Investigation into the circumstances surrounding the death of a man at an Approved Premises in the Humberside Probation Area in February 2008

Report by the Prisons and Probation Ombudsman for England and Wales

August 2008

This is the report of an investigation into the circumstances surrounding the death of a man on 12 February 2008 at an Approved Premises, Scunthorpe. The man collapsed and was discovered approximately ten minutes later by another resident, outside the main entrance to the building. Attempts were made to resuscitate him before paramedics arrived. The man was pronounced dead at the hospital. He had suffered an acute heart attack. The man was 42 years old.

The loss of any family member is distressing and I offer my sincere condolences to the man's family and friends.

The investigation was undertaken by one of my colleagues. We would like to thank the manager of the Approved Premises and her staff for their cooperation, and for gathering all relevant documentation and ensuring it was made available.

The man had been released on a nine month conditional licence from HMP Lindholme on 1 February. He lived at Victoria House for just 11 days. The man's family had a history of heart problems and high cholesterol, unbeknown to staff at Victoria House until after he died. The man was not taking any prescribed medication before his custodial sentence, during and post release from prison. On arrival at the hostel, he registered with a local GP surgery but did not make an appointment.

The man's heart attack is typical of someone his age and with his lifestyle. Heart attacks remain the most common cause of death amongst men over 40 years old and occur when the blood supply to part of the heart is interrupted by a blockage to the coronary artery. The man's symptoms of apparent sudden chest pain on the day he died were also characteristic of a heart condition. Unusually, his heart attack was captured on Close Circuit Television, albeit obscurely. The staff response to the man's collapse was also captured, more intelligibly.

At the time of writing, there have been 67 deaths of residents in Approved Premises since I took over responsibility for investigations in 2004. This was the first death in custody at Victoria House for four years, and my investigation has revealed how, despite the lengthy period without a death under their supervision, staff at Victoria House acted professionally in their response. Following the man's death, the approved premises manager identified where one improvement could be made to internal instructions covering emergencies. This concerns the compilation of a grab sheet to act as staff guidance in emergencies. I agree with her judgement.

In short, this is an investigation that reflects well upon staff at Victoria House and the Yorkshire and Humberside Probation Area. It gives me pleasure to issue this report without any recommendations.

Jane Webb
Deputy Prisons and Probation Ombudsman **August 2008**

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SUMMARY

The man was sentenced to 18 months imprisonment on 9 October 2007, following a period on remand. He served four months at HMP Hull and, latterly, HMP Lindholme before being released on licence.

The man's licence conditions dictated he reside at Victoria House. He arrived on 1 February 2008 with his licence enforcement plan. The man's nine month licence, due to expire on 11 November was explained to him in full both before he was released from prison and once again at the Approved Premises. He had some difficulty understanding and accepting part of his licence conditions but worked well with his offender manager in the short time that he was a resident. During his induction with an appointed key worker, the man said he had no physical or mental health problems.

On 12 February, the man had an arranged meeting with his offender manager and a trainee probation officer to discuss his action plan for the future. Later that day, the man apparently asked other residents if they had any indigestion tablets. None of the residents could help him. At about 3.00pm, he spoke to his sister and complained that he had been experiencing chest pains. The man's sister advised him to tell the staff at the hostel. They also arranged to meet at around 4.00pm that day, after his meeting with the offender manager.

It is not known precisely when but at sometime around 3.00pm, the man spoke to his sister and the Deputy Manager of the hostel. The man told his sister that he had chest pains. According to the Deputy Manager, he told her that he had heartburn. The man asked for some tablets but was told by the Deputy Manager that if he needed over the counter medication, he should go to the local chemist and purchase his own.

At 3.20pm, the man went outside with a cup of tea. He sat down on one of the chairs, obscured from the CCTV camera that filmed the front door entrance. Approximately 15 minutes later, the man collapsed. At the same time, his offender manager arrived early for their planned meeting, due to start at 3.45pm. The man lay for around thirteen minutes before he was found by another resident.

The man's offender manager was the first member of staff to raise the alarm and the hostel's Assistant Warden responded, followed by other members of staff. Life support was given while an ambulance was called. Paramedics arrived within four minutes and took over the resuscitation procedures.

Around 15 minutes later, the man was taken to hospital. His sister arrived at the hostel to find out where he was and had seen an ambulance enter the premises from where she was parked. The Hostel Manager explained what had happened, and told the man's sister which hospital he had been taken to. The man's sister mentioned that there was a history of high cholesterol in the family.

The manager telephoned the hospital's Accident and Emergency Department at around 5.10pm, and was told that the man was pronounced dead shortly after his arrival.

THE INVESTIGATION PROCESS

1. The investigation was opened by one of my investigators, on 14 February 2008. My investigator requested all relevant documentation and, following receipt of the man's files, began to identify the key issues and the staff who interacted with him during his brief time at Victoria House. My investigator interviewed the manager of the Approved Premises on 3 March. My investigator also asked for further documentation during her visit and received the remainder of the man's documentation in due course.

2. The Coroner was informed of the Ombudsman's investigation. In return, the Coroner's Officer contacted my investigator to confirm that there would not be an inquest into the man's death. My investigator asked for a copy of the post mortem report and I am grateful to the Coroner's Officer for sharing this information so speedily. The post mortem report concluded that the man's cause of death was acute myocardial infarction and dilated cardiomyopathy. The Coroner will receive a copy of this report.

3. One of my Family Liaison Officers contacted the man's next of kin shortly after the investigation was opened. The family liaison officer explained her role and that of my office and provided information about the investigation process. My investigator also offered the man's family the opportunity to raise any issues or concerns. The man's sister expressed concern that the man did not feel well on the day he died. She asked for further information about the man's chest pains on the day he died, which he told her about over the telephone. She advised him to tell a member of staff. The man said that he had already told staff and was told to go to the local pharmacy to buy his own medication, but he did not have any money. His sister asked who the man spoke to and whether the action by staff was appropriate.

4. Following sight of the draft report, the man's sister highlighted one factual inaccuracy relating to the meeting that she arranged with the man. I have made the necessary amendment in the appropriate section of this report. The draft was also sent to Humberside Area Probation Service.

VICTORIA HOUSE APPROVED PREMISES

10. The purpose of Approved Premises (formerly known as probation and bail hostels) is to provide an enhanced level of residential supervision in the community, alongside a supportive and structured environment. Such premises are approved by the Secretary of State (Justice Secretary) under Section 9 of the Criminal Justice and Court Services Act 2000. Approved Premises do not function to imprison offenders in the community. Residents have to comply with their individual licence or bail conditions, curfews, and the 'house rules' of premises but essentially, they are free to come and go from the building(s).

11. Victoria House is one of 101 Approved Premises in England and Wales and one of 13 premises in the Yorkshire and Humberside Probation Area. It has a total of 20 beds (one emergency bed), and normally accommodates 19 residents. It is staffed 24 hours a day by probation employees whose role is to provide support and ensure that the rules and licence or bail conditions are complied with. Victoria House operates a curfew from 11.00pm to 6.00am. It also operates a 24 hour CCTV facility which covers all communal areas inside the hostel, the main office area and the front door entrance to the building.

13. On arrival, all residents are offered a tour of the premises and the opportunity to register with a local GP surgery. Victoria House has an arrangement with the surgery to enable all new residents without a GP of their own to register during their stay. Appointments can be made within 24 hours of arrival. Victoria House also has an arrangement with the GP surgery and local pharmacy to facilitate the delivery of medication to the premises. All prescription medication must be handed in to the staff in the front office, where each item is logged and stored safely. Residents can request their medication at any time up to 11.00pm. They are also permitted to place a request for medication during the night.

14. Information about relevant rules, procedures and expectations whilst a resident at Victoria House is also given during induction and residents are allocated both a key worker (Assistant Warden or the Probation Service Officer) and a link/support worker. Regular key work sessions then take place which gives residents the opportunity to discuss any issues or difficulties in more depth. Within five working days, a three way meeting is arranged between a new resident, the key worker and the offender manager. The resident's action plan (setting out the courses to be taken and issues to be addressed as part of a rehabilitation programme) is discussed. Three way meetings then take place every four weeks.

15. The day-to-day routine at Victoria House is relaxed, although residents do have to surrender their keys on weekdays between the hours of 9.00am – 11.30am to allow for all communal areas to be cleaned. Key work sessions run during the day, and some residents have to attend offender management meetings or groupwork appointments with external staff in the probation service area. Other residents occupy their time in employment or attend counselling and other life skills sessions in the local probation offices.

16. Victoria House keeps basic first aid equipment in the main office, which includes resuscitation face masks. All staff are fully trained in first aid and the four day training they complete is comprehensive. Refresher courses are also available every two years (on a rota system). Staff and visitors are also required to carry personal alarms with them at all times.

17. Her Majesty's Inspectorate of Probation (HMIP) last inspected the Yorkshire and Humberside Probation Area in July 2005. The area was inspected under the Effective Supervision Inspection Programme which did not include Approved Premises. Under HMIP's current programme, Approved Premises are inspected and Yorkshire and Humberside is due for inspection later this year.

18. In a recent joint inspection of Approved Premises, 'Probation hostels: Control, Help and Change?' (published in March 2008), Her Majesty's Chief Inspectors of Probation, Prison and Constabulary visited a number of Approved Premises and concluded that, overall, the control function of hostels was being delivered. Inspectors found that both 'Help' and 'Change' functions required some improvement, however, many examples of good practice in these areas had also been evident.

KEY FINDINGS

26. The man was sentenced to 18 months imprisonment on 9 October 2007. As he had already spent just over five months on remand, he became eligible for release on conditional licence on 1 February 2008. Arrangements were made, as part of his pre-release from Lindholme, for him to take up residency at Victoria House Approved Premises.

27. The man was subject to an exclusion zone as part of his licence conditions. This was explained to him along with the other conditions of his release. The man appeared happy with the conditions in the main, but regularly questioned whether this would hinder his chances of securing employment in the transport industry.

28. The man arrived at Victoria House during the afternoon of 1 February. He brought with him some personal belongings but no prison record of being on medication. He was inducted by a Probation Support Officer (PSO) who became his key worker. The man said that he had no health problems but agreed to register with the local GP surgery. He was allocated a room on the first floor. After a tour of the building and an explanation of the hostel rules, he settled in well.

29. Later that day, the man attended his first 'three way' appointment with his Offender Manager, and his key worker. They discussed his licence conditions again. The man expressed some unhappiness about one of the conditions but confirmed that he understood what was expected of him and signed the licence. An initial action plan was completed with the man's full engagement. This set out how his risk and rehabilitation would be managed in order to prepare him for a return to the community. In agreement with the offender manager, the man would focus on securing accommodation and employment as part of his resettlement programme.

30. For the next two days, the man was checked on by staff and appeared to be doing well. He stayed close to the hostel and spoke to one of his brothers about the prospect of helping him at work as an initial step towards re-employment. The man agreed to speak to the offender manager about it before going out with his brother. He also made enquiries with the Benefits Agency about making a claim for Job Seeker's Allowance. His progress was recorded on the Probation Area's database.

31. On 5 February, the man met with the offender manager and her co-worker, a trainee probation officer. They discussed his accommodation and the prospect of the man going to live with one of his sisters. The man could not provide a full address but explained that he was due to meet up with his sister later in the week and would obtain it then. The offender manager provided him with a copy of a map showing the areas where the man was prohibited from going. He expressed some concern over his licence conditions again, and said that he felt they may hinder his chances of re-employment and resettlement. The man's next appointment was scheduled for 12 February at 3.45pm.

32. The man met his key worker the next morning for his first session. Reflecting on the meeting, the key worker recorded that the man had got used to the hostel and was getting on well with staff and residents. His sister had offered him accommodation and he was continuing to focus on getting a job with his previous employer. The key worker mentioned that the man's licence conditions may have implications but that the man was discussing the issue with the offender manager.

33. On 7 February, the man spent the day with his sister. When he returned to the hostel that evening, he told one of the Assistant Wardens and duty officer that night, that he had an infection in his left eye and had been to see the local GP. The man then went to the Accident and Emergency Department at the local hospital and was prescribed eye drops to treat the infection.

34. Four days later, on 11 February, another Assistant Warden made a note in the man's log that his left eye was still causing him problems. Seeing that the man's eye was red, this assistant warden asked him if he wanted to make an appointment with the doctor. The man declined and said that he preferred to go to hospital and had not seen a doctor for approximately 19 years. He kept his eye drops (Maxitrol, 5ml) in his room in agreement with hostel staff.

Tuesday 12 February

35. At some point during the morning, another resident helped the man apply his eye drops. The man then watched television in the lounge and seemed fine according to the residents who saw him. During the early part of the afternoon, the man began to complain of indigestion and asked if anyone had any indigestion tablets. None of the residents he asked could help him. At approximately 2.50pm, the man spoke to his sister on the telephone and arranged to meet her after his planned three-way meeting with the offender manager and the trainee probation officer. The man told his sister that he had pains in his chest. His sister advised him to speak to a member of staff. He said that he already had and was told to buy his own medication.

36. According to the approved premises manager's chronology of events, shortly after 3.00pm, the man knocked on the main office door and asked the Deputy Manager if she had any indigestion tablets. The deputy manager explained that she did not, and advised him to walk down to the chemist to purchase his own. The deputy manager later confirmed to the approved premises manager that the man did not tell her he was having chest pains and did not show signs of being ill. The approved premises manager's statement of her interview with my investigator, said that the man described heartburn to the deputy manager.

37. At around 3.14pm, CCTV footage of the upstairs corridor showed the man walking towards the staircase. He then disappeared down the stairs and reappeared on camera in the kitchen. He made a hot drink, and from the footage viewed, he did not present as noticeably in pain or distress. The man then left the kitchen and made his way to the front door. At approximately

3.20pm, the camera filming the inside of the main office showed the man's silhouette through the window in the main office door as he left the building. It was not clear from the footage whether the man could open the front door or needed to be let out by staff in the main office. My investigator later confirmed that the man let himself out.

38. The man went outside to drink his tea while he waited for the offender manager to arrive. One of the CCTV cameras is positioned to look directly at the front door to the hostel. It is positioned high up, on the outside wall of the entrance to the building, and therefore, looks down at the front door at an angle much higher than eye level. From the camera position, the man could clearly be seen walking around in the front garden. At 3.27pm, he sat down on one of the chairs that had been placed along the front of the building by the residents who smoked. Unfortunately, this was a blind spot for the camera. He went 'off screen' for approximately five minutes.

39. The next image of the man was at 3.32pm. Two minutes later, he sat back down and again went off screen. The offender manager arrived for their planned three-way meeting at 3.36pm, a few minutes early. As she followed the path and turned left to face the front door of the hostel, the offender manager looked left, through the window to the main office and pressed the buzzer to alert staff that she had arrived. The man's key worker let the offender manager in. She made her way to the main office, signed in and collected her personal alarm.

40. At roughly the same time, the man presumably slumped in the chair. It is not clear from the CCTV footage exactly what happened, given that he was mostly obscured from the camera. What is clear is that the man dropped his mug of tea, which could be seen rolling down the path, and his right leg (the only visible part of his body) kicked out to the side of him slightly. The man's right foot remained in camera view for approximately two and a half minutes. In the main office, the man's key worker and the offender manager could be seen talking and looking at the four CCTV screens sporadically. The offender manager continued to wait for the man and her colleague, the trainee probation officer, unaware that the man was outside.

41. At 3.39pm, the man fell from his seat and collapsed on the pavement. His head came partly into camera view on the bottom right hand side of the screen. Neither the man's key worker or the offender manager noticed. About four minutes later, at 3.43pm, the trainee probation officer arrived at the front door of the hostel. As the offender manager had done moments earlier, the trainee probation officer stayed on the path, turned left towards the front door, and then looked left into the main office window to alert staff that she had arrived. The trainee probation officer was buzzed in and made her way to the main office. The trainee probation officer did not see the man's head to the right of the main entrance door.

42. The key worker left both the offender manager and trainee probation officer in the main office to tell the man that they had arrived. He could not find him. According to the approved premises manager's chronology of events, the key

worker first checked the man's room, and then looked in the two residents lounges on the ground floor before knocking on other resident's doors. At around the same time, the Assistant Warden on duty, was about to finish her afternoon break and made her way outside through the main office, to the fire escape to have a cigarette. This assistant warden was joined outside by her colleague, a support worker at the hostel, who had come in early for his shift.

43. At 3.50pm, another resident, made his way outside to have a cigarette. He used the front door entrance. The CCTV footage showed the resodent open the front door and walk outside from one camera angle. He could also be seen walking past the main office window to go outside from another camera angle. The resident looked to his left as he stepped outside the door, and saw the man lying on the floor. He bent down, saw that the man was motionless and went back inside. The resident knocked on the main office door, and when the offender manager opened it, the resident told her that the man had collapsed. They went outside. On seeing the man lying on the floor, the offender manager pressed her personal alarm to alert other staff that there was an emergency.

44. The assistant warden on duty was the first member of staff to respond to the alarm. She was closely followed by several other members of staff, including the approved premises manager and deputy manager. At 3.51pm, the assistant warden was seen on camera bending down to check the man. At the same time, the key worker went back to the main office and telephoned for an ambulance.

45. The approved premises manager told my investigator that, on realising that the man was motionless, the assistant warden asked her to get a resuscitation pack which included a protective face shield. It is clear from the CCTV footage that the approved premises manager walked back into the office for a resuscitation pack at 3.52pm. The deputy manager took a pillow out to the assistant warden, who then placed it under the man's head for support. The approved premises manager closely followed and handed the assistant warden the pack. At approximately 3.53pm, the assistant warden began to administer mouth to mouth and chest compressions.

46. The approved premises manager stayed outside while the assistant warden gave the man CPR. At 3.55pm, paramedics arrived and took over his life support. Between them, the key worker, deputy manager and approved premises manager gave paramedics further information about the man. The approved premises manager wrote in her chronology of events that this included details about his next of kin (named as the man's brother), his date of birth and the medication he was using. A member of staff, believed to be the support worker, obtained the man's eye drops from his room and handed them to paramedics. The man was placed on a stretcher and left Victoria House for the local hospital at 4.10pm. The approved premises manager and assistant warden returned to the office at 4.11pm with the used equipment.

47. Shortly after the man left for the hospital, staff gathered in the main office and watched what appeared to be a recording of the CCTV footage covering the

time of his collapse. The approved premises manager told my investigator that the deputy manager telephoned the relevant agencies and Area Chief Officer for Humberside Probation and began her own log of what happened. The approved premises manager filled in a green accident report form and held a debrief session with assistant warden and the key worker. All other staff on duty were offered support and were reminded of the counselling service.

48. By coincidence, the man's sister had been parked relatively near the hostel and was waiting for the man when he collapsed in the front garden. She had rung his mobile phone a few times between 4.05pm and 4.30pm to see where he was. At around 4.30pm, she went to Victoria House to look for him. The approved premises manager took the man's sister into the interview room, explained that the man had collapsed, and that he was taken to hospital by ambulance. The man's sister said that she had seen the ambulance drive by from where she was parked and had hoped it was not for her brother. She also told the approved premises manager that the man had complained to her that he was having chest pains. The approved premises manager said that she was not aware that he was having pains, and that unfortunately, he had not disclosed this to her staff. The approved premises manager later told my investigator that, at the time of speaking to the man's sister, she was unaware that the man had asked other residents for indigestion tablets a few hours before he collapsed.

49. The man's sister left her contact details with the approved premises manager before making her way to hospital. At approximately 5.10pm, the approved premises manager telephoned the hospital and was told that the man had died. The approved premises manager explained that his sister was on her way and was his next of kin contact. The man's sister's details were given to hospital staff. Shortly after, at about 6.00pm, the approved premises manager and the deputy manager gathered residents in the lounge and told them that the man had died. The resident that found the man was specifically asked if he was okay and the appropriate care and support services were offered. Other residents not present at the time, were told as and when they arrived back at the hostel.

50. Later that evening, the Assistant Chief Officer for Approved Premises, arrived at Victoria House. He offered support to the staff and was further briefed on what had happened. The remaining staff on duty were also offered support by the Assistant Chief Officer for Offender Management in the area.

51. The approved premises manager made arrangements with the man's sister to collect his personal belongings. The staff at Victoria House sent a card of condolence to the man's family but did not attend the funeral.

ISSUES

52. The man came to Victoria House as part of his release on licence from Lindholme. Little was known about him on arrival, and during the short time he spent there, the man preferred to keep himself to himself. He complied with his licence conditions and was looking to regain employment in the fishing delivery industry. The man's wish to live with his sister was also being explored as part of his 'moving on' action plan, and would have been a positive step toward re-integrating into the community.

53. I mention in my introduction to this report that the man's family had a history of heart problems and high cholesterol, but staff at Victoria House did not know this until after he died. In a previous investigation at another approved premises, I reported that rapid responses to cardiac arrest significantly increases the likelihood of someone surviving a heart attack. When the heart stops, the absence of oxygenated blood can cause irreparable brain damage in a few minutes, and death invariably occurs within ten minutes. Crucial to that investigation, and the main focus of my investigation into the man's death, has been in how staff responded to his collapse. I have also concentrated on the effectiveness of CCTV, the monitoring of residents' behaviour and the concern raised by the man's family. I deal with the issues raised by my investigation below.

The man's complaint of chest pain and request for non-prescribed medication

54. During the early stages of my investigation, the man's sister told the approved premises manager and my FLO that he had complained of chest pains on the afternoon of his death. The man's sister advised him to let staff know about his symptoms and was surprised to learn of the response the man got, which was to medicate himself. There was some discrepancy over exactly when the man told the deputy manager that he was in pain and what type of pain he experienced. The deputy manager told the approved premises manager that the man did not tell her that he was experiencing chest pain, but that he had heartburn. The approved premises manager's chronology of events said that this happened just after 3.00pm. The man's sister said that when she spoke to him at 2.50pm, he said that he had already told a member of staff he had chest pain. I have not been able to confirm the precise time that the man knocked on the office door, nor the type of pain the man described. From the CCTV footage, the man did not present as in distress while he made a hot drink at 3.14pm and took it outside a few minutes later. The deputy manager also told the approved premises manager that he did not show signs of being ill when they spoke. The man had no known medical problems and did not come to hostel with medication from prison. As a resident, but effectively in the community, the man could come and go as he pleased save for his two licence conditions. I cannot level any criticism at the deputy manager for responding in the way that she did to the symptoms the man described.

The man's collapse and the staff's response

55. The man lay collapsed outside the main building for approximately 14 minutes before a resident discovered him. When the assistant warden arrived at the man's side at 3.51pm, there was a further two minute delay before she commenced CPR. My investigator viewed the footage of the man's collapse several times during the investigation process. In addition, she consulted the Head of Probation and Diversity for my office, who also viewed the footage from the camera in the main office, and the camera pointing at the front door entrance to Victoria House. My investigator also followed the route to the front door entrance that both the offender manager and trainee probation officer took when they arrived for their three-way meeting with the man that day. This investigation has considered two questions. Firstly, whether staff could have reasonably discovered the man any earlier, and secondly, whether attempts to commence CPR should have started as soon as he was found. I deal with these questions in turn below.

CCTV and monitoring

56. Under Humberside Approved Premises Controlled Exit and Entry Policy, staff are required to make residents aware of the 'T card system', which in Victoria House, is located by the front door. The system simply asks residents to move a card to let staff know whether they are in or out. By 'in or out' the policy is aimed at residents who intend on leaving the building. Residents who go outside but remain in the grounds are not subject to this requirement. The man was one of those residents.

57. With regard to CCTV monitoring, the approved premises manager confirmed when interviewed that there is at least one person based in the main office 24 hours per day. The main office has four CCTV screens positioned opposite the main desk. The local policy and procedure covering monitoring and surveillance expect staff to be aware of the importance of being vigilant in observing the CCTV cameras. However, it is not the sole responsibility of one person to monitor the screens all the time. Nor is it mandatory for hostel managers to dedicate members of staff solely to monitoring duties.

58. The recent Joint Inspection of Approved Premises (mentioned on page 8 of this report), commented on the differing approaches to monitoring residents using CCTV. From the sample of Approved Premises they visited, inspectors concluded that some hostels operate a policy similar to Victoria House, whilst others do not. The rationale hostel managers gave for not dedicating a member of staff to constant CCTV monitoring was that this freed up staff to spend more time working with residents.

59. Highlighting the inherent problem with monitoring, the approved premises manager told my investigator:

> "…the second you do something else and take your eyes off the screen, something could happen".

The key worker that staffed the office on the afternoon of 12 February, did not see the man go outside. Nor was he expected to know where the man was. Footage of the man walking around outside was clear. However, for much of his time outside, the man sat in a blind spot and the subsequent image of him, once he collapsed, was barely noticeable in the bottom right hand corner of the screen.

60. In one of my previous reports where a resident died in comparable circumstances, I maintained that it would be unreasonable to level any criticism at staff for failing to notice such an image. Given that there are four CCTV screens showing simultaneous pictures, and that the key worker was not able to watch all of the screens all of the time, it is not surprising that the obscured image of the man went unnoticed. My investigator had the benefit of hindsight in viewing the footage. The key worker did not. Since my investigation, residents have been prohibited from sitting in the blind spot.

61. At the precise moment that the man dropped his mug of tea, the offender manager arrived but did not notice him to her right. The key worker booked the offender manager in and took his eyes off the screen to give her a personal alarm. Closer inspection of the route the key worker took, confirmed to my investigator that it was difficult to see how she could have noticed the man. The offender manager looked to her left to get the attention of the key worker. There would have been no reason for her to look right on her approach to the front door. In addition, the front door has a large wooden frame around it which slightly obscures the right hand corner from an eye level position. As the trainee probation officer followed exactly the same path when she arrived, it seemed perfectly natural for both visitors to look left, press the buzzer, and enter without noticing the man.

Staff response to the man’s collapse

62. The CCTV footage clearly shows the assistant warden respond to the alarm first. When she got to the man, the assistant warden made him comfortable but did not commence CPR until the approved premises manager handed her a resuscitation pack. The Assistant Warden holds a full first aid certificate, valid for three years. All first aid trained staff are required to carry a mouth shield and other resuscitation aids at all times. Section E, paragraph 17 of Probation Circular 35/2006 stipulates that:

    “In addition, Probation Areas/Voluntary Management Committees (sic) should ensure that staff considering whether to commence CPR (Cardiopulmonary Resuscitation), should follow advice in their training, and that where mouth guards and other resuscitation aids are issued, they are of a type with non-return valves and are carried on the person of staff at all times.”

63. That said, in a telephone conversation with my investigator on 27 June, the assistant warden explained that at break times, she is required to hand in her keys, pager and first aid pack. This is presumably for security reasons as Assistant Wardens are permitted to leave the premises during break times.

As the assistant warden was on her break when the man was found, she had to ask for the equipment before administering CPR.

64. The administration of CPR is a stressful and tiring experience for staff, and the man had been lying outside for approximately 14 minutes before being found. I do not believe that the delay in obtaining a face mask for the assistant warden would have changed the outcome for the man. Nor do I feel that it is reasonable to level any criticism at the assistant warden for waiting until she was better equipped to begin life support. That said, the expectations of immediate first aid support have been revised since the assistant warden qualified. I highlight the significant change in the next section.

First aid training

65. A Probation Circular entitled 'Preventing Deaths of Approved Premises Residents' (PC35/2006) was issued to all senior managers in each probation area in September 2006 (implementation date October 2006). It provides advice about reducing the incidence of deaths and self harm amongst residents and draws on the lessons learnt from my reports into deaths of residents in Approved Premises. Among the common themes my previous investigations have highlighted, is the importance of appropriate and up to date first aid skills.

66. When interviewed by my investigator, the approved premises manager confirmed that all her staff had to complete full first aid training (four day course) and that a rota system was in place for the delivery of refresher courses every two years. As I mention above, all Assistant Wardens hold First Aid at Work certificates (FAW) which remain the only legally recognised first aid qualification. The certificate is valid for three years and the assistant warden told my investigator that she was scheduled to attend her refresher course in the weeks that followed the man's death.

67. Under the revised guidelines for resuscitation, published by The Resuscitation Council (UK) in 2006, first aid trained staff are no longer expected to administer breaths automatically. Newly trained staff and staff attending refresher course are now instructed to check the airway, commence 30 chest compressions immediately, and if necessary, administer two breaths at the end of this cycle. The previous guidelines made breaths more compulsory, and recommended two breaths to 30 chest compressions. It is likely that the assistant warden was first aid trained under the old guidelines and would automatically administer breaths. The refresher course will familiarise all staff at Victoria House with the new guidelines.

Contingency Plans following a death at an Approved Premises

68. The approved premises manager conducted a debriefing session with the assistant warden and key worker and used the CCTV footage to compile a log of events. The approved premises manager captured their involvement effectively in the chronology of events that she passed to my investigator.

The approved premises manager did not ask staff to make personal statements. During a visit to Victoria House on 3 March, my investigator discussed the benefits of personal statements with the approved premises manager. The benefits of statements are two fold. An account of personal involvement helps staff to identify what went right and on occasion, what went wrong. Personal statements also capture what happened as soon as or very shortly after it happened, and are often a reliable source of information. Probation Circular 40/2004 advises at Annex C that if a death has occurred:

"All members of staff are advised to make their own personal notes of the sequence and timing of events for future reference if required"

Regionally, paragraph 8.6 of Humberside Probation Area's procedures and practice further strengthens this advice. It says that:

"All actions taken must be recorded on the case record and hostel log. Each member of staff on duty should make notes of exactly what happened as soon as practically possible and, if interviewed by the police and/or Ombudsman's representative, they should keep a copy of the statement that they give."

The approved premises manager agreed to incorporate statements into the hostel's existing contingency plans for accidents and emergencies. Her action brings Victoria House in line with national and regional guidelines on preventing deaths in approved premises. I make no formal recommendation.

70. In general, my investigator found that staff at Victoria House followed good contingency plans and that the approved premises manager and her deputy manager, had reflected a great deal on how well they had responded to the man's heart attack. During her informal interview, the approved premises manager also explained that she was considering the introduction of a grab sheet which would serve to document the essential requirements for an effective emergency response. The grab sheet would be an at-a-glance document, and would further improve her staff's efficiency and effectiveness in dealing with emergencies. I would like to congratulate the approved premises manager for her learning the lessons approach to the man's death, and for her foresight in wishing to introduce her own guidance to staff at the hostel.