff within the hostel 24 hours a day. Out of normal office hours, a Senior Probation Officer is always on call. The hostel also has the benefit of a full-time Community Psychiatric Nurse being based there. Other mental health support staff, as well as three Consultant Psychiatrists, regularly visit the hostel to see individual residents under their care.

Key Findings

Events prior to 15 November 2005

33. Due to the nature of the man's offending history and behaviour, he was monitored under the MAPPA arrangements level three until 21 April 2005. Thereafter, he was reduced to level two.
34. In May 2005, Manchester Probation Service's Central Admissions Unit made a referral to the hostel at the centre of this report for the man to be allocated accommodation there on his release from prison. However, before making a decision, the manager of the hostel requested further information from the Field Probation Officer (now retired) regarding the man's behaviour and health at the time. The manager also asked for information about the man's mental health, and deferred his decision until he had that information. He followed up the request for information in September, as he had not received anything.
35. On 28 September, he received a telephone call from the Field Probation Officer informing him that the man was refusing to be accommodated in Approved Premises in Greater Manchester. He was told that the man wanted to go to North Wales to be near to his mother. However, neither the Probation Area in North Wales nor the Approved Premises initially identified would accept him. It is not known for certain why the Probation Area had taken a decision not to accept him. However, the manager of the Greater Manchester Area hostel believes that it may have been due to there being no places available at the Approved Premises in North Wales and that a child was living at his mother's address.
36. On 19 October, the manager of the hostel in the Greater Manchester Probation Area received an e mail from the Community Psychiatric Nurse informing him that the man was to be assessed by a member of the Mental Health In-Reach team.
37. There are a number of entries in the man's prison records to show that he had been a difficult man to manage: intimidating and threatening prison staff, medical staff, and, on at least one occasion, a doctor. The Assistant Director of Quality and Nursing at Norwich PCT says in her clinical review "*...there is documented evidence that [the man] was abusive, threatening and intimidated staff within prison and the community. He often bullied and manipulated staff for prescriptions. There is no evidence to support the demand for increase of medication was based on any clinical need. Healthcare staff need to be supported to ensure healthcare is provided on health needs, not demands.*" A further entry instructs healthcare staff that the man was not to be seen by a certain doctor, as the man had been aggressive and threatened to hit them. The medical record contains an entry from another doctor which states that he would not be intimidated by the man into giving him medication.
38. As recently as October 2005, the man had been placed on closed visits after attempts had been made to supply him with drugs through the post. However, the name of the person who sent the drugs in to him remains

unknown. The man told prison staff that it was someone wanting to get him into trouble and nothing to do with him. (A closed visit prevents the prisoner and visitor from having any physical contact, but does not restrict them from seeing or talking to each other.)

39. The manager of the hostel followed up the Mental Health In-Reach assessment on 1 November and spoke to the man's new Field Probation Officer. This man told him that the man was no longer interested in going to North Wales and that he appeared content to be accommodated in Greater Manchester.
40. As a result of his custodial behaviour, the man had been located in prison segregation units on a number of occasions, the most recent being 1 November 2005. This was after he refused to return to his own cell at the end of the evening association period.
41. On this occasion, the review board met on 2 November and recommended the continued segregation. The IMB member has signed to indicate agreement to the decision. During his period of segregation, the man appears not to have caused any further problems and his behaviour suggests that he was content to be in the segregation unit.
42. On 8 November, the manager of the hostel received a brief report from the Community Psychiatric Nurse regarding the man's current mental health. This told him very little. However, from the information contained in the report and a later conversation with the Community Psychiatric Nurse and the man's new Field Probation Officer, he made an assumption that the man was more settled and that his health was not causing any problems.
43. Later that day, the manager of the hostel received a telephone call from the Senior Probation Officer at Atherton Probation Office, asking him for a decision as to whether he would accept the man or not. At interview, the manager said that he was unhappy at the lack of information available to him but, due to the man's imminent release from prison, he felt that he had little option other than to make a decision to accept him.
44. Because of his imminent release, the man was de-registered to MAPPA single agency management, which meant that the Probation Service would be solely responsible for supervising him once he was released from prison. The Central Admissions Unit for the Greater Manchester Probation Authority, Approved Premises Division, receives all Approved Premises referrals and ultimately makes decisions regarding the acceptance or rejection of such referrals. This decision may be taken in discussion with individual Approved Premises Senior Probation Officers, where this is deemed appropriate. Once the decision is taken the Approved Premises Senior Probation Officer becomes involved in planning and making arrangements which may relate to the individual offender. However, it was clear to the investigator that the Senior Probation Officer (the hostel manager), had not been included in the discussions in this case.

45. Following a request to Norwich Healthcare from the CPN at the Greater Manchester hostel, a list of the man's prescribed medication was faxed to the hostel on 8 November.
46. On 9 November 2005, the man submitted an application to the Governor asking for time held in police custody to be taken into account when calculating his release date. The dates he asked to be taken into account were 7 and 8 January 2005, whilst he had been in custody at Swinton Police Station.
47. That same day, at 1:15pm, a member of staff in the prison's Discipline Office faxed the man's request to Swinton Police Station for their consideration. Later that day, an officer in Swinton Custody Office faxed back to Norwich confirmation that the man had been in their custody from 11:04pm on 7 January to 5:40pm on 8 January 2005. This meant that the time should have been calculated as part of the original sentence and the release date of 15 November was wrong.
48. Although the fax was received at Norwich at 11:57pm, which was clearly too late to be actioned that day, the evidence shows that the recalculation of sentence was not carried out until 14 November. The Discipline Officer Manager was certain that her staff would have processed the change on their return to work on 10 November or 11 November at the very latest. However, neither she nor my investigator could find any supporting evidence to indicate that the notification was dealt with any earlier than 14 November.
49. The change to the man's sentence calculation meant that, instead of being released on 15 November as originally planned, he was to be released with immediate effect on 14 November. In fact, he was not released until 4:00pm that day.
50. My investigator asked why the man was released so late in the day. He was told that it was possibly due to a serious, ongoing incident at the prison which resulted in some difficulties with releasing prisoners. However, I judge it more likely that the incident had no bearing on the lateness of this release and that it was a result of the sentence recalculation not being carried out until the morning of 14 November. This meant that once the new release date had been recognised and confirmed, the prison was required to bring forward the release arrangements by one day and re-arrange travel documents, reissue the man's licence and prepare his property - all of which takes time to arrange.
51. My investigator discussed the delay in recalculating the man's sentence with the Governor of Norwich and I am satisfied that the delay was a genuine procedural mistake. As a result of this investigation finding, the Governor has introduced new safeguards to ensure the same mistake cannot be repeated.
52. The investigator has confirmed that Atherton Probation Office was not notified by the prison until the early afternoon that the man was to be released that day. This meant that they had to re-arrange their supervision plans for him

and agree the new licence. Fortunately, the Greater Manchester hostel was able to accommodate the imminent arrival. It would otherwise have been necessary to make emergency accommodation arrangements.

53. After his release at 4:00pm, the man was required to make his own way to the hostel, some 213 miles from Norwich, and to be there by 11:00pm or otherwise be in breach of his curfew time. It is evident that no special arrangements were made by either the prison or Probation Service to transfer the man to the hostel, and it is to his credit that he managed to travel the distance and arrive before the curfew time.
54. My investigator discussed the lateness of the release and travel arrangements with the Governor. The Governor was clearly unaware that this had occurred and gave examples of how he had facilitated late releases by paying for individual taxis to take prisoners to their destinations, irrespective of distance. It was clear to the investigator that the Governor's expectation was that his managers should be able to identify late releases, and if necessary, arrange suitable transport. He said that he would ensure that his managers knew what he expected from them for any future similar circumstances. I welcome his approach.
55. The late change of release date caused a number of difficulties, affecting not only the man himself, but also the Probation Service and the Greater Manchester hostel. However, I am satisfied that none of these difficulties resulted in the man's death.
56. At the request of the CPN at the hostel, the man was discharged from prison with seven days supply of prescribed medication. My investigator found that there was confusion at the hostel regarding the amount and type of medication that he had been given when released from prison, and that there was a suggestion from the hostel that they were unaware of the man's medical condition. The prison pharmacy records show that the list of medication given to the man when he was released was faxed to the hostel that afternoon. The case notes at the hostel show that the fax was received at 13:40pm the same day, and that an entry had been made on the fax by the CPN at the hostel to show what each medication was required for. I am therefore unable to explain why staff at the hostel were uncertain as to the amount of medication and its purpose, as the case notes clearly provide that information.
57. The man arrived at the hostel at 10:25pm. He was immediately given a short induction session and asked to sign the induction document to acknowledge that he had received the briefing. Additionally, he was asked to hand in all of his medication but he refused and became aggressive towards the member of staff. Because there were only two staff on duty, they took the decision not to challenge the man at that time but to wait until the morning. The night staff made notes in the records about this behaviour and how intimidating he had been at the time. The man did hand in a small amount of his medication which was then stored in a cupboard.

58. My investigator discussed with the hostel manager the necessity and value of trying to carry out an induction programme at that time of night with someone who had travelled such a long way and was probably tired. He said that it was normal to carry out the induction as soon as possible after arrival, but agreed that in this man's case it might have been better to have left the majority of the induction process until the following day.
59. Soon after arriving at the hostel and following the induction meeting, the man went into a communal area where he met with a number of residents. The investigator spoke to residents who met the man that evening and one said that he immediately began asking for drugs and wanted to know where he could access drugs in the local area.

15 November 2005

60. Shortly before 6:00am, the man went to the office and handed over some more of his medication to the staff, including two boxes of penicillin and diazepam. He told the staff that he was going to see his son and then left the building. The staff made further entries in the records describing him as intimidating towards them.
61. Due to the concerns that the man had not handed in all of his medication, the CPN along with a visiting psychiatrist looked in his room for any further medicines. A quantity of warfarin tablets were found and removed and locked in the cupboard containing the man's other medication.
62. At 1:30pm, the man returned to the hostel, accompanied by his ex partner, stepson and a male friend. He wanted to take his visitors to his room and became aggressive and intimidating when told that visitors were not allowed in residents' rooms. Staff became sufficiently concerned about the man's behaviour that the manager of the hostel was asked to attend the reception area and speak to the man.
63. The manager noticed that the man was swaying and said that he looked intoxicated. He asked him if he had been drinking, and the man told him that he had had three cans of Foster's lager. The manager told the man that visitors were not allowed to enter residents' rooms, but that they were welcome to use the communal rooms on the ground floor. The man continued displaying aggressive behaviour towards staff, but calmed down when his ex partner intervened.
64. The man and his visitors went into one of the communal rooms but he was soon seen wandering alone around the building, looking lost. At one stage he was so disorientated that he went through a fire door, activating the fire alarm. His visitors left the building at 3:00pm.
65. Due to what has been described as aggressive and intimidating behaviour, the manager returned to his office to commence re-call procedures as he felt the man was unsuitable to remain at the hostel.

66. The man's bedroom was in an annex to the main building. As he was having difficulty finding his way back to his room, a member of the hostel's staff accompanied him. The man went into his room, closing the door behind him. The member of staff returned to his own duties and was the last person to see him alive.
67. At approximately 4:20pm, the Home Office Licence Recall Section responded very quickly to the hostel manager's request and confirmed that the man's release on licence had been revoked. The Licence Recall Section sent confirmation to New Scotland Yard for them to inform the local police and instruct them to re-arrest the man and return him to custody. The man himself was not aware that recall procedures had commenced and had been approved.
68. At about the same time, a member of staff began a routine check of all the bedrooms and accommodation areas. When she arrived at the man's bedroom some minutes later, she knocked on the door but could not obtain any response from him. She entered the room and saw him laying face down on his bed, with his arms outstretched above his head. She called out his name several times but he did not respond. She left the room and summoned the assistance of colleagues and then returned to the man's room.
69. One of the people to respond was a CPN, based at the hostel. She checked for signs of life but could not find any, and so asked a member of staff to ring for an ambulance. The CPN commenced Cardio Pulmonary Resuscitation (CPR).
70. The member of staff dealing with the emergency telephone call began telephoning for an ambulance at approximately 4:35pm. But despite the operator answering the 999 call immediately, he experienced difficulty in getting through to the ambulance service as they did not answer the telephone. It appears that the demand on the ambulance service was high at that time of day.
71. Whilst performing mouth to mouth resuscitation, the CPN attending to the man swallowed a quantity of his body fluid. This accident appears to have occurred due to the face mask which had been given to her folding over during the resuscitation attempt, allowing fluid to pass from the man's mouth to hers. After cleaning her mouth with water, she returned to her patient and continued to give mouth to mouth resuscitation. She demonstrated an extraordinarily high level of care and dedication by returning to the man to continue mouth to mouth resuscitation and is a credit to her profession.
72. Paramedics arrived at 4:55pm. After completing their own checks, they stopped any further attempt to resuscitate the man and pronounced him dead at 5:00pm.

Clinical review

73. The introduction to the clinical review shows that, following a meeting with my investigator on 10 January, the Assistant Director of Quality and Nursing at Norwich PCT examined the following documentation and information to compile her report:
- The man's Clinical Record
 - HMP Norwich Local Guidelines for Healthcare Reception Screening
 - Copies of notes from Mental Disordered Offenders Team at the hostel
 - Copies of notes from a doctor at Bolton, Salford and Trafford Mental Health NHS Trust
 - Copies of notes from a CPN at Bolton, Salford and Trafford Mental Health NHS Trust
 - Resuscitation Council (UK) Guidelines
74. Additionally, the Assistant Director held further informal discussions with the Head of Healthcare at HMP Norwich, with the Mental Health In-Reach Team and with my investigator.
75. In her review, the Assistant Director says that the man's medical records show that he had been known to Bolton, Salford and Trafford Mental Health Trust since 1991, and had received inpatient and mental health outreach services at various times. She said that the man had a history of intimidating and aggressive behaviour and had been diagnosed as schizophrenic. He also had a history of substance misuse and self harm.
76. The review notes that the man was abusive, aggressive and intimidating towards medical staff when he did not receive medication at the level he wanted. He would request sleeping medication, Dihydrocodeine, painkillers and sedatives. Additionally, the medical records show that he was often non-compliant with blood tests to monitor blood clotting times which were necessary in order for him to be prescribed a therapeutic dose of warfarin. The man's medical records show that he would threaten to harm himself if he was not given the medication that he felt he required.
77. My investigator asked the clinical reviewer to comment on the resuscitation problems, specifically the resuscitation equipment, available at the hostel. I am extremely grateful for her opinions and recommendations. My report does not imply that the man had any of the following illnesses and is simply an explanation of the resuscitation issues identified by the Resuscitation Council. The Assistant Director of Quality and Nursing at Norwich PCT says:
- *The Resuscitation Council UK updated their 'Resuscitation Guidelines' in 2005. Within the section on risks to the rescuer it states, "There have*

been few incidents of rescuers suffering adverse effects from undertaking CPR, with only isolated reports of infections such as tuberculosis (TB) and severe acute respiratory distress syndrome (SARS). Transmission of HIV during CPR has never been reported.”

- *Regarding barrier devices during CPR; they go on to state that there have been no human studies to address the effectiveness of barrier devices during CPR however laboratory studies have shown that certain filters, or barrier devices with one way valves, prevent oral bacteria transmission from the victim to the rescuer during mouth to mouth ventilation.*
- *Regarding airway management, the Resuscitation Council UK 2005 state within their ‘Guidance for Clinical Practice and Training’ that expired air ventilation is the minimum standard expected and should be performed with a pocket mask incorporating a one way valve to prevent secretions from the patient reaching the rescuer. Other simple airway barrier devices do not permit ventilation to be performed as effectively as the pocket mask and many provide significant resistance to lung inflation. Both of these documents can be found on the Resuscitation Council UK website.*

Post Mortem

78. A registered medical practitioner and Consultant Histopathologist at Hope Hospital, Salford, carried out the post mortem on 17 November 2005. In the comments section of the report he said:

- *Dihydrocodeine is present in the blood at a concentration within the (range >1000 microg/l) often associated with serious acute toxicity*
- *The major effects of ingestion of an excessive amount of Dihydrocodeine are hypothermia, confusion, respiratory depression and coma*
- *Depending on the subject’s recent pattern of use, these findings are probably consistent with a diagnosis of death due to the toxic effects of ingestion of an excessive amount of Dihydrocodeine*
- *The presence of morphine, amitriptyline and benzodiazepines and exposure to cocaine may have been contributory. There was no evidence of recent ingestion of alcohol.*

The medical practitioner gave the cause of death as Dihydrocodeine toxicity.

Issues considered in the investigation

Referral to the Hostel in the Greater Manchester Probation Area

79. The investigation has shown that the initial referral for the man to be accommodated at this hostel was made in May 2005. Following the referral, the hostel manager made a number of attempts to obtain up to date information about the man in order to make an informed assessment as to his suitability to be accommodated in the hostel. It was some six months after he first made the request that he received a limited amount of information (and only a matter of seven days before the man was due to be released from prison). This delay gave him little time to come to an informed decision and clearly placed him in a difficult position when asked on 8 November to decide whether he would accept the man.
80. It is of great importance that those making the decisions to accept potentially dangerous offenders into the local community are given as much information as is required to make an informed judgement and assess risk. Anything less could lead to a potential breakdown of confidence in the system and unnecessary anxiety for the public.

Greater Manchester Probation Area should ensure that, before any offender is allocated to an Approved Premises, the person assessing the allocation has been able to access all relevant information and been given sufficient time to make an informed judgement.

Greater Manchester Probation Area (GMPA) accepted the recommendation.

81. I am satisfied that the allocation to an Approved Premises was correct and in keeping with the decisions taken by the MAPPA arrangements.

Resuscitation Attempts

82. As noted above, the nurse attempting to resuscitate the man swallowed a quantity of his body fluid. However, after cleaning her mouth with water, she returned to carry on with mouth to mouth resuscitation. This was a remarkable act of dedication and a credit to her profession. I commend her actions and I wish her well for the future.

The Community Psychiatric Nurse should be commended for her attempt to resuscitate the man.

The Chief Officer of GMPA will write to the Community Psychiatric Nurse to commend her actions in attempting to resuscitate the man.

The hostel should consider purchasing the recommended pocket masks. The number required and their location will need to be risk assessed.

The GMPA Approved Premises Division replaced resuscitation masks in all Approved Premises in the area immediately following the man's death.

Clinical Review

83. The clinical review has identified a number of areas that will need to be considered by Norwich Prison, Norwich Primary Care Trust and the Probation Service. I record here the recommendations from the review:

All prisoners that are transferred to Norwich Prison undergo the full Healthcare Reception Screening process.

The Prison Service have accepted the recommendation

External Mental Health Services should proactively share information into the Prison Healthcare and Mental Health In-Reach Teams to ensure continuity of care and enable more robust discharge planning

The Prison Service have partially accepted the recommendation and said: the responsibility for this rests with external NHS services, over which the establishment has no influence. Local providers and Court Division Services should already provide these services and it is a requirement for them to proactively share information.

There are clear systems in place to support the Healthcare Staff when seeing patients that are known to use aggressive and intimidating behaviours. This recommendation applies to Prison and Community settings.

The Prison Service have accepted the recommendation

The Norwich Prison newly developed local prescribing formulary is implemented as soon as possible.

The Prison Service have accepted the recommendation

Medical consultations and medication reviews must be clearly documented and state the rationale in prescription changes.

The Prison Service have accepted the recommendation

84. The above findings and recommendations in relation to Norwich Prison have been discussed with the Head of Healthcare at Norwich prison and are being taken forward. They will be monitored via the HMP Norwich and Norwich PCT Healthcare Governance structure

Recommendations

1. Greater Manchester Probation Service should ensure that, before any offender is allocated to an Approved Premises, the person assessing the allocation has been able to access all relevant information and been given sufficient time to make an informed judgement.
2. The hostel should consider purchasing the recommended pocket masks. The number required and their location will need to be risk assessed.
3. The Community Psychiatric Nurse should be commended for her attempt to resuscitate the man.

Clinical Review Recommendations

Norwich PCT and HMP Norwich

4. There are clear systems in place to support the Healthcare Staff when seeing patients that are known to use aggressive and intimidating behaviours. This recommendation applies to Prison and Community settings.
5. External Mental Health Services should proactively share information into the Prison Healthcare and Mental Health In-Reach Teams to ensure continuity of care and enable more robust discharge planning.
6. Medical consultations and medication reviews must be clearly documented and state the rationale in prescription changes.
7. All prisoners that are transferred to Norwich Prison undergo the full Healthcare Reception Screening process.
8. The Norwich Prison newly developed local prescribing formulary is implemented as soon as possible.