

**Investigation into the circumstances surrounding the
death of a man in the Greater Manchester Probation Area**

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

July 2008

This is the report of an investigation into the death of a man. The man was a resident in an Approved Premises in the Greater Manchester Probation Area and died from natural causes in February 2008. He was 55 years old.

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 Greater Manchester Probation Area.

I have judged that the man was well looked after by the staff of Greater Manchester Probation Area. I have also found much to commend in the way the aftermath of his death was handled.

I make one recommendation in this report.

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

July 2008

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SUMMARY

The man was born in 1952. He was 55 years old when he died whilst resident at an Approved Premises in the Greater Manchester Probation Area. The man died from natural causes as a consequence of a haemopericardium (a collection of blood in the pericardial sac surrounding the heart) caused by a heart attack and heart disease.

In March 2006, at Manchester Crown Court, the man had been sentenced to three years imprisonment. He was released on licence from HMP Wymott in June 2007. One of the conditions of the man's licence was that he reside at an Approved Premises. He had to sign at the duty office in the hostel at 3:00pm and remain indoors until 5:00pm. He also had a curfew from 7:00pm until 9:00am.

During his induction at the Approved Premises it was noted that the man had a history of schizophrenia. His prescribed medication was kept in a locked cabinet in the duty office. The man was supported by a community psychiatric nurse (CPN) whilst he at the Approved Premises.

The man had a history of alcohol abuse before he arrived at the Approved Premises and staff carried out breathalyser tests whilst he was a resident. The man was also warned by staff on two occasions about drinking in local public houses. This was because he told other clientele about his offences and where he lived. His actions put both the man and the Approved Premises at risk from possible reprisals.

The man also had learning difficulties and was easily influenced by other residents who tried to take advantage of his good nature. Soon after the man arrived at the Approved Premises he received a large amount of money that he found quite hard to manage. The man found it difficult to refuse requests from other residents when they asked him to buy things for them. Staff supported the man with his money management.

During the early hours on 5 January 2008, the man told staff that he was feeling suicidal. Staff spoke at length to the man and carried out regular checks throughout the night. During the following evening, the man was moved to a different room to separate him from other residents who might adversely influence him. The new room could also be observed on the Approved Premises's closed circuit television system. The man's behaviour did not raise any further concerns for staff. Greater Manchester Probation Area is piloting the Assessment, Care and Teamwork (ACT) self-harm observation and support regime. My investigator could not find evidence that staff considered opening an ACT document. I make a recommendation in relation to this issue.

During 21 February 2008, the man and another resident had been out of the hostel all day looking for alternative accommodation. Around 3:15pm, a member of the public buzzed the door of the Approved Premises. The woman told staff that she had found a man lying in the alleyway at the side of the Approved Premises. Staff found the man lying face down. He looked very pale and was unresponsive. An ambulance was called and paramedics confirmed that the man had been dead for around 30 minutes.

THE INVESTIGATION PROCESS

1. My investigator opened the investigation on 28 February 2008. He issued notices to staff and to residents, including an invitation to those who wished to submit information about 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 7 March and 1 April and discussed aspects of the man's treatment with staff.
2. My investigator contacted Her Majesty's Coroner to inform her of the nature and scope of my investigation and to request a copy of the Post Mortem report. Upon completion, my report will be sent to the Coroner to assist in her 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 that they wanted explored and addressed. The man's family said they felt staff at the Approved Premises did all they could to assist him and did not wish to raise any concerns at this time. I hope that this report helps the family better understand the events leading up to the man's death.

KEY EVENTS

4. As noted earlier, in March 2006 the man received a sentence of three years imprisonment. He had already been remanded in custody since December 2005. The man served his sentence at HMP Wymott and was released on licence on 15 June 2007. As part of his licence conditions, he was required to reside at an Approved Premises in the Greater Manchester Probation Area.
5. When the man arrived at the Approved Premises he was assessed as MAPPA Level 2 but this was reviewed on 6 July 2007 and reduced to Level 1. There are three levels of MAPPA:
 - Level three - Anyone subject to level three is considered as being the highest risk case, where more than one agency will take responsibility for the management of the person concerned.
 - Level two - As with level three, anyone who has been identified as falling into the level two heading would be managed by more than one agency, very often limited to probation and the police. However, it is possible to involve more agencies if the circumstances warrant it.
 - Level one - An offender on level one MAPPA is normally managed by a single agency. This is the lowest monitoring procedure available under the MAPPA system.
6. It was noted in the man's induction record that he had a history of schizophrenia. He had been prescribed medication for his condition. Whilst he was resident at the Approved Premises, the man cooperated with his medication routine and his schizophrenia did not cause any concerns for staff. Medication for all the residents at the Approved Premises is kept in the duty office in a locked cabinet. My investigator saw how this process is administered and was able to view the man's medication record. The man also registered with the local General Practitioner (GP) surgery.
7. On the man's arrival at the Approved Premises, Mr A, a Residential Services Officer, was appointed as his key worker. When interviewed by my investigator, Mr A confirmed that at their initial key worker meeting he checked how the man felt about being at the Approved Premises and how he was settling in. Mr A also explained his role as a key worker to the man. This was an opportunity for the man to express any concerns he had about his situation. Mr A explained the man's responsibilities and the expectation of the Probation Service whilst he was a resident at the Approved Premises.
8. Mr A worked in partnership with Mr B, the Approved Premises's Probation Officer (PO), and the man's offender manager to support the man. Mr B is also the Deputy Manager of the hostel. Ms C, another Probation Officer, was the man's offender manager.
9. Mr A described the man as quite a vulnerable resident who had learning difficulties. He said that the man was affable and was compliant with the hostel regime. Mr A confirmed that the man's health was not very good. He said that the man smoked, was overweight and would become breathless after any

exertion. Mr A added that prior to his arrival in custody the man had been a heavy drinker for a number of years. Mr A told my investigator that he felt the man's health deteriorated whilst he was at the Approved Premises. The man put on weight as his diet was quite poor. Mr A recalled that the man ate the meals provided by the Approved Premises and also snacked a lot and had takeaways. Mr A thought that a side effect of the man's medication might have been his increased appetite (weight gain is a noted side effect of olanzapine).

10. Mr A said when he had any concerns about the man he would discuss them with Mr B either on an ad-hoc basis or at their regular resident review meetings. Mr A would also regularly liaise with Ms C when she visited Approved Premises. Ms C was based in Stockport, but the man was not allowed to visit Stockport due to the conditions of his licence so she attended the Approved Premises for their meetings.
11. Mr A recalled that Ms C had worked hard to get alternative accommodation with suitable support for the man's individual needs. She was able to persuade Social Services to accept responsibility for the man's care. Mr A pointed out that the man did not have a social worker and this did not help with his support in the community. Both Ms C and Mr A were trying to find sheltered accommodation for the man with local housing associations.
12. Mr B told my investigator that he acted as a link between Mr A and Ms C. Mr A confirmed that Ms C had worked very hard to ensure that the man had adequate support for his mental health needs. Mr B said that the man was seeing a psychiatrist and a community psychiatric nurse (CPN), both of whom were supporting him with his mental health needs.
13. Mr B recalled that, just before Christmas 2007, he accompanied the man to court when he had appeared as a witness in a trial. The man had been witness to an assault in HMP Wymott and had been quite nervous about having to give evidence. Mr B said that the man was well liked by staff as he was a bit of a character.
14. Mr A said that soon after the man arrived at the hostel he received a large sum of money. Mr A described how it was difficult for the man to manage his money. He was easily influenced by other residents who would convince him to buy things for them or to pay for their drinks in local public houses. With the man's permission, staff at the Approved Premises retained his cashpoint card to try to assist with his money management. The man would collect his cashpoint card from staff in the duty office when he needed money. He would usually return the card afterwards.
15. Mr A recalled that the man had on occasion gone into local public houses with other residents. It was noted in the man's records that he was breathalysed by staff at the Approved Premises on 22 July 2007. The reading was 1.90mgs (five times over the drink driving limit). The man was given a written warning the following day. On 16 August, the man was given another written warning letter about going into public houses. When the man was in the public houses he told other patrons where he lived and also about his offences. He was

warned by staff not to do this as it put both the man and the Approved Premises as a whole at risk.

16. Around 9:40pm on 29 November 2007, the man complained to hostel staff that he had pain in his right side. Staff phoned NHS Direct and were told that someone would call them back. A nurse rang back at 9:41pm and was given the man's symptoms. The nurse decided that he needed to be referred to the duty doctor who would ring back. At 10:30pm, the GP rang back and an appointment was made for the man to attend the local hospital. The man was sent by taxi to the hospital to attend his appointment at 11:10pm. When staff at the Approved Premises rang the hospital at 11:40pm, they were told that the appointments were running late and that he would be seen shortly. The man returned to the Approved Premises at 00:25am. The man told staff that he had pulled a muscle and had been given pain killers. He attended a follow up appointment with his own doctor on 18 December.
17. On 4 January 2008, a routine breathalyser test was carried out by hostel staff and the man's blood alcohol reading was 0.22mg. He told staff that he had been drinking down by the canal with another resident.
18. Around 2:00am on Saturday 5 January, there was a disturbance in the grounds of the Approved Premises when some youths jumped over the external wall. Two Residential Support Workers who were carrying out a hostel room check, spoke to the man. He told them he was feeling suicidal and asked if he could come to the duty office. Staff rang the duty Senior Probation Officer (SPO). He suggested that they talk to the man and, once he went back to bed, they should carry out regular checks on him. Staff also removed all the blades from the man's room as he said that he had thought about cutting his wrists. At 2:55am, the man returned to his room and it was recorded at 4:00am that he was asleep. Around 8:30pm the following evening, the man was moved to a different room to separate him from other residents who might adversely influence him. The new room could also be observed on the Approved Premises's closed circuit television system. When interviewed, Mr A said that the man's behaviour on 5 January was uncharacteristic and that he was quickly back to his normal self.
19. My investigator asked the Manager of the Approved Premises why an Assessment, Care and Teamwork (ACT) self-harm observation and support regime was not opened on 5 January. (ACT is a flexible, resident-centred assessment and care planning system, which aims to identify individual needs and offer personalised care and support before, during and after crisis, in a safe and caring environment. ACT is currently being piloted in the Greater Manchester Probation Area.) The Manager noted that, although the man had expressed suicidal feelings, staff took advice from the SPO who recommended checks on him throughout the night. This was done and the man was asleep fairly soon afterwards. The man had a settled night and he was back to his normal mood in the morning. The Manager also noted that the man did not have a history of low mood whilst he was resident at the Approved Premises, and he had been compliant with his medication and generally settled. The

Manager accepted that an ACT form could have been opened by staff but she did not think that it was necessary in this case.

20. I recognise that hostel staff sought advice and were supportive when the man expressed his suicidal feelings. However, my investigator could not find any evidence that ACT was considered in this case. I recommend that, in the future, any considerations with regard to an ACT document being opened are fully recorded by staff.

Staff should record the circumstances in which they have considered opening an Assessment, Care and Teamwork (ACT) self-harm observation and support regime document, and the factors influencing their decision.

21. On Monday 7 January 2008, Mr B had a meeting with the man and they discussed the events of 5 January. The man said that he was no longer feeling suicidal but had felt very low over the weekend. The man told Mr B that he had given money to another resident who had then allegedly told the man that he would not pay the money back. Mr B discussed the need for the man to choose his friends carefully and for him to stay away from the other resident.
22. The man had a meeting the following day with Mr B and the Approved Premises's CPN. There were no significant issues in relation to his mental health needs. It was noted that the man was a vulnerable resident who tried to buy friendship and gave money away if he felt pressurised. It was also recorded that the man was taking his medication on a regular basis.
23. On 9 January, the man attended a key worker session with Mr A. The man explained that he had felt suicidal at the weekend because he had lent money to another resident and not got it back. Mr A reminded the man that he had previously been told not to lend money. Mr A also noted that the alleged suicidal feelings were on the Saturday night and the alleged incident with the other resident occurred on the Sunday morning. (For his part, the other resident denied receiving the money.)
24. The man had been in a room next door to the other resident and they had been spending a lot of time in each other's room. Staff therefore decided to move the man to another room away from the other resident. Mr A also discussed alternative accommodation and the efforts being made by Ms C to get funding for a move.
25. On 14 January, Ms C attended a meeting at the Approved Premises with the man, Mr B and the Approved Premises's CPN. They discussed at length the need for the man not to disclose his offences to other residents as this would place him at risk. He was also told not to allow himself to be targeted by other residents due his vulnerability with money. The man was advised that Ms C would be attending a professionals meeting on 21 January with staff from Mental Health Services and the Approved Premises to discuss his accommodation needs

26. The meeting to discuss the man's future housing took place during the morning on 21 January. The outcome was that Mental Health Services agreed to accept responsibility for the man and to locate suitable supported accommodation for him. The man attended a key working session with Mr A during the late afternoon on the same day. The man had already been made aware of the outcome of the earlier meeting. Mr A explained that the move could take quite a while to come through.
27. On 31 January, the man was informed that his sister had died and he was asked by his family not to attend her funeral. Mr B authorised random checks to be carried out on the man. Mr A said that the man had been upset by his sister's death but had understood the reason why he could not attend her funeral.
28. On 1 February, Ms C visited the Approved Premises to see the man. They discussed the death of the man's sister and how he was coping with the situation. Ms C also informed the man that a CPN from Mental Health Services would be visiting the Approved Premises on 20 February. Ms C was going to carry out a joint assessment of the man's mental health needs with the Approved Premises's CPN. Ms C told the man that the CPN from Mental Health Services would also be looking at suitable alternative accommodation with support in place.
29. The man took part in the pancake-making evening that took place at the Approved Premises on 5 February. On the following day, the man told staff that he had a rash and back pain and asked for doctor's appointment to be made for him. An appointment was made at the local GP surgery but the man did not attend. Staff only found out about the man's non-attendance after his death.
30. On 15 February 2008, Ms C visited the man. They discussed the meeting with the CPN from Mental Health Services and the aim of the joint assessment. The man expressed his anxieties about moving out of the Approved Premises although he said that he felt that it was the right time to do so. He told Ms C that he had sent a wreath and card to his sister's funeral.
31. The CPN from Mental Health Services contacted the Approved Premises during the afternoon on 20 February. She informed staff that she would be unable to attend the man's joint assessment meeting as she had moved to a new job. The CPN from Mental Health Services also said that her replacement had not yet been appointed but her manager would be managing the case in the interim. During the early evening, the man attended a key worker session with Mr A. They discussed the fact that, although the man had given up smoking, he was still spending a lot of time in another resident's room inhaling his smoke. They also spoke about exercise as the man said that he wanted to go the gym. Mr A suggested that the man start by walking into the local town and then getting the bus back. They also discussed the situation with regard to alternative accommodation. Mr A emphasised the need for the man to keep his spending under control and not to let other residents spend his money for him.

32. When interviewed by my investigator, Mr D, a Residential Services Officer, said that around 3:20pm on 21 February he was about to finish his shift when the hostel door buzzer rang. Mr D went to answer the door and saw that a young woman with a child in her arms had pressed the buzzer. She told Mr D that one of the residents was drunk and lying down in the alley (at the side of the Approved Premises). Mr D asked how the woman knew that the man was one of the residents and she handed him a medical card for Mr E, another one of the residents, which listed the Approved Premises as his place of residence. Mr D went with the woman to the alleyway. As soon as he got there he realised that the resident who had collapsed was not Mr E, but the man. The man was face down and his skin was blue. Mr D tried to find evidence of a pulse by feeling both the man's neck and wrist. As he could not find any evidence of life Mr D did not attempt cardio-pulmonary-resuscitation (CPR). Although Mr D could see that the man was dead he tried to put him into the recovery position. He then asked the woman to leave as Mr D was aware that her child was asking whether or not the man was asleep.
33. Mr A arrived and Mr D told him that the resident who had been found was the man and not Mr E. Mr D asked Mr A to phone the police and an ambulance as the man was dead. Mr A then ran back to the Approved Premises to make the relevant calls. Mr D remained with the man until the ambulance crew arrived about ten minutes later. The ambulance crew also checked for signs of life and attached a defibrillator but they confirmed that the man was dead. They thought that he had been so for about 30 minutes. The police arrived soon afterwards but would not move the man's body until a doctor had certified death. One of the police officers accompanied Mr D back to the hostel and took a statement from him. Mr D left the hostel around 5:30pm. Before he went off duty, the Manager and Mr B both checked that Mr D was okay. On the following day, when Mr D returned to Approved Premises, the Chief Officer of Greater Manchester Probation Area visited him at work to offer support. The Chief Officer also spoke to other staff at the Approved Premises to check on their well being. (It needs hardly saying, but the Chief Officer's actions are to be commended.)
34. One of the conditions for the man's residence at the Approved Premises was that he had to sign at the duty office in the hostel at 3:00pm. Mr B told my investigator that he thought the man was probably running late and could have been rushing back to the Approved Premises for his 3:00pm sign in. Mr B said that it would have been typical for the man to be rushing around. Mr B confirmed that another resident had been on a bus with the man shortly before his death. The other resident and the man had both been looking for housing. They came back together on the bus, but the man got off to go back to the hostel while the other resident stayed on as he wanted to go shopping. The other resident later confirmed to staff that the man had rushed off the bus to get back to the Approved Premises in order to make his 3:00pm sign in.
35. After the man's death, Mr B assembled the residents in the games room and told them what had happened. The police contacted the man's family to inform them of his death. After the police had told the family, the Manager of the Approved Premises contacted them to offer condolences and support. Whilst

the Manager was on leave, Mr B spoke to the family on 6 March to confirm the arrangements for the man's funeral on 10 March in Cheadle Crematorium. (These kindnesses on the part of Mr B and the Manager are also to be commended. I should be grateful if my comments could be drawn to their attention.)

36. The post mortem report records the man's death as being due to natural causes, as a consequence of a haemopericardium (a collection of blood in the pericardial sac surrounding the heart) caused by a myocardial infarction (heart attack) and coronary artery atheroma (heart disease). The Coroner has decided that an inquest will not take place as there were no suspicious circumstances surrounding the man's death.

CONCLUSIONS

37. The man moved to the Approved Premises in June 2007 and died of natural causes whilst resident there in February 2008.
38. Staff at the Approved Premises ensured that they supported the man with his mental health needs, and his medication regime was well organised. The man was not a healthy man and he did not look after himself very well. On the day before his death the man had decided to start to address this by taking more exercise.
39. The man had learning difficulties and staff were worried about other residents taking advantage of his good nature. The action taken by staff to try to prevent the man from being influenced by less scrupulous residents was well documented. I commend their efforts in this matter. Staff also challenged the man when he abused alcohol and made it clear when his behaviour was unacceptable.
40. The man told staff that he was feeling suicidal on 5 January but an ACT document was not opened. As already recorded, I recognise advice was sought and action taken to support the man. However, evidence could not be found that ACT was properly considered. I have therefore recommended that staff record any considerations they may have with regard to an ACT document being opened.
41. 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 was well supported by staff at the hostel. I would like to acknowledge the efforts made by staff in relation to supporting the man with his money management. This was clearly a difficult issue that was managed well.
42. In light of the findings of my investigation, I conclude that the care provided to the man was entirely appropriate. Indeed, I judge that staff from Greater Manchester Probation Area treated the man with sensitivity and professionalism.

RECOMMENDATION

Staff should record the circumstances in which they have considered opening an Assessment, Care and Teamwork (ACT) self-harm observation and support regime document, and the factors influencing their decision.

Accepted by Greater Manchester Probation Area – Actions arising from this report, coupled with findings of a recent audit of ACT procedures in the North West Approved Premises will result in a review of the process, including further staff training as required.