

**Investigation into the circumstances surrounding the  
death of a resident at an Approved Premises in the North  
Wales Probation Area in January 2007**

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

**June 2007**

This is the report into the death of a resident at an Approved Premises in Bangor in January 2007. He was 76 years old when he died of a heart attack.

He was resident at the hostel from 21 August 2006, when he had been released from HMP Wymott. He stayed at there for two months before being discharged to his home address with the approval of the police and probation services. Unfortunately, his return to the community attracted unwanted publicity. For his own safety, he was returned to the hostel under the direction of the police and probation on 6 November.

One of my Family Liaison Officers contacted the man's son to inform him of my investigation and to offer the opportunity to raise any concerns. The man's son expressed some concerns on behalf of the family about the way his father's return to the hostel on 6 November had been managed. I hope this report goes some way towards addressing this and any other matters raised by the family, and I offer them my sincere condolences for their loss.

This investigation has been undertaken by two members of my team. I would like to thank the manager of the Approved Premises, and his staff, for their co-operation and active participation.

The man's son told my Family Liaison Officer that, in all his dealings with the hostel, he found the staff to be professional and good at their jobs. He said that the staff showed his father kindness and respect. My investigators were similarly impressed by the professionalism and commitment shown by the staff team. Their knowledge of individual residents is also worthy of note.

It is clear to me that the man who died was treated very well at the hostel. My report highlights three areas of good practice. I conclude that the support and care shown to the man reflect very well upon the hostel staff, their managers, and North Wales Probation Area as a whole.

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

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## SUMMARY

The man who is the subject of this report appeared at Mold Crown Court on 21 February 2005 and received a sentence of three years' imprisonment. He was released from custody on 21 August 2006, and took up residency at the Approved Premises.

He arrived at the hostel with a nebuliser that had been loaned to him by the prison. He told hostel staff that he had a history of serious ill-health, including three heart attacks. He was formally inducted and an appointment was arranged for him to see a local General Practitioner (GP).

The man initially struggled to adapt to life at the hostel, and he would frequently request permission to go out when he did not need to. He also regularly asked when he would be allowed to go home to live with his wife. Hostel staff attempted to explain that could only happen when approval was given by his supervising probation officer working in conjunction with the police.

In early October 2006, the man was granted permission to go home on a trial basis, initially for overnight visits and then for a whole weekend. When the visits passed without incident, it was decided that he could move home permanently. He was discharged from the hostel on 24 October.

During the night of 26-27 October, a brick was thrown through the window of the man's home. A week later, on 6 November, an article about him appeared in a local newspaper. Due to concerns about his safety, police and probation decided that he should return to the hostel immediately. He arrived there later that day.

In mid-November, the man developed a serious rash. He was referred to his GP and prescribed various treatments, although the problem would persist for another seven weeks until it was finally brought under control.

Over the next few weeks, efforts were made to try to get him re-housed in accommodation more suited to his needs. However, these attempts faltered and he was left feeling anxious as a result of the uncertainty.

In late December, it was noticed that the man's compliance with his medication was becoming erratic. This coincided with incidents when he would wander aimlessly around the hostel late at night, often oblivious to the time of day.

Around 10.30am on 7 January 2007, the man staggered from his bedroom and told staff that he could not breathe. An ambulance was called immediately, and staff and residents made concerted efforts to make him as comfortable as possible. The ambulance arrived within a matter of minutes and took him to hospital. Sadly, he died on the way.

## THE INVESTIGATION PROCESS

1. My investigators considered the man's probation records, including those held by the hostel, before formally opening the investigation on 12 February 2007.
2. Prior to my investigators arriving, 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 investigators. Nobody came forward, although five members of staff were interviewed by prior arrangement.
3. One of my Family Liaison Officers contacted the man's son to offer him the opportunity to participate in the investigation process. He expressed some concerns that, despite his father suffering from a particularly aggressive form of eczema, hostel staff were not allowed to apply any cream. He also questioned the way in which his father's return to the hostel was managed by probation and the police. I hope this report addresses both of these issues and any other concerns he and other family members may have.
4. My investigators 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

5. 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. They operate on each day of the year with 24 hour staff cover.
6. The Approved Premises where the man lived is a 23 bed hostel for men, located in Bangor, North Wales. It is managed by a senior probation officer. 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 nine permanent members of staff, comprising three probation 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.
7. 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 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.
8. Each resident is allocated to a keyworker soon after their arrival. 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. Residents are required to pay rent and abide by the rules and regulations of the hostel, including observing a strict overnight curfew between 9.00pm and 12.00pm the following day.
9. The hostel has close links with local health services, and all residents are registered with a local GP surgery. At the time of my investigators' visit, the hostel was in the process of drawing up a service level agreement with the GP surgery to ensure that newly-admitted residents receive a priority service for first appointments.
10. 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. However, if a resident is known to have difficulties in remembering to come at the right time, staff will seek them out and remind them.
11. When residents are subject to statutory supervision, pertinent information is shared regularly with field probation officers who act as case managers, responsible for decisions about the management of offenders.

## *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
  - receiving visits from the probation officer at their place of residence
  - only undertaking approved work
  - not travelling outside the United Kingdom
  - being well behaved, not committing any offence and not doing anything which 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 which 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.
17. 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) which is made up of senior managers from the MAPPA agencies.

## KEY FINDINGS

18. On 21 February 2005, the man appeared at Mold Crown Court and was given a sentence of three years' imprisonment for a number of serious offences. As the term of imprisonment was less than four years, he was released automatically halfway through his sentence.
19. Due to the nature of his offences, his 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 the Approved Premises upon his release. The others were:
  - To not seek to approach or communicate with the victim.
  - To not enter a specified area of Rhyl in North Wales.
  - To attend a specified offending behaviour programme.
20. On 21 August 2006, the man was released from HMP Wymott and taken by his family to the hostel. Due to his respiratory problems, when he was released Wymott loaned him a nebuliser which he was expected to return as soon as he acquired a replacement from the hostel doctor.
21. Upon his arrival, the man who later died received a full induction from a Probation Service Officer (PSO). Due to his poor health he was located in the hostel's disabled room. In the man's Record Of Contact, the PSO noted that he seemed confused and did not appear to understand everything that was being said to him. She also recorded that he had previously experienced three heart attacks and took a great deal of medication for his heart, lung and blood problems.
22. The following day, the PSO received a call from a specialist community nurse who told her that the man had been treated for tuberculosis whilst in prison. The nurse assured the PSO that the condition was not contagious as the man had been receiving treatment for the past two months. The PSO subsequently contacted the hostel's GP surgery to pass on the information about his treatment for tuberculosis.
23. Later in the day, the man met his keyworker for the first time. The keyworker explained to the man the requirements of his licence, and also discussed his health needs. During their meeting, the man asked about leaving the hostel to stay at his home address overnight. The keyworker explained that this could only take place if he had permission from his supervising probation officer.
24. On 24 August, the man who later died again asked staff when he could return home to visit his family. He was reminded that a condition of his residency at the hostel was that he had to be at the hostel between 9.00pm and 12.00noon the following day. After this discussion took place, the man attempted to get up out of his chair and was observed to have considerable difficulties. He was left to rest before trying to get up again.

25. Two weeks later, on 6 September, the man's supervising probation officer telephoned the hostel to check on his progress. The supervising officer and hostel staff agreed that the hostel was not the best place for the man, given his poor physical health and confusion. The supervising officer subsequently wrote to the man's GP, asking her to undertake an assessment of his mental health and cognitive functioning.
26. On 27 September, the supervising officer visited the man at the hostel to discuss his move on plans. She explained that the MAPPA agencies, specifically the police and probation, were willing to let him return home to live with his family. On 5 October, the supervising officer and the police agreed that it would be sensible for the man's discharge from the hostel to be phased so that the community reaction to his return could be gauged. (His court case received coverage in local newspapers and the MAPPA agencies were aware that his offences evoked strong feelings amongst residents in the area.) Plans were put in place for him to return home for two day visits, followed by a weekend stay.
27. Over the next two weeks, the man returned home three times as planned. There were no reported incidents at his address, and the police and probation services were therefore satisfied that there was no reason to delay his discharge from the hostel. He was collected by his family during the afternoon of 24 October and taken home.
28. During the night of 26-27 October, a brick was thrown through the window of the man's house. The supervising officer and a member of the police Public Protection Unit visited the man at home on 27 October to assess his safety and tell him what to do in the event of further incidents.
29. On 30 October, the man reported to his supervising officer at the probation office, accompanied by members of his family. During the meeting, the supervising officer noted that he looked ill and he said that he was experiencing tight pains across his chest. The man mentioned that he had an appointment at a clinic scheduled for the next day, and had re-registered with a GP in his local area.
30. Three days later, on 2 November, the man's son telephoned the supervising officer's normal place of work to tell her that the man had suffered a stroke. Another member of staff took the call and told the man's son that, if the man was going to miss his scheduled probation appointment on 6 November, he would have to provide a medical certificate signed by a doctor as evidence.
31. On 6 November, an article about the man's offences appeared in a local newspaper. His supervising officer spoke to her colleague in the Public Protection Unit and they agreed that the man could be at risk if he remained at his home address. The supervising officer arranged with the Approved Premises that the man could return there as an emergency case. She and the hostel agreed that he would stay at the hostel for up to two weeks, by which time it was hoped that more appropriate accommodation could be found. He was re-admitted to the hostel in the early evening and placed in the same room

as before. Despite the fact that he had only been living away from the hostel for two weeks, he received a full hostel induction again. This is an example of good practice.

32. Eight days later, on 14 November, a public meeting regarding the man was held in his home area. This came about partly in response to the newspaper article of 6 November which had created a lot of interest in the local community. The meeting was told that the man had been moved out of the area by the police and probation, although not where to. By this point, the MAPPA agencies had decided that the man would have to remain at the hostel for up to eight weeks - longer than originally planned - for his own safety.
33. On 18 November, hostel staff observed that the man who later died had developed a rash. He was convinced that this was a result of the staff giving him the wrong medication, although the hostel records show that these fears were unfounded. An appointment was made for him to see his GP, although it is not recorded whether this took place.
34. A meeting to talk about the man's resettlement was arranged for 6 December. His supervising officer, a police officer from the Public Protection Unit, three representatives of the local housing department, the man and four members of his family attended, and discussed three possible housing options. No firm decisions were made, and the man's supervising officer noted in her case records that he became upset and anxious because of the uncertainty.
35. On 12 December, the supervising officer met the man at the hostel for a planned supervision session. During the meeting, the man repeatedly said that probation was preventing him from returning home to live with his family. He thought this was unfair because he wanted to go home. His supervising officer explained that she and the other MAPPA agencies had decided to return him to the Approved Premises for his own safety. She further explained that more suitable accommodation, outside of his home area, was being sought. After the supervision session was over, the man's keyworker wrote in his case records that he was "suffering badly with his rash and can hardly be still for a moment". A further GP appointment was arranged for 14 December. That day, another article about the man appeared in a local newspaper.
36. On 29 December, the keyworker made another entry about the rash, which by now was covering the whole of the man's body. The keyworker expressed a view that the man should be sent to hospital if the rash did not improve by 1 January 2007.
37. The same day a Residential Service Officer (RSO) at the hostel e-mailed his colleagues about the man's deteriorating health and his faltering compliance with his medication. The RSO acknowledged that the hostel could not compel the man to take his medication, but suggested that his colleagues find the time to assist him and convince him of the benefits of taking it as prescribed. I commend the RSO for noticing the man's dwindling compliance with his medication and alerting his colleagues. This shows that the staff team, whilst

recognising the man's right to refuse his prescribed medication, were aware that this was not in his best interests.

38. During the morning of 2 January, the hostel manager was informed by an RSO who works nights that the man had started to wander around the hostel during the early. He spoke to the man who told him that he was having difficulty sleeping because his eczema was so painful. The man showed the hostel manager his back which was covered with a severe rash. The hostel manager contacted the hostel GP and an appointment was arranged the following day. On the advice of the surgery, the hostel manager told the man to keep using the gel prescribed at an earlier appointment.
39. At 3.00am on 3 January, the night RSO observed the man on CCTV making himself some breakfast. He later recorded that the man had spilt milk around the kitchen, left the fridge door open and was walking around the hostel with boiling water. When asked what he was doing, he appeared confused and had no idea of the time. The night RSO guided the man back to his room and asked him to stay there until later in the morning. He also made other staff aware that he was at risk of causing himself and others unintentional harm by wandering around with boiling water.
40. Later in the morning, the hostel manager took the man to his appointment with the GP and he was prescribed a course of chlorphenamine, an antihistamine frequently used to treat allergic skin reactions. It was also arranged that a practice nurse would visit the man at the hostel every day to apply the ointments to his body. This she did on 4 January, 5 January and 6 January. (Approved Premises staff are neither trained nor permitted to undertake nursing tasks such as this.)
41. On 5 January, the hostel manager and a PSO met the man to discuss his health and move on plans. The hostel manager observed that the man's skin was improving already and he said that he had slept properly for the first time in a while. It is recorded that he looked a lot better. The hostel manager told the man that he was attending a MAPPA meeting on 8 January when a decision would be made whether he would be allowed to return to his home. The man told the hostel manager that he was willing to risk moving back, irrespective of possible media attention and a negative community response. The manager assured him that he would relay his views to those present at the meeting.
42. The following day, the man's physical condition was observed by staff to have improved further still. For the first time in a while, he booked out of the hostel and went into central Bangor. His trip apparently passed without incident.
43. 7 January was a Sunday. As there are no organised activities or appointments for residents on Sundays, and the staff complement is reduced to two RSOs, residents are allowed to have a lie in. At approximately 10.30am, the man came to the reception area outside the general office. A male staff member, one of the two RSOs on duty, observed that his face appeared flushed and his mouth was gaping. The male RSO opened the hatch door and the man said that he could not breathe.

44. The male RSO and his female colleague decided that the man's condition was serious and that an ambulance should be called. Whilst the female RSO telephoned 999, her male colleague saw that other residents were helping the man to sit down in the chairs in reception. As the man was being tended to, the male staff member went to the man's file and removed his medication sheet to give to his female colleague, who by this time was speaking to an ambulance operator. She told the ambulance operator that the man had previously suffered a heart attack and a stroke. The ambulance operator advised her not to give the man anything to eat or drink. The female RSO then telephoned the hostel manager to tell him that the man was seriously ill.
45. Whilst the man's fellow residents attempted to make him comfortable, the male RSO went to get the man's nebuliser from his room and prepare it for use. The male RSO knew that the man was an asthmatic and had observed that his breathing was extremely laboured. The nebuliser was brought into the reception area and a resident at the hostel placed the breathing mask over the man's face whilst the male RSO prepared the machine. In a statement made available to my investigators, the male RSO noted that by this point the man had become very pale compared to the redness he observed just minutes earlier.
46. After a few seconds, the male RSO observed that the normal colour was returning to the man's face. However, at the same time he was becoming weak and floppy in the chair. The male RSO took the decision to remove the mask and took a pillow from the nearest bedroom (which was actually the man's room) and placed it behind him to make him as comfortable as possible.
47. An ambulance crew arrived shortly afterwards, minutes after being called. The female RSO supplied the paramedics with the details of the man's medication, whilst her male colleague applied a damp cloth to the man's forehead in an attempt to cool him down. The ambulance crew asked the female RSO to phone 999 again and request a secondary response vehicle. The man was then removed from the hostel and placed in the back of the ambulance. The ambulance crew continued to treat him in the car park, before departing for the local hospital, Ysbyty Gwynedd. The male RSO telephoned the man's family to tell them that he had fallen ill and was being taken to hospital.
48. The hostel manager arrived at the hostel shortly afterwards to check on the staff and residents. He then made his way to the hospital, where he was informed by the Accident and Emergency Department that the man had died on the way. The hostel manager went to the mortuary where he formally identified the man's body. He gave a statement to the police before returning to the Approved Premises.
49. Upon his return, the hostel manager told the two RSOs that the man had died, offering them the opportunity to go home early. He then spoke to residents to pass on the sad news and offer support. The hostel manager and the male RSO spent most of the afternoon clearing the man's room and packing up his belongings.

50. The man's wife and daughter visited the hostel on 8 January to collect his belongings and to talk to staff and residents about what happened. The man's family passed on their thanks to the two RSOs for their efforts. Hostel staff and residents subsequently attended the man's funeral to pay their respects.
51. The post mortem subsequently carried out at the direction of the HM Coroner for North West Wales attributed the cause of death to myocardial infarction (heart attack), coronary artery disease and hypertensive heart disease.

## ISSUES

### *Issuing of prescribed medication*

52. All members of staff interviewed during the course of the investigation said it was an on-going challenge to persuade the man to take his prescribed medication. He took about eight tablets, twice a day, and was extremely sensitive when his prescription was changed by either the doctor or pharmacist. By way of example, the keyworker told my investigators that if the man's tablets were changed from two 50mg capsules to one 100mg, he would refuse to take it as it did not look the same. If the man did not accept the explanation that it was the same medication but in a different form, the staff would have to telephone the GP who would then try to convince him that the medication was right.
53. According to the staff interviewed by my investigators, the man became increasingly confused in the weeks prior to his death. This is illustrated by the incidences of him wandering aimlessly around the hostel late at night. One member of staff said he was showing early signs of dementia. This coincided (or possibly caused) his compliance to wane still further and, at the end of December, an RSO was sufficiently concerned to alert his colleagues to the problem.
54. Whilst hostel residents have the right, as does any other patient, to refuse their medication, it is important that hostel staff are aware of their legal status and the expectations of their employers when it comes to issuing medication. Although there is no evidence to indicate that the man's death would have been prevented or delayed by different medication practices at the hostel, my investigators detected a sense of uncertainty amongst the staff group about where they stand. Three members of staff said that they would welcome training.
55. I was pleased to learn that the hostel was already making preparations for training staff in dispensing medications prior to my investigators' visit. In its response to the draft version of this report, North Wales Probation Area has confirmed that plans for staff training are now at an advanced stage. As a consequence, there is no need for me to make a formal recommendation although I draw this matter to the attention of the National Probation Service as a whole.

### *The management of the man's return to the hostel*

56. The man's son expressed some concerns to my Family Liaison Officer about the way his return to the Approved Premises was managed by police and probation. As detailed above, the man's return was precipitated by a brick being thrown through the window of his house and a negative article appearing in a local newspaper.
57. Having considered the available evidence and spoken to probation staff, I am satisfied that the two agencies, working in accordance with the MAPPA

protocols, acted with the man's best interests (and safety) in mind. I am aware that the man was firmly of the opinion that he would prefer to stay at home, irrespective of the consequences for himself. However, the primary function of the MAPPAs is to protect the public. This includes not only those who could be at risk from an offender, but also the offender himself and those who could be harmed by association, in this case the man's wife.

58. Whilst the man's return was hastily arranged, this came about because of the speed with which external events occurred. In the circumstances, I think the police and probation went down the only defensible path.

### ***Appropriateness of the man's placement at the hostel***

59. In the last weeks of the man's life, staff at the hostel became increasingly concerned about their ability to care for him. Not only was he starting to wander around the hostel late at night, he was noticeably more confused about his medication and finding his way around the premises. Whilst there is no doubt that the hostel staff did their very best to look after him, they are not trained to deliver what might be considered nursing care.
60. Given this, it was very encouraging to learn that the hostel manager and the man's supervising officer had already started exploring alternative housing options when events took over. The hostel manager told my investigators that he was scheduled to attend a MAPPAs meeting on 8 January to discuss moving the man on to a nursing home. Sadly, he died the day before and this meeting did not take place. Given that the deterioration in the man's health was only evident shortly before he died, I cannot criticise probation staff for not acting sooner.

### ***Staff support for the man during his stay at the hostel***

61. Notwithstanding the question of the appropriateness of the man's placement in the weeks before he died, it is clear that he was treated very well throughout his stay. He was a vulnerable individual who was treated with care and compassion. For example, the man's keyworker told my investigators that staff routinely accompanied the man to his GP appointments to offer him support. This is good practice.

### ***Conclusion***

62. Overall, 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, and North Wales Probation Area as a whole.

## **GOOD PRACTICE**

1. Formally inducting the man again after just a short absence is an example of good practice.
2. The RSO who identified the man's deteriorating compliance with his medication should be commended for alerting his colleagues to the problem.
3. Ensuring that the man was accompanied by staff when he attended GP appointments is a further example of good practice.