

**Investigation into the circumstances surrounding the
death of a resident at an Approved Premises in the Greater
Manchester Probation Area in November 2006**

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

July 2007

This is a report into the death of a resident at an Approved Premises in the Greater Manchester Probation Area in November 2006. The man was 71 years old. He appears to have died from natural causes.

The man had been found in his bedroom during the morning curfew check. He was assessed by the member of staff who found him as being beyond resuscitation. An ambulance was called to the hostel and arrived within minutes. The paramedics confirmed that he could not be revived.

The man who died had lived at the hostel since 19 October 2005 as a condition of his release from custody. He suffered from a number of chronic health problems, and over the course of 12 months, was admitted to hospital on no fewer than seven occasions. Concerted efforts were made by both the manager of the hostel and his supervising probation officer to arrange more suitable accommodation. Unfortunately, these efforts proved unsuccessful and he died a week after being discharged from hospital for the last time.

This investigation has been undertaken by one of my investigators. I would like to thank the Senior Probation Officer in charge of the hostel and her staff for their co-operation and active participation. Oldham Primary Care Trust (PCT) carried out a clinical review into the man's care and I thank the clinical reviewer for his comprehensive account.

One of my Family Liaison Officers contacted the man's wife to inform her of my investigation and to offer her the opportunity to raise any concerns. I add my condolences to those already expressed by my Family Liaison Officer, and hope this report answers any questions the family may have about the circumstances surrounding the man's death.

I make two recommendations in this report. One relates to how hostel staff should be consulted by medical staff when decisions to discharge residents from hospital are taken. The other challenges the National Offender Management Service (NOMS) to consider how it can better meet the needs of an increasingly frail hostel population. The clinical review has made five further recommendations, which I endorse.

In my view, the man's medical and social care needs could not be fully met at the hostel. Approved Premises have a very specific function, namely to protect the public through monitoring of residents' behaviour. They are not set up to deal with people struggling with chronic ill health. Yet if the current trend for longer prison sentences continues, there will be many more elderly former prisoners like the man who is the subject of this report housed in Approved Premises and presenting with complex health needs. The implications of this are far-reaching, and extend far beyond those hostels making up the Approved Premises estate.

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SUMMARY

The man who died appeared at Manchester Crown Court in April 2003 and was sentenced to five years' imprisonment for a number of serious offences. The Court of Appeal subsequently reduced his sentence to four years. He was released on licence from HMP Risley on 19 October 2005, when he became a resident at the hostel in the Greater Manchester Probation Area.

The following day, he was admitted to hospital after becoming short of breath whilst on a social outing with his wife. He was kept in overnight and was discharged back to the hostel on 21 October.

On 20 March 2006, the man was found collapsed in his room suffering from chest pains and breathlessness. An ambulance was called and he was taken to hospital where he was diagnosed as having suffered a stroke. He was discharged to the hostel the next day. Three days after being discharged, he suffered a heart attack and was again taken to hospital. He was admitted and remained an inpatient for a week before being discharged.

During the early hours of 2 April, the man was found on the floor of his room by hostel staff. The emergency services were called and he was admitted to hospital where he remained for two days.

Less than two weeks later, he was admitted again to the Royal Oldham Hospital after suffering kidney failure. On this occasion, he was admitted for over a month, during which time he was assessed by medical and social care professionals. He was deemed to be fit to live independently and was discharged to the Approved Premises on 19 May.

On 5 July, the man was admitted to hospital once more, this time after suffering a coughing fit. He stayed there for five days before being discharged to the hostel, five days later. The next day, he was observed clutching at his chest and struggling for breath. An ambulance was called and he was taken to hospital where it was diagnosed that he was suffering from anaemia. He remained at the hospital until 18 July.

On 19 October, the man who is the subject of this report was taken to the Royal Oldham Hospital after vomiting and feeling dizzy and breathless. He was admitted as an inpatient and stayed at the hospital until 26 October.

At 5.00am on 3 November, hostel staff heard the man coughing in his bedroom. They asked if he was 'alright' and he said that he was. At 7.55am, he did not respond to the daily wake up call. Staff found him lying sideways across his bed with the TV remote control in his hand. His eyes were wide open and he was unresponsive to verbal stimuli. The staff believed he was dead because blood had started to pool in the pressure points under his skin. They therefore did not commence emergency life support. An ambulance was called and the paramedics confirmed that the man had died.

THE INVESTIGATION PROCESS

1. My investigator considered the man's probation records, including those held by the hostel, before formally opening the investigation on 29 January 2007.
2. Prior to my investigator arriving at the Approved Premises, notices were issued to staff and residents announcing the investigation and inviting anyone who had information relevant to the man's death to make themselves known to the investigator. Nobody came forward, although six members of staff, including the man's supervising probation officer, were interviewed by prior arrangement.
3. One of my Family Liaison Officers contacted the man's wife to offer her the opportunity to participate in the investigation process. She expressed concern that her husband had been allocated to a bedroom unsuited to his needs following a lengthy hospital admission in April and May 2006. She wanted to know why her husband was told he would only be at the hostel for four months when in fact he stayed there for more than a year. She also expressed concerns about whether the hostel was able to meet the man's health needs – she thought he should have been moved elsewhere. Finally, she was unhappy that she only learned of the man's death when she arrived at the hostel three hours after he had been found. I hope this report addresses these concerns and answers any other questions she or any other family members may have about the circumstances surrounding the man's death.
4. Having spoken to hostel staff and considered the hostel and probation records, my investigator became concerned about how the man's health was managed. It is unusual for my investigators to ask for clinical review when a resident dies in Approved Premises. However, my investigator was sufficiently concerned about the circumstances of the man's death that he asked Oldham PCT to look into the care he was given. I am most grateful to the PCT for agreeing to undertake a review. It has proved to be invaluable to the investigation.
5. My investigator also contacted Her Majesty's Coroner to inform him of the nature and scope of the investigation and to request a copy of the post mortem report. Upon completion, this report will be sent to the Coroner to assist him in his enquiries.

THE APPROVED PREMISES

9. The Secretary of State approves Approved Premises (formerly known as probation and bail hostels) 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. They operate on each day of the year with 24-hour staff cover.
10. The Approved Premises where the man died is a 27-bed hostel for men, located in north Manchester. It is the only one of the seven Approved Premises in the Greater Manchester Probation Area that has disabled access. It is managed by a Senior Probation Officer who has overall responsibility for the running of the hostel. There is also a deputy manager who is responsible for the day-to-day management of residents and for making decisions about enforcement. The 'frontline' team is made up of ten permanent members of staff, comprising four residential service officers, five residential service workers and an administrator. The services of relief staff are also drawn upon to cover staff sickness, training and annual leave. Staff are trained in risk management and emergency first aid, but are not trained to do nursing tasks.
11. The hostel has an admissions policy based on assessment of risk. In recent years, the resident profile has changed significantly with prolific lower risk offenders being superseded by individuals convicted of more serious violent or dangerous offences. The hostel now takes fewer people coming straight from court, and the majority of residents are required to stay at the Approved Premises as a condition of a court order or prison licence.
12. Each resident is allocated to a keyworker soon after his or her arrival, and this member of staff acts as their primary point of contact for sorting out practical issues. Regular keywork sessions give residents the opportunity to discuss their difficulties in depth. Although these sessions are not governed by a set agenda, issues such as benefits, health and move-on accommodation are routinely discussed. The man had two keyworkers over the course of his stay at the hostel.
13. The hostel has close links with local health services, and all residents are registered with a General Practitioner who is located two doors away. A service level agreement between the hostel and surgery ensures that residents have open access to medical services every morning. Prescribed medications are stored in a locked cupboard to which only staff have access. There are set medication times throughout the day and the onus is on residents to present themselves to the staff at the right times.
14. Residents are required to pay rent and abide by the rules and regulations of the hostel, including observing a strict overnight curfew between 11.00pm and 6.00am. When residents are subject to statutory supervision, pertinent information is shared regularly with field probation officers who act as case managers.

Release on Licence

15. All prisoners sentenced to more than 12 months imprisonment are released on licence, which means they are supervised by the Probation Service until the licence expiry date. In general terms, the expiry date falls threequarters of the way through a released prisoner's sentence. There are standard conditions for all licences, which include:

- keeping in touch with the probation officer in accordance with any instructions that may be given
- residing at an address approved by the supervising officer
- only undertaking approved work
- not travelling outside the United Kingdom
- being well behaved, not committing any offence and not doing anything that could undermine the purposes of supervision, which are to protect the public, prevent re-offending and help successful resettlement into the community.

Further conditions can be added by the Secretary of State if they are deemed necessary to manage a person's risk.

Multi-Agency Public Protection Arrangements (MAPPA)

16. The MAPPA is a formal partnership between police, probation, prisons and other statutory and non-statutory agencies that assesses and manages offenders in order to minimise the risk of serious harm they may pose to the public. There are four core functions:

- identification of offenders with the potential to commit serious violent and sexual offences
- sharing relevant information between agencies
- assessing the risk of serious harm
- managing that risk.

Offenders who come within the MAPPA remit are classified according to the nature of the risk and its management. The higher the risk, the higher the level at which they are managed. Level one offenders are managed by one agency, usually the police or probation service. Level two offenders are managed jointly by all the MAPPA agencies, and level three offenders are managed by the Multi-Agency Public Protection Panel (MAPPP) made up of senior managers from the MAPPA agencies.

KEY FINDINGS

17. The man who is the subject of this report was sentenced to five years imprisonment by Manchester Crown Court in April 2003 for a number of serious offences. He lodged an appeal and his sentence was subsequently reduced to four years in October 2003. He spent the majority of his time in custody at HMP Risley, where he had a lot of contact with healthcare as a result of his complex health needs. His diabetes was monitored as an on-going concern and he was also treated for chest pains and breathlessness.
 18. On 26 July 2005, the man's case manager submitted a referral to Greater Manchester Probation Area's Approved Premises Central Admissions Department. The referral form consists of 17 sections which need to be completed with relevant information about potential hostel residents. Section 11, headed Health and Special Needs, states that potential residents must be fit to function at a probation hostel. It qualifies this by saying that they need to be mobile and able to care for themselves. It further says that they must not be in need of nursing care. In section 11, the case manager has written that the man had a 'previous heart bypass operation' and currently suffered from 'kidney problems linked to heart and artery problems'. It was also noted that the man 'has previously resided in a hostel before following release from custody'.
 19. According to the documentation, the man's referral was received at the Approved Premises Central Admissions Department on 3 August. He was provisionally accepted for a place at the Approved Premises on 7 October, and a bed was made available for him for 19 October onwards.
 20. Due to the nature of his offences, the man's case was managed in accordance with the local Multi-Agency Public Protection Arrangements (MAPPA). One of the conditions inserted into his licence under the direction of the MAPPA was that he reside at an Approved Premise upon his release. The others were:
 - To not seek to approach or communicate with the victims.
 - To not enter a specified area in Manchester.
- These conditions were enforceable for the duration of the man's licence, from the day of his release until 18 February 2007.
21. On 19 October, the man was released from Risley. He was met at the prison by his wife and his supervising probation officer. The supervising officer told my investigator that the man was released with a significant amount of prescribed medication by the prison. The supervising officer drove the man and his wife to the Approved Premises and remained at the hostel until the man had been shown round and formally inducted. The induction was completed by a member of hostel staff. Due to his health needs, the man was allocated to a disabled room on the ground floor. All of his prescribed medication was taken from him and locked in the medication cabinet, with the exception of his insulin.
 22. The following day, the man who later died left the hostel accompanied by his wife. During the outing, he became short of breath and was taken to the

Accident and Emergency Department of Oldham General Hospital. He was admitted as an in-patient and kept in overnight. The hospital established that the exercise had aggravated the man's angina. He was discharged from the hospital and returned to the hostel later in the day.

23. On 30 December, the man attended an outpatient appointment at Manchester Royal Infirmary to undergo a heart scan. He also saw a vascular surgeon, as it was known that he suffered from ischaemia (reduced blood supply to the heart). A follow-up appointment with the surgeon took place on 31 January 2006 when it was decided that he needed to be admitted to hospital for surgery.
24. During the course of his keywork session on 20 February, the man said that his poor health continued to pose problems. He disclosed that he was awaiting an appointment for a cataract operation, but had been told that this could only be arranged after a vascular operation had taken place. He told his keyworker that the vascular operation was necessary to relieve the pressure in his arteries.
25. On 13 March, the man was admitted to Manchester Royal Infirmary to undergo vascular surgery. The operation would appear to have been a success and he was discharged from hospital on 17 March. Upon his return to the hostel around 2.30pm, he told a member of staff that he was feeling well.
26. Three days later, during the morning of 20 March, the man was found collapsed in his room, suffering from chest pains and breathlessness. An ambulance was called and he was taken to the Royal Oldham Hospital. The diagnosis was that he had suffered from a mild stroke. He was discharged to the Approved Premises the next day.
27. At around 12.30pm on 24 March, the man was again found collapsed in his room. An ambulance was called and he was again admitted to the Royal Oldham Hospital. On this occasion, the diagnosis was that he had suffered a heart attack. He remained at the hospital as an inpatient until 30 March when he once more returned to the hostel.
28. Around 4.25am on 2 April, a Residential Service Worker (RSW) heard the man shouting "hello" from his bedroom. When the RSW entered the room he found the man on the floor with blood coming from his mouth. The RSW examined him and ascertained that the blood was the result of a cut tongue. The RSW told my investigator that the man was both conscious and lucid at this point. He kept trying to get up, but the RSW was concerned about the unintentional damage this might cause so put him in the recovery position and told him to stay there. However, the man started coughing so the RSW assisted by manoeuvring him into an upright position. He then called an ambulance which arrived minutes later. The man was removed by the paramedics and taken to the Royal Oldham Hospital where he was once again admitted as an inpatient. On this occasion, his collapse was attributed to dehydration caused by his diuretic medication. He was kept at the hospital for two days before being discharged to the hostel on the afternoon of 4 April.

29. The following day, 5 April, the hostel manager and the man's supervising officer discussed the hostel's ability to meet his health needs. The hostel manager said that hostel staff are not trained to deliver nursing-type care and questioned whether the hostel was meeting its 'duty of care' as defined in law. The hostel manager expressed a view that the man's quality of life might be improved if he was allowed to return home to live with his wife. She also said that, in her opinion, the man's care needs were now more important than the potential risk of harm he posed to others.
30. As responsibility for managing the man fell to the MAPPAs, the supervising probation officer alone could not give him permission to move home. An emergency Level Two MAPPAs meeting was therefore arranged for 6 April. According to the supervising officer's record of the meeting, the consensus of the MAPPAs was that the option of the man returning home was not one to consider at that time because of unresolved victim issues and media scrutiny. Instead, the supervising officer and hostel manager were given the task of finding the man a placement at a nursing home.
31. The man who died was again admitted as an inpatient to the Royal Oldham Hospital on 16 April. It is not recorded in his probation records what happened prior to his admission, although the hospital records obtained by the clinical reviewer cite renal failure (kidney failure) as the reason.
32. Three days later, the hostel manager telephoned the hospital and explained that the man was managed by the MAPPAs and that it had given her responsibility for finding him a placement at a nursing home. A social worker at the hospital subsequently arranged for a needs assessment to be carried out by Manchester Social Services. This took place on 20 April.
33. On 21 April, the man's bed at the hostel was formally withdrawn by Greater Manchester Probation Area. The logic behind this decision, made jointly by the hostel manager and senior management, was that it would force either the hospital or social services to accept responsibility for the man's care, as the hostel manager did not believe he could be adequately looked after by hostel staff.
34. Later in the day, the hostel manager and the man's supervising officer visited the man at the Royal Oldham Hospital. During the visit, the hostel manager and supervising officer told the man that they did not think his health needs were being met at the Approved Premises. They encouraged him to think about living in a residential care home where the staff would be better able to care for him. The man disclosed that he had some fears about the standard of care he was receiving at the hostel and, at the end of the meeting, accepted that a care home was probably the best option. I commend the hostel manager and supervising officer for jointly visiting the man in hospital and engaging with him in this way. It was very good practice.
35. On 24 April, the supervising officer was telephoned by Manchester Social Services who said that the man was ineligible for assistance because he was living in Oldham. The supervising officer explained that he was not a

permanent resident and that the man's home address was actually in Manchester. Contact was subsequently made with Oldham Social Services who said that the man was not eligible to receive help from them as he was only a temporary resident and that his permanent address was in Manchester.

36. The man's supervising officer visited the man in hospital again on 28 April. The supervising officer later recorded that he was up and about but not yet well enough to be discharged. He also noted that the man appeared to have accepted the need to go into a care home. The supervising officer visited him again at the hospital on 5 May to see how he was doing.
37. The supervising officer received an e-mail from Manchester Social Services on 9 May. They now accepted that the man was their responsibility as his residence in Oldham was only temporary.
38. However, on 12 May, the supervising officer was told by Manchester Social Services that the man did not meet their criteria for assistance. The needs assessment carried out on 20 April showed that the man needed support with some household chores and personal care, but he did not fall into the 'critical' or 'substantial' categories of need. He was deemed to be able to climb stairs without assistance and to bathe and dress himself unaided. The supervising officer contacted a senior manager within Greater Manchester Probation Area and told them that a hostel place needed to be found urgently as the hospital was preparing to discharge the man. The supervising officer mentioned that the disabled room at the Approved Premises was now occupied.
39. The man's referral was accepted by the Approved Premises Central Admissions Department on 15 May on the understanding that he would be a temporary resident. In the absence of more suitable accommodation, he was once again allocated to the Approved Premises he was resident in previously.
40. The man was discharged from hospital on 19 May. He arrived at the hostel around 1.00pm, when he was reminded of the hostel rules and his licence conditions. As the disabled room was occupied by another resident, he was allocated to a room on the first floor. This can only be reached via the stairs. He was moved to a room on the ground floor a few days later, but it was not one with disabled access.
41. The next six weeks were relatively uneventful. The man saw his doctor five times for routine appointments, and he attended an outpatient appointment with the vascular surgeon at Manchester Royal Infirmary on 12 June. His health was regularly discussed with his new keyworker, who recorded on more than one occasion that he reported feeling unwell as a result of the hot weather. The keyworker helped the man develop strategies for coping with the heat, such as staying indoors during the hottest part of the day.
42. During the evening of 5 July, the man suffered a coughing fit. An ambulance was called and he was taken to the Royal Oldham Hospital where he was admitted as an inpatient. After a period of assessment, he was discharged to the hostel on 10 July.

43. The following day, the man who is the subject of this report was observed clutching at his chest and struggling for breath. An ambulance was immediately called and he was again taken and admitted to the Royal Oldham Hospital. Tests carried out at the hospital revealed that he suffered from anaemia (a deficiency of red blood cells). This condition means that there is less oxygen in the body, which in turn leads to episodes of acute breathlessness. The man was given a blood transfusion to treat the condition.
44. During the morning of 18 July, the man was visited in hospital by the hostel manager and a probation officer who was temporarily covering for the man's supervising officer. The hostel manager and the probation officer told him that they had identified a residential home in Manchester which they thought met his health and care needs. After being told that it was not a home for the elderly (as he had previously thought), the man signed the documentation needed to make a referral, although it was noted that he had reservations about leaving the hostel. The paperwork was sent to the home later that day. The man was discharged from the hospital around 3.00pm and arrived back at the hostel a short time later.
45. On 3 August, the man was taken to the residential home by his keyworker. The purpose of the visit was so that he could view the property and make an informed decision about whether he wanted to go there or not. After being shown round, the man said that he would be willing to move as long as his wife was happy for him to do so.
46. A week later, on 9 August, the home wrote to the man saying that they would not be offering him a place. The letter said that he did not want to live there and, if he did become a resident, he would not stay there after his licence expired in February 2007.
47. Between August and mid-October, the man's health was relatively stable. He saw his GP on nine occasions for scheduled appointments, and he attended four outpatient appointments at the Royal Oldham Hospital and Manchester Diabetes Centre respectively. On 22 September, he was taken to the Accident and Emergency Department after suffering from severe cramps in his legs. The problem was diagnosed as intermittent claudication, a condition common to those who suffer from ischaemia, and he was returned to the hostel without being admitted. Throughout this period, the man's supervising officer and the hostel manager continued to make efforts to find him accommodation more suited to his needs.
48. On 11 October, the man told his keyworker he was unwell. He described feeling dizzy, and other residents told the keyworker that they had seen him almost fall over. The keyworker advised the man to sit down. An emergency GP appointment was made, and the man attended with his wife. Hostel staff subsequently received a telephone call from the doctor telling them not to issue the man with two of his medications for the next two days as his blood pressure was low. Hostel staff asked the doctor to send confirmation of this instruction in writing.

49. At 9.20pm on 19 October, the man came to the general office and told the RSW that he was feeling dizzy and breathless. He also disclosed that he had vomited 20 minutes previously. The RSW called an ambulance which arrived at 9.25pm. The man was taken to the Royal Oldham Hospital and admitted as an inpatient.
50. He remained an inpatient for eight days. His ill health was attributed to anaemia and a myocardial infarction (heart attack). The man was discharged to the hostel on 26 October, with outpatient appointments at the hospital lined up for the coming weeks.
51. On 31 October, the man attended Moss Side probation office for a prearranged supervision session with his case manager. His health problems were discussed at length and the supervising officer subsequently recorded that he did not look like "a picture of health at all". The man and his supervising officer also talked about life at the hostel. The man who later died said that he felt very settled and reported feeling happy with his situation. The supervising officer wrote in his case records that, the man "has clearly benefited from the high quality support and supervision the staff [at the hostel] have provided."
52. At 9.50pm on 2 November, an RSW started her waking night shift. Shortly afterwards, a resident approached her and told her that there was excrement on the floor in the kitchen area. She went to room 18, the man's bedroom, and asked him if he had had an accident. Initially he denied it, but then admitted that he had soiled himself. After checking that he was okay, the RSW provided the man with some cleaning materials to clear up the mess, which he did.
53. At 11.00pm, the RSW commenced the night time curfew check. She told my investigator that she remembered the man sitting in the conservatory area near his bedroom and asking him if he was okay. He said he felt tired, before making himself a hot drink and going to bed.
54. As the man was known to be vulnerable and his health problematic, he was checked throughout the night by hostel staff. My investigator has been unable to confirm the exact date when the hostel brought in this measure, although it is an example of good practice. At 1.00am and 3.00am, the man was observed to be asleep. At 5.00am, the RSW heard him coughing and asked him if he was alright. He replied in the positive and was therefore left alone.
55. Around 7.50am, a Residential Service Officer (RSO) started her shift. At the same time, the RSW commenced the morning wake-up call of residents. As the man's room was in the annex building, she did not reach it until 7.55am. She knocked on the door and told him it was time to get up. He did not answer, so she knocked again. There was no response, so she opened the door. Upon entering the room, she saw the man lying flat on the bed breadthways. His feet and hands were dangling off the side. She noticed that he had the remote control to his TV in his right hand and his eyes were wide open, staring at the ceiling. The RSW shouted the man's name a couple of times, but again received no response. She saw that the tips of his ears were red and that blood had started to pool on the underside of his arms and bottom of his hands. From

experience, she knew that this signifies that a person is dead and therefore did not check for a pulse.

56. The RSW then left the man's room and locked the door. She went to the general office and told her colleague that she thought the man had died. They returned to his room together and went in. The RSO saw that the man was not breathing and quickly returned to the office to phone for an ambulance. The ambulance operator advised the RSO to commence Cardio Pulmonary Resuscitation (CPR), but upon returning to the man's room she and the RSW agreed that to do so would be futile – more blood was pooling around the pressure points of the back of his head, his arms and underside of his hands.
57. The ambulance arrived at the Approved Premises within five or six minutes. The paramedics quickly established that the man was beyond resuscitation and rigor mortis had started to set in. Emergency life support was therefore not started.
58. Over the next few hours, police officers arrived at the hostel to arrange the removal of the man's body. In the midst of these formalities, the RSO, the RSW and the rest of the staff team spoke to the other residents to make sure they were okay. Similarly, the RSO and RSW were spoken to by colleagues and management. They both told my investigator that they felt supported.
59. Later in the morning, the man's wife arrived at the hostel, expecting to see her husband as usual. She was told by hostel staff that he had sadly passed away earlier that morning. By this point, the RSO had been out to purchase some flowers which were placed in the man's room out of respect.

ISSUES

Clinical

60. The clinical review carried out by the PCT offers a detailed account of the man's medical history and a critical analysis of his treatment and care. It describes a long history of vascular problems and diabetes dating back at least 15 years, during which time he suffered a number of heart attacks. In 2006 alone, he experienced a myocardial infarction (heart attack), was diagnosed with anaemia and underwent surgery on his arteries. The man had a "poor medical history".
61. At the request of my investigator, the clinical reviewer examined the nursing and social care assessment completed by Manchester Social Services in April and May 2006. As detailed above, this assessment concluded that the man did not meet the criteria for residential / nursing home care. This ultimately led to him being returned to the Approved Premises where staff felt unable to cope with his health problems. In the clinical reviewer's professional opinion, the assessment carried out by Manchester Social Services is comprehensive and detailed. It incorporates the views of the patient, family and hospital staff and also acknowledges the concerns of hostel staff about their ability to care for the man. The assessment clearly states that the man was able to negotiate stairs and independently maintain his personal hygiene, whilst noting that he did not experience problems with his bowel or bladder. The only issue raised related to the man's blood sugar levels, which it said needed to be monitored by external parties if he was not capable of doing it himself.
62. The clinical reviewer's view is that Manchester Social Services' assessment of the man's needs is valid, as was the decision not to categorise him as being in 'critical' need. He concludes that, "there is no evidence that his needs could not be met [at the Approved Premises]" and points out that "a number of individuals with similar or worse problems can be managed in their own homes with the appropriate support package being in place."
63. However, the clinical reviewer acknowledges that the concerns and worries of hostel staff were not addressed by the hospital or Manchester Social Services. He highlights that the hostel was not involved in any discussions concerning the management of the man's health needs and at no point were hostel staff told what was expected of them. This probably explains why a number of hostel staff told my investigator that they felt isolated and ill-equipped to deal with the man.
64. I therefore fully endorse the clinical reviewer's recommendation that, "staff from the bail hostel should be involved in case conferences where the future medical care of residents is discussed."

Approved Premises staff should be involved in case conferences where the future medical care of residents is discussed.

Greater Manchester Probation Area has accepted this recommendation and the Senior Probation Officers in charge of Manchester's seven Approved Premises

have been informed of the need to involve hostel staff in medical case conferences.

65. The clinical review also makes five other recommendations, two of which relate to how the Prison Service passes on information and records to community health services. I fully endorse these. Two more relate to the practices of GP and associated services and therefore fall outside of my remit. The final recommendation concerns how prescribed medication is stored and dispensed in Approved Premises. I am aware that this matter is currently being reviewed at a national level by the National Offender Management Service (NOMS)

The Prison Service should undertake a full medical, nursing and social needs assessment prior to discharge to Approved Premises when there are complex medical problems. A full package of support would therefore be in place that met the person's needs.

All individuals should be fully registered with a local General Practitioner if they are expected to be resident at an Approved Premises for more than three months. The GP would then have access to the medical records prior to the prison sentence.

A copy or full summary of the prison medical records should be forwarded to the new General Practitioner at discharge from prison

The community matron, or equivalent, should be involved in the discharge and aftercare when there have been multiple admissions over a short period of time.

Approved Premises should review the storage and dispensing of medication and consider the use of seven day dispensing packs.

In its response to the draft version of this report, Greater Manchester Probation Area said the Approved Premises division has already looked at the issue of dispensing medication. As the use of seven day dispensing packs depends on the willingness of the local pharmacy to provide this service and the current provision is inconsistent, alternative arrangements are being explored.

The appropriateness of the man's placement at the hostel

66. From March 2006 onwards, the man's health deteriorated significantly. In the four weeks between 20 March and 16 April alone, he was admitted to hospital four times, experiencing chest pains, breathlessness, acute dehydration and kidney failure.
67. Numerous members of hostel staff, including the Senior Probation Officer, told my investigator they did not feel equipped to deal with the man's complex health problems. Certainly they are not trained to do so, and it is therefore not surprising that they described feeling 'out of their depth'. The hostel manager said she did not think the man should have been at the Approved Premises after this time.

68. I fully acknowledge the clinical reviewer's point that people with health problems similar to the man's are routinely cared for in their own homes. The inference is that the hostel should have been able to meet his personal needs. However, an Approved Premises is fundamentally different to a person's home. Whereas a family member might be prepared to help a loved one with their personal care and hygiene needs, the same relationship does not exist between hostel staff and residents. In addition, Approved Premises are currently not resourced to deliver personal care to residents.
69. There is little doubt that the man's quality of life was only maintained because of the goodwill of hostel staff and the unwavering dedication of his wife who visited him every day. The clinical reviewer has identified that the man could have received input from community nursing services. I would go one step further and say that he should have received community nursing services or been placed in a residential care home. I was pleased to learn that the hostel manager and the man's supervising officer continued to pursue this option even after Manchester Social Services had declined responsibility.
70. The man's case poses serious questions about whether Approved Premises are able to meet the needs of ageing and ailing residents. If the current trend for longer prison sentences continues, it is almost inevitable that the resident profile will continue to change, with younger, healthier bailees being replaced by older released prisoners, some with chronic illnesses. NOMS needs to consider how the changing resident profile is affecting and will affect Approved Premises on the frontline.

The National Offender Management Service (NOMS) should conduct a review of the Approved Premises estate to assess its ability to meet the needs of frail, elderly residents. Local initiatives suggestive of good practice should be shared across the estate.

I am pleased to report that Greater Manchester Probation Area has expressed a willingness to contribute to any national review.

Mr man's location after being discharged from hospital

71. After the man was discharged from the Royal Oldham Hospital on 19 May 2006, he was allocated a bedroom on the first floor. He remained there for a couple of days, before being given a room on the ground floor, albeit not one with disabled access. His wife has expressed concerns about this and asked why her husband was not given the disabled room he had occupied prior to his hospital admission on 16 April.
72. My investigator has discovered that, during the course of his hospital admission, the man's residency at the hostel was terminated by Greater Manchester Probation Area. The reason given for this was that it was hoped it would force Social Services to take responsibility for his care. After his residency was terminated, the disabled room was allocated to a new resident who suffered from

emphysema. When the man returned to the hostel in May, the disabled room was still occupied. He was therefore allocated to the room on the first floor.

73. The hostel manager told my investigator that the man was allocated to this room partly on the basis of the Social Services needs assessment which clearly stated that he was able to climb stairs unaided. When a room on the ground floor became available, he was moved there straightaway.
74. Given that medical professionals said that, in their opinion, the man was able to get around without assistance, allocating him a room on the first floor was entirely reasonable. Similarly, in situations where there are competing demands on resources (as I understand it, there is only one disabled room in the seven hostels run by Greater Manchester Probation Area), managers have to make difficult decisions based on need on a daily basis. The decision to allocate the disabled room to an elderly man suffering from emphysema rather than to the man who is the subject of this report is not therefore one that I criticise.

The length of the man's stay at the Approved Premises

75. Prior to being released from Risley, the man was apparently told that he could expect to be at the hostel for four months. His wife told my Family Liaison Officer that both she and her husband were concerned when he was still at the hostel over a year later. She asked my investigator to look into the matter.
76. My investigator was unable to establish who told the man that he could expect to be at the hostel for four months. However, it is not uncommon for prisoners to be given this sort of information whilst in custody. Four months is also not an unrealistic timescale to expect to be at an Approved Premises after being released from custody.
77. As detailed above, released prisoners have to reside at an address approved by the supervising probation officer for the duration of their licence. In practice, this means that the supervising officer can compel a released prisoner to live at an Approved Premises for the whole licence period if they feel it is justified.
78. The man's licence commenced on 19 October and expired on 18 February 2007. The supervising officer was therefore fully entitled to compel him to stay at the hostel until February 2007. For this reason alone, it would be wrong to criticise probation for prolonging the man's residency. However, there is clear evidence in this case that the supervising officer and hostel manager made concerted efforts to find the man alternative accommodation at a relatively early stage. These efforts continued even after Manchester Social Services refused to fund a place at a residential or nursing home and the care home rejected the man's application.
79. Given that there is also evidence that the MAPPA considered the option of the man returning home and rejected it on public protection grounds, I cannot see anything that the probation service could have done differently to shorten his stay.

Informing the man's next of kin of his death

80. The man's wife was extremely unhappy that she only learned of her husband's death when she arrived at the hostel around 11.00am, some three hours after he had been found in his room. As she visited the man almost every day he was at the hostel, she was disappointed that the staff did not telephone her at home before she left around 10.20am.
81. My investigator raised this issue with the hostel manager, who would have been responsible for contacting the man's next of kin or delegating the task to somebody else. The hostel manager said that, when the police arrived at the hostel, they made a point of telling her not to telephone the next of kin. They said that they would take care of it by sending an officer to her home to break the news face-to-face. Unfortunately, the officer arrived at the house after 10.20am by which time she was already on her way to the hostel.
82. When family members and loved ones are to be informed of the death of a prisoner or hostel resident, it is always my preference that they are told face-to-face rather than over the phone. In prisons, it is now normal for a senior member of staff and a trained Family Liaison Officer to carry out this task, geographical considerations allowing. However, in Approved Premises, this may simply not be practical – most hostels have only two or three members of frontline staff on at any time and they are often responsible for managing upwards of 20 residents. (I leave to one side a separate argument that the Probation Area as a whole should take on this responsibility.) In this instance, given that the Greater Manchester Police specifically told the hostel manager not to telephone the man's wife, it would be very unfair of me to criticise the hostel for not doing so. Nevertheless, I understand and share her concern that she only learned of her husband's death when she arrived for her daily visit at the hostel.

Conclusion

83. Overall, despite the very difficult issues raised by this case, I judge that the support and care offered to the man following his release from prison reflect very well upon the hostel staff, their managers, his supervising officer and Greater Manchester Probation Area as a whole.

RECOMMENDATIONS

To the National Offender Management Service

- 1. Approved Premises staff should be involved in case conferences where the future medical care of residents is discussed.**
- 2. The National Offender Management Service (NOMS) should conduct a review of the Approved Premises estate to assess its ability to meet the needs of frail, elderly residents. Local initiatives suggestive of good practice should be shared across the estate.**
- 3. Approved Premises should review the storage and dispensing of medication and consider the use of seven day dispensing packs.**

To the Prison Service

- 4. The Prison Service should undertake a full medical, nursing and social needs assessment prior to discharge to Approved Premises when there are complex medical problems. A full package of support would therefore be in place that met the person's needs.**
- 5. A copy or full summary of the prison medical records should be forwarded to the new General Practitioner at discharge from prison.**

To the Primary Care Trust

- 6. All individuals should be fully registered with a local General Practitioner if they are expected to be resident at an Approved Premises for more than three months. The GP would then have access to the medical records prior to the prison sentence.**
- 7. The community matron, or equivalent, should be involved in the discharge and aftercare when there have been multiple admissions over a short period of time.**