

**Investigation into the circumstances surrounding the
death of a man in the Merseyside Probation Area
in October 2007**

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

March 2008

This is the report of an investigation into the death of a man at an Approved Premises in the Merseyside Probation Area, who died from natural causes on 22 October 2007. He was 64 years of age.

I would like to add my personal condolences to those already expressed to the man's family on behalf of this office by one of my Family Liaison Officers.

This investigation was undertaken by one of my investigators. I am grateful for the assistance he received from staff from the Merseyside Probation Area.

I believe that the man was well looked after by probation staff and I make no recommendations.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and residents involved in my investigation.

Stephen Shaw CBE
Prisons and Probation Ombudsman

March 2008

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SUMMARY

The man was born in 1943. He was 64 years old when he died at an Approved Premises in the Merseyside Probation Area. The man died as a consequence of a heart attack.

In July 2007, at North Sefton Magistrates' Court sentenced the man to four months imprisonment which was suspended for a period of 18 months. He moved into the Approved Premises on 18 July.

During his induction at the Approved Premises it was noted that the man had a history of depression and heart disease. His prescribed medication was kept in a locked cabinet in the duty office. The man had suffered a heart attack in March 2006 and three angina attacks in 2007. He had been prescribed a glyceryl trinitrate (GTN) spray which he used when he experienced angina.

During the early evening on 22 October 2007, the man was watching television with other residents in the lounge at the Approved Premises. Around 8.00pm, after the programme finished, the man returned to his room. Whilst carrying out room checks around 9.40pm, a member of staff discovered the man lying on the floor of his room. The man did not respond to his name being called so the member of staff felt his neck. It was cold to touch and the member of staff could not feel a pulse. An ambulance was called and paramedics confirmed that the man had been dead for some time.

THE INVESTIGATION PROCESS

1. On 24 October 2007, my investigator issued notices announcing the investigation to staff and to residents at the Approved Premises. The notices included an invitation to those who wished to submit information relating to the man's death to make themselves known. In the event, nobody came forward. My investigator also studied all relevant probation records relating to the man. These included his main probation record, medical records, supervision plan and licence. My investigator visited the Approved Premises on both 1 and 20 November and discussed aspects of the man's treatment with staff.
2. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my 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 into the man's death.
3. One of my Family Liaison Officers contacted the man's family. This gave them the opportunity to discuss the purpose of the investigation and to raise any concerns or questions they would like explored and addressed. The man's wife described her husband as a "lovely man" who, due to circumstances beyond his control, had in recent years suffered from depression and problems with alcohol. She spoke positively about the support that staff at the Approved Premises had given her husband prior to his death, and the kindness they had showed her in the weeks following. The family did not ask for any specific concerns to be investigated at this time. I hope that my report helps the family to understand the events leading up to the man's death.

KEY EVENTS

4. As noted earlier, in July 2007 the man received a suspended sentence of four months imprisonment. He was to be supervised during this period by his offender manager. He also had to carry out 120 hours of unpaid work.
5. The man moved out of the marital home after attempts at reconciliation with his wife were unsuccessful. On 18 July 2007, as he was homeless, he moved into the Approved Premises.
6. Upon arrival at the Approved Premises, residents receive a full induction and are made welcome. During the induction process they are told about the local house rules and the behaviour expected of them. The man was allocated room 8 and the member of staff who carried out his induction was appointed as his key worker.
7. The role of the key worker is to provide one-to-one sessions underpinned by objectives outlined in the sentence plan. The key worker was also a conduit between the man and his offender manager. The offender manager is responsible for assessing an offender's risks and needs, planning how a sentence will be organised, deciding what activities need to be carried out and how they will be delivered. They are also responsible for reviewing the offender's progress against their sentence plan and for adjusting the plan in the light of changing circumstances. Residents are required to maintain regular contact with the key worker and the offender manager.
8. On his arrival at the Approved Premises, it was noted that the man had a history of depression and heart disease. He had been prescribed medication for his conditions. (He had suffered an angina attack within the previous week.) Medication for all the residents at the Approved Premises is kept in the duty office in a locked cabinet. Residents have 24 hour access to the medication via a hatch in the duty office. The Approved Premises expects residents to take their medication at the correct intervals but, if someone is absent minded, staff will remind them to take it. My investigator saw how this process was administered and was able to view the man's medication record.
9. On 11 August, the key worker noted in the record of the man's key working session that the man had suffered a heart attack in March 2006 and had three angina attacks in 2007. The man had a GTN spray that he used to alleviate symptoms when he experienced an angina attack. When the key worker saw him on 31 August at his next key working session, the man said that he felt much better.
10. On 14 September, the man left the hostel as he had been given permission to travel to Germany for the weekend. On 19 September, he attended community service but was sent back early to the hostel as he was feeling unwell.
11. The Deputy Manager of the Approved Premises wrote to the local housing centre on 28 September to ask them to make arrangements for the man's

accommodation. When my investigator spoke to the Deputy Manager she described the man as “a polite, courteous and pleasant man”.

12. During his first key worker session on 11 August, the man had asked whether he could be given accommodation on a lower floor as there would be fewer stairs to climb. The Approved Premises is not a purpose built hostel and there is no resident accommodation on the ground floor. There are some bedrooms on the first floor but, as there are no other facilities, residents have to climb the stairs to the next floor to use the bathroom, lounge or tea making facilities. There are also some bedrooms on the second floor. When a shared bedroom became available on this floor, the man declined it saying it was too noisy (as it was next to the lounge). He preferred to stay on the third floor because he wanted his own room. When interviewed for this investigation, the Deputy Manager said that the man moved into his own room on the third floor (room 10) on 22 October.
13. During the early morning on 12 October, the man left the hostel as he had been given permission to travel to Germany to play at a charity function. He returned just before lunch on 15 October.
14. On 17 October, hostel staff reminded the man that he needed to make an appointment with his doctor for a repeat prescription. He handed his new medication to staff the following day.
15. When interviewed for this investigation, the key worker recalled that during the day of 21 October he had a conversation with the man. During the conversation, the man had spoken about his life and recounted how he had played at a famous theatre in London.
16. During the early evening on 22 October just before 6.00pm, the man left the hostel to go to the local corner shop. On his way past the duty office he asked if anyone wanted anything. The key worker recalled that a colleague, a Probation Service Officer (PSO), had asked for a bottle of Lucozade. When interviewed by my investigator, the PSO confirmed that he had seen the man before he went to the corner shop. He next saw him again in the pool room and they had a brief chat about Germany as the man was planning another trip there.
17. The key worker saw the man again around 7.45pm, watching television with two other residents in the lounge. The key worker reminded the man to ensure that he took his medication. The man said that he would be down later to collect it.
18. The key worker said that he had no concerns about the man’s health as he looked well and was with two other residents. The key worker knew from previous experience that if the other residents had any concerns about a fellow resident’s health they would immediately tell staff. Residents had not raised any concerns about the man’s health nor told staff that he was unwell.

19. The man and the other two residents finished watching television around 8.00pm. All three men then went up to the man's room so that the other two residents could collect a spare television which was kept there.
20. Around 9.30pm, the PSO started to do room checks. He arrived at the man's room at around 9.40pm as this was the last room to check. The PSO noticed that the door was slightly ajar. He knocked on the door and shouted the man's name a couple of times. He then entered the room and called his name again. The PSO found the man on the floor and his initial thought was that he was dead. He felt the man's neck, which was cold to touch. Nor could he establish a pulse.
21. The PSO then rushed downstairs to the duty office whilst making a call to the emergency services on his mobile. At the duty office he informed the key worker about the man. The two colleagues ran upstairs to the man's room. The key worker opened the door and called the man's name. The man was collapsed on the floor. His skin was very pale, his ears had gone blue and there was no movement in his chest. The key worker held onto the man's wrist to feel for a pulse but could not find one. He also noted that the man's skin was very cold. The paramedics arrived soon afterwards and took over the man's care. The paramedics attached a monitor to the man's chest. This confirmed that he had died.
22. Around 10.00pm, the key worker notified the Duty Manager about the man's death and he then logged what had happened. The Deputy Manager and a Probation Residential Officer (PRO) along with the Duty Manager then came to the hostel. The Deputy Manager and the PRO informed the other residents that the man had died.
23. The police contacted the man's family to inform them of his death. They had trouble locating the family home. Contact was made late the following day as there was no one at the family home during the day. After the police had informed the family, a Senior Probation Officer contacted the man's family to offer condolences and support. Arrangements were later made for the man's belongings to be given to his family. Staff from the hostel also attended his funeral.
24. The post mortem report records the man's death as being due to natural causes, as a consequence of a heart attack caused by ischaemic heart disease. The Coroner has decided that an inquest will not take place as there are no suspicious circumstances surrounding the man's death.

CONCLUSION

25. The man moved to the Approved Premises in July 2007 and died there of natural causes in October 2007.
26. From interviews with staff, the man appeared to be a well liked and respected resident. He seemed to be very happy at the Approved Premises and had used his time there as a launch pad towards a new future. Music had come back into the man's life, and he had turned a corner. He was due to play at a concert in Germany the weekend after his death. It is particularly sad that his death occurred when the man was about to start on his new path in the music industry.
27. In light of the findings of my investigation, I conclude that the care provided to the man was entirely appropriate. Indeed, I think that staff at the Approved Premises treated the man with sensitivity and professionalism. I make no recommendations.