

**Circumstances surrounding the death of a man on 25 July
2006 whilst a resident at an Approved Premises in the
London Probation Area**

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

December 2006

This is the report of an investigation into the death of a man on 25 July 2006. He was 68 years of age and was a resident at an Approved Premises in the London Probation Area, where he had been since 9 February 2005. He was also subject to Home Detention Curfew and had been electronically tagged.

My colleagues and I would like to extend our condolences to the man's family and friends on their loss.

This investigation was carried out by a member of my team. She and I would like to thank the manager and staff at the Approved Premises for their assistance. One of my Family Liaison Officers was in contact with the man's family and invited them to contribute to the investigation process.

The post mortem shows that the man died as a result of acute left ventricular heart failure and hypertensive heart disease. His leg had swollen to such an extent that his electronic tag had become tight around his leg, and the monitoring company had to release it. Swollen ankles are a symptom of hypertensive heart disease and this may be why his leg had swollen.

I have made no recommendations in this report. The circumstances of the man's death are sad, but my investigation has found no evidence that staff at the Approved Premises could have prevented it.

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Prisons and Probation Ombudsman

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SUMMARY

The man upon whom this report focuses arrived at the London Approved Premises on 9 February 2005 as a condition of his parole licence. He was also subject to electronic tagging and several curfew checks throughout the day. He denied the offence of which he had been convicted and so attended an offending behaviour programme designed for people in denial. The course was one day a week for 12 weeks. It caused him some stress but was completed the week before he died.

The man was described as pleasant, compliant and quite content, although he did not mix much with other residents. He had been verbally abused by one resident but staff monitored the situation and the abuse stopped after he moved to a different corridor. There were also problems with other residents borrowing money from him, although eventually the man managed to stop this as well. He had a gambling problem but had brought it under control. Securing future accommodation was a difficulty for the man, and his keyworker thought it led to stress and hence to gambling.

The weekend before he died, the man's leg was swollen up to his knee and he dragged it as he walked. His keyworker noticed that the swelling had made the electronic tag tight around his ankle, and advised him to go to the doctors or to hospital. He also asked the electronic tagging company to come and change the tag. This was done within three hours.

Staff at the Approved Premises were unaware of the man having a heart condition or any particular health problems, except that he was asthmatic and used inhalers and an occasional painkiller. His probation officer mentioned that the man had sinus problems and often had trouble breathing, about which she believed he had seen the doctor.

On the day he died, the man complained to another resident about pain in his groin but did not mention it to staff. He went out in the afternoon and approximately half an hour later staff were notified that someone had collapsed on the road opposite. The man's keyworker was on duty and went out in response to the information and recognised the person lying on the road as the man .

An ambulance arrived and the man was taken to Kings College Hospital. After 15 minutes of attempted resuscitation, he was pronounced dead.

THE INVESTIGATION PROCESS

1. The terms of reference for the investigation and notices to staff and residents were issued. My investigator was given unrestricted access to the man's records and to the Approved Premises.
2. My investigator visited the Approved Premises where she met several staff including the man's keyworker. She also liaised with the man's probation officer.
3. A former resident, who was one of the man's friends, asked to speak to my investigator. They spoke on the telephone, and he told her about the man's leg being swollen for about four days and raised concern about the tag being too tight.
4. HM Coroner for Inner South District of Greater London was informed of my office's investigation. The Coroner kindly provided my investigator with the cause of death and will receive a copy of this report when it is completed.
5. One of my Family Liaison Officers spoke to the man's daughter to ask if the family had any concerns. His daughter questioned whether loosening the tag might have been a factor in his death.

The Man

6. This man was born in 1937. He was one of four children and described himself as coming from a 'broken home'. His parents separated when he was six, and he and his younger sister lived with their father. He returned to live with his mother and her new partner when he was nine years old. He moved between his parents several times until he joined the army where he served for four years.
7. In 1964, he married and had two children. The marriage broke down in 1977 and he had no contact with either his children or his siblings.
8. After leaving the army, the man was mainly employed as a labourer but since 1977 he had been unemployed in order that he could nurse his mother. She died 14 years later in 1991. The following year, the man's girlfriend died of cancer after which he became depressed and sought treatment.
9. In 1998, he received a three year Probation Order, with a condition to attend an offending behaviour programme and psychiatric treatment as directed. He complied with both conditions, and in 2000 was discharged from hospital back into the care of his General Practitioner as he had been "clinically stable for the past two to three years".
10. The man re-offended and in August 2002 was remanded into prison. He was sentenced in June 2003 to two years imprisonment, with three years extended licence. He was released in August 2003 and a condition of his licence was not to enter the area where he offended. He breached the condition and was recalled to prison the next day, eventually being released again in February 2005 to live at the Approved Premises in London.

APPROVED PREMISES

11. Approved Premises were formally known as Probation and Bail Hostels. They are approved by the Secretary of State within section 9 of the Criminal Justice Act 2000. Approved Premises provide a supportive, structured environment in the community for high risk and difficult to manage offenders. The management of those accommodated in Approved Premises is governed by the National Standards for Supervision of Offenders and the guidance contained in the National Approved Premises Handbook.
12. The purpose of Approved Premises is to provide an enhanced level of supervision for some of the most difficult and high-risk offenders in the community. They are not principally an accommodation resource.
13. It is Approved Premises procedure that, in the event of a death at the hostel, the police are called. The Approved Premises staff will notify the police of next of kin details and the police are responsible for informing the next of kin.

The London Approved Premises

14. This Approved Premises is a catered premises, which means that breakfast and dinner are provided for residents, who pay £22.80 per week service charge for their meals, rates, maintenance and facilities such as a laundry. Closed circuit television (CCTV) is installed with the monitors in the front office where, during the core day, staff are always present. The staffing complement is:
 - one Senior Probation Officer (Hostel Manager)
 - one Deputy Manager
 - five Assistant Managers
 - two Night Security Officers
 - one Office Manager.

There is a minimum requirement for two staff to be on duty at all times.

15. There is room for 29 residents, in 23 single and 3 double rooms. One room is allocated for residents with a disability. Currently there are four rooms allocated for residents on electronic tagging.
16. The hostel has a curfew for all residents from 11.00pm to 7.00am, and those subject to tagging may have additional curfews managed individually. Outside those hours, residents are free to leave the premises without disclosing where they are going. There are further checks, known as wellbeing checks, at 8.45am, 3.00pm and 7.00pm, when each room is checked to ensure that residents are well. In addition, random room searches for banned items are also carried out.
17. When there is a problem with bullying in the hostel, a warning is issued to all residents that it will not be tolerated and they risk losing their place. The warning is issued to everybody so that the victim cannot easily be identified.

18. Each resident has a keyworker to help them meet their specific needs, and a probation officer. Keyworkers hold regular one-to-one meetings which are additional to supervision sessions with the probation officer. Keyworkers liaise with the probation officer and other agencies to monitor and facilitate the resident's reintegration back into the community.
19. Residents of the hostel have access to a local GP surgery. Out of hours doctors visit as needed, and are usually locums. Approved Premises staff are not required to have clinical qualifications, and any medical matters would be confidential unless disclosed by the resident.

Home Detention Curfew and 'tagging'

20. The Home Detention Curfew (HDC) scheme applies to prisoners serving sentences between three months and four years. It is designed to help prisoners prepare for life in the community, and they are released subject to the conditions of their licence. HDC is not an entitlement, and can only be granted subject to prisoners meeting the eligibility criteria and passing a risk assessment.
21. Electronic monitoring is the technology used to monitor the offender's compliance with a licence or court order. It establishes whether the offender is present or absent from a particular place at any given time. The condition can either be imposed by a court as part of a community sentence, or as part of the licence conditions imposed following release from prison.
22. If a prisoner is to be released on HDC, he or she must sign the licence which states the times they have to remain at their home address or Approved Premises. This is normally 7:00pm to 7:00am. An electronic tag is fitted to the individual (usually on their ankle), and monitoring equipment (a tagging box) is installed at the appropriate address by a private contractor. In this instance, the equipment was installed by Premier Monitoring Services Ltd (Premier). If the curfew is broken, the tag alerts the contractors and recall to prison may be ordered.
23. Premier also carry out unannounced spot checks and, if there is a breach of conditions, they telephone the relevant tagging box and verify the individual's whereabouts with staff. Staff are also contacted if there is no reply from the individual.

KEY EVENTS

24. The man was re-released from prison on 9 February 2005, with a licence condition to reside at the London Approved Premises and subject to an electronic tag and strict curfews. He had to remain within the Approved Premises between 11:00pm and 9:00am daily, and on weekdays between 11:45am and 2:00pm and 3:00pm and 4:00pm.
25. In April 2005, the man attended a doctor's appointment and was given a clean bill of health. Notes in his file describe him walking in a circuit round the streets near the hostel for exercise.
26. On 26 April a probation officer carried out a session on the man's offending behaviour course and she highlighted that he was isolated and had few meaningful relationships. She felt that he suffered from bouts of loneliness, which he was afraid to acknowledge in case it opened up feelings of depression.
27. At a meeting with his probation officer on 8 June, the man reported that his gambling had become out of control. He had been gambling every day and was trying to reduce it to once a week. As an additional safeguard, he gave some of his money to hostel staff to keep in the safe.
28. The assistant manager who was the man's keyworker had been trying to help him open a bank account. The man had experienced problems because he did not have a fixed address, but did eventually manage to open a Post Office account. There was approximately £800 in the account, and he asked hostel staff to hold another £800. The money was from his pension and some gambling winnings. He did not smoke or drink and was never in arrears with his hostel service charge.
29. Some other residents were in the habit of borrowing money from the man, which was of concern to the keyworker. He said that he often spoke to the man about it, but did not think that his advice made any difference. Subsequently, the man said he told the residents that he was a pensioner without much money and this seemed to curb their requests.
30. In July 2005, the man told his probation officer that he had been suffering from sinus problems and a skin condition, but that medication from the doctor was helping. He was following his familiar routines and said that the gambling was under control. His probation officer discussed his accommodation needs, and the man thought that he could cope with any arrangement having lived in bed and breakfast accommodation for eight years. Due to his offence, there were strict restrictions about where he could live and his reintegration back into the community.
31. When the man met with his probation officer again on 16 August, he said that he had been suffering with chest and sinus problems. He had pain in his kidney, apparently caused by a stone, and had high blood pressure. A doctor's appointment was booked for the following week but, because he

looked poorly and had difficulty breathing, his probation officer advised him to attend the surgery as an emergency. The man followed this advice, and afterwards told his keyworker that he had been prescribed a stronger nasal spray and anti-histamine. He had also been asked to return the following day to remove some skin tags. The keyworker discussed the man's accommodation needs with him, and was going to contact the appropriate housing authority to see what was available. The man reported that he was doing fine, and was not experiencing any great difficulties at the hostel. However, he was apprehensive about repeating the offending behaviour programme.

32. It was a requirement of the programme that the man attend pre-course tests, which were scheduled for 4 October 2005, and his curfew was amended for the time. Despite the amendment, Premier still contacted the Approved Premises to say that he had breached the rules. There followed several occasions when Premier requested breach action, even though the man was not in breach and was in fact exemplary at signing in for his curfew. On 5 January 2006, the man's tag was renewed because it was not working properly. It was changed again a month later.
33. During a meeting with the man on 20 January, his keyworker helped him fill in a housing application. The man was also going to try to get an appointment with the council. He remained quite content, and enjoyed playing pool and watching the big television downstairs which let him interact with some of the other residents. In March, another resident began making veiled threats about his offence which the man reported to staff. He was asked to report any further incidents so that they could be dealt with appropriately.
34. On 16 March, the man was arrested by the local Public Protection Unit (PPU), for failing to sign the sex offender register. He was reported to be very anxious and troubled, and said that he had not realised that he was required to sign the register regularly. He appeared at a local Magistrates' Court and was conditionally discharged.
35. In April, the man received a response to his housing application which he discussed with his probation officer on 21 April. He had been told that he did not have enough points to proceed with the application. His probation officer intended to ask that the man be assessed as a vulnerable person because of previous health problems, and his previous lengthy residence in the borough. The probation officer also gave permission for the man's daytime curfew to be removed from 24 to 28 April so that he could attend the first week of the offending behaviour course. The man completed the week, although again felt anxious about attending.
36. The man was subjected to more verbal abuse by a resident on 24 May, which he reported to staff. In response on 28 May, he was moved to another part of the Approved Premises. When my investigator asked why the man rather than the perpetrator was moved, the keyworker explained that it meant that he would not have to use the main corridor where the other resident could easily

be present. The other resident would not need to go down the man's new corridor, and could be seen more easily by staff.

37. The same day the keyworker also discussed the man's programme work with him. The man said that some difficult issues had arisen and were causing him stress. His keyworker advised him to go to the doctor for a check up, but it is not clear whether he attended or what the outcome was.
38. During a keyworker session on 12 June, the man reported no more instances of verbal abuse, and said that he was managing to deal with the issues raised in his programme work. He admitted lending money to some residents again, and was advised to resist any future requests. It was noted that his tagging restrictions were still in place, with no sign of them being varied apart from his weekly attendance at his course.
39. At the next keyworker session on 24 June, the issue of lending money and gambling was discussed again and the man felt that it was under control. He had established a friendship with another resident who was disabled. He used to run errands for his friend, such as going to get newspapers or bringing his dinner. There had been some concerns that he was doing too much, but the man assured staff that he was happy to be kept occupied and did not feel he was being used.
40. There was nothing much of note over the next few weeks. The man continued to report for his curfews, and on 10 July his tagging equipment was checked. He completed the offending behaviour course and felt less anxious. The resident who had been threatening him had been rearrested for other offences and was no longer at the hostel. There had been no further progress on his housing applications.
41. On 23 July, the keyworker noticed that the man was limping. His lower leg was swollen which was thought to be due to the heat and possible fluid retention. As a result, the tag was very tight on his leg and the keyworker telephoned Premier to request a new one. He said that Premier arrived within three hours, and the man was fitted with a new tag.

25 July

42. The man was seen leaving the hostel at approximately 2.30pm by an assistant manager. She noticed that he was wearing a jacket although it was very hot outside, and he explained that he needed to carry things.
43. Approximately half an hour later, a member of staff from a nearby adult education centre came to the Approved Premises and reported that someone had fainted on the corner of the street. The keyworker went out to assist and found the man lying on his back on the pavement. Another member of the public was with him and had already called for an ambulance. The keyworker described the man as talking, but breathless. He told the keyworker that he had been walking up the short hill and felt faint, so lent on a junction box and then fell backwards. He said that he felt sick. The keyworker placed him in

the recovery position which eased the nausea but increased the pain in his leg. The keyworker tried to move his leg into a more comfortable position, and stood over the man to shade him from the hot sun. While they waited for the ambulance, a St John's ambulance drove by and stopped. They made the man more comfortable, but could not treat him because paramedics had already been called.

44. The emergency ambulance arrived, and the man was placed on a trolley which was moved into the ambulance. He was described as lucid, but breathless. The paramedics placed a heart monitor on him, and he talked normally but became confused. He then suddenly became aggressive. Subsequently, the paramedics performed cardiopulmonary resuscitation (CPR).
45. The ambulance crew asked the keyworker to accompany them to the hospital. He needed permission to go, as two members of staff should be on duty in the hostel at all times, so he returned to the hostel and his line manager agreed that he should go with the man. When the keyworker returned to the ambulance, he said he found that the man was breathing, albeit struggling to do so.
46. A third paramedic arrived in a rapid response car and there was some confusion about who had been called out to assist. The third paramedic had been given a different description of the casualty, but the same location. Nevertheless, he assisted the ambulance crew and began to administer various drugs to the man, whilst the others continued with CPR. They attended to the man for approximately ten minutes in the ambulance outside the hostel, and then took him to King's College Hospital. They stopped during the journey, in order to have a steady platform to administer more drugs.
47. The man was taken straight to the resuscitation room at the hospital. Approximately 15 minutes later a staff nurse came out to tell the keyworker that, despite their efforts, the man had passed away. The keyworker was asked if he wanted to see the man, and described him to my investigator as looking peaceful. He was given the man's belongings and then returned to the hostel.
48. During a meeting that afternoon, the news of the man's death was broken to the residents. Afterwards his friend told staff that the man's leg had been swollen for approximately four days, and that he had complained of pain in his groin that morning.
49. The post mortem found that the man died of acute left ventricular heart failure and hypertensive heart disease. It is known that one symptom of the disease is swelling of the ankles.
50. The police notified the man's family. His sister and daughter then contacted the Approved Premises, as they had several queries. I believe that these were answered appropriately. Staff and some residents attended the man's

funeral. His family returned to the hostel after the funeral to pick up his belongings.

CONCLUSIONS

Health and Healthcare

59. Like any other member of the community, residents of Approved Premises must register with a local General Practitioner, and their health issues remain confidential between them and the doctor. Hostel staff would not be party to such confidential information unless the resident chose to disclose it or signed a confidentiality disclaimer. There is no evidence to suggest that either this man or staff at the London Approved Premises were aware he had heart disease.

Electronic tagging

60. Concerns were raised by the man's family, his friend and hostel staff, about whether the loosening of his tag contributed to his death. My investigator could find no evidence that it was a contributory factor. I am satisfied that, when hostel staff realised that his tag was tight, appropriate steps were taken to make him more comfortable. The monitoring company also responded promptly and the tag was changed within a few hours.

The role of Approved Premises staff

61. The circumstances of the man's death were sudden and unexpected, and there is no evidence to suggest that it could have been prevented by hostel staff. Although he was taken ill outside the Approved Premises, by chance his keyworker attended and so he was with a familiar person. It was a humane decision which allowed the keyworker to accompany him in the ambulance to hospital.

RECOMMENDATIONS

I make no recommendations in this case.

Good Practice

The hostel records were in good order. They contained good, relevant information which was very useful to the investigation.

The keyworker was able to accompany the man to the hospital so that he was with someone familiar in the moments before he died.