

**Investigation into the circumstances surrounding the
death of a man at hospital in April 2008, whilst a resident of
a Probation Approved Premises**

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

August 2008

This is a report of the investigation into the death of a man who died at hospital. The man was a resident at an Approved Premises until he was involved in a road traffic accident in January 2008. He sustained very serious injuries and was taken to a local hospital. He was moved on 9 March to a hospital closer to his family but remained critically ill. He died, with his mother present, on 7 April. My colleagues and I offer our condolences to the man's family.

The investigation was carried out by one of my investigators. My investigator visited the Approved Premises and I am grateful to the staff there, in particular the key worker, for their co-operation.

A road traffic accident is an unforeseen event. The probation staff involved with the man's supervision carried out their duties of monitoring and attempting to reduce the risk of the man reoffending. I do not think that there was anything the staff could have done to prevent the accident. I make no recommendations in this case.

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Deputy Prisons and Probation Ombudsman

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SUMMARY

The man had completed the custodial part of his sentence and was living at a Probation Approved Premises as part of his extended licence and reintegration into the community.

Having been released from prison in October 2007, the man made his way to the Approved Premises. His mother was with him and remained nearby to support him in his first few days of release from prison.

During the three months that the man was at the hostel, he appears to have settled, which is echoed by comments his mother made after his death. He would spend his time out of the hostel cycling on the bicycle he had bought or going to the shops. The man was subject to frequent reporting checks, which meant that initially he had to report to the hostel every two hours. After a month and a half this was reduced to every three hours.

On 18 January 2008, the day appears to have started as normal. The man, who was diabetic, signed for his medication at 8.50am and for his reporting check. There is no record of the exact time he left the hostel, but he was not required to report again until 12.00pm. At 11.00am, another resident from the hostel returned and alerted staff that the man had been in a road traffic accident and had been taken to hospital in a critical condition.

Hostel staff received daily updates on his condition from the hospital. He was transferred to another hospital on 9 March, which was closer to his family. The man's mother was present when he died in hospital on 7 April 2008.

INVESTIGATION PROCESS

1. My investigator requested all the relevant documentation held by the Approved Premises. She visited the hostel during the course of her investigation and spoke to the police constable dealing with the accident.
2. Notices to staff and residents were displayed by the hostel. These invited anybody with information to talk to my investigator. In this instance, no-one raised any matters of concern.
3. HM Coroner for the area was informed of my investigation and will receive a copy of this report. At the time of issuing this report, my investigator had not received the post mortem or official cause of death.
4. The man's mother was his next of kin. One of my Family Liaison Officers contacted the man's mother to offer the opportunity of involvement in the investigation. His mother did not have any issues or concerns for the investigation, but would like to receive a copy of this report. She added that the staff at the hostel were good and her son had settled there well.

PROBATION APPROVED PREMISES

5. Approved Premises were formally known as Probation and Bail Hostels. They are approved by the Secretary of State within section 9 of the Criminal Justice Act 2000. Approved Premises provide a supportive, structured environment in the community for high risk and difficult to manage offenders. The management of those accommodated in Approved Premises is governed by the National Standards for Supervision of Offenders and the guidance contained in the National Approved Premises Handbook.
6. The purpose of Approved Premises is to provide an enhanced level of supervision for some of the potentially most difficult and high-risk offenders in the community. They are not principally an accommodation resource.
7. Residents will have curfews and reporting checks, but they are not expected to remain in the hostel at all times and as a result are not supervised 24 hours a day as in prisons.

THE APPROVED PREMISES WHERE THE MAN WAS RESIDENT

8. The Approved Premises currently has a capacity for 19 residents. The bedrooms are a mix of single and double occupancy, with some having self catering facilities.
9. Each resident has a dedicated key worker. Key workers hold regular one-to-one meetings with their residents. They also liaise with other agencies and the resident's offender manager (formerly probation officer) to monitor and facilitate as appropriate the resident's reintegration back into the community and to address specific needs.
10. The Approved Premises is staffed 24 hours a day. There is a minimum requirement for two staff to be on duty at all times. The generic curfew time when residents have to be in the hostel at night is 11.00pm – 6.00am, although this can be extended where relevant.
11. Residents' medication is securely stored within the office. It is handed to residents by staff according to the medication instructions. Each resident has a drug dispensing chart which a member of staff signs when the medication is dispensed. The Approved Premises has a contract with a local doctor to whom all residents have access. The doctor sees all new residents and holds a 'surgery' every Thursday for those who need to see him.
12. Residents are expected to adhere to hostel rules. One of these is to comply with alcohol and drug tests.

KEY FINDINGS

13. The deceased man was released from prison on 17 October 2007. His licence conditions stipulated that he was to reside at an Approved Premises and he duly arrived at the hostel later that day. (Due to an exclusion zone in his licence, he was unable to reside at the hostel closer to his family and home area.)
14. As do all new residents, the man underwent the induction process. Unusually however, he had his mother present. It is not normal practice for family member to be present however, the man's mother had arranged to stay locally when he arrived at the hostel and, due to him being nervous, the hostel staff agreed to let her be present.
15. Under hostel rules, residents are monitored for drug and alcohol consumption. This is generally on a random basis unless it related to offending or behavioural issues. The man had a negative drug test in his first week at the hostel. His alcohol levels were tested regularly and with the exception of one test which showed levels over the driving limit, the tests were either negative or showed low consumption. No action was deemed necessary in these instances.
16. The man had diabetes. He was prescribed medication (insulin and metformin) for this and had access to the local doctor and diabetic nurse when necessary. Staff would ask him about his blood sugar levels and remind him of the importance of a balanced diet and unnecessary sweets which would affect his health and mood. However, it remains the resident's responsibility to take his medication and, in this man's case, monitor his blood sugar levels.
17. The hostel records show that, with one exception, the man reported when necessary. He had a formal warning for aggressive behaviour in December and there was concern after he was found to be in an area he should not have been. Other than these entries, the man is shown to have complied with the conditions of his licence. He had regular one to one sessions with his key worker, the last was on 13 January 2008.
18. There are no movements sheets for the man for the dates 15 January 2008 – 17 January 2008, so it is not possible to say where he had been and what he had been doing outside of the hostel. The hostel records show that he reported as necessary and had taken his medication. He had also had alcohol tests on 15 and 16 January which were negative. There is a note of a contact with his offender manager for 17 January, but there is no comment in the log.
19. On the morning on 18 January, the man collected his medication at 8.50am. His reporting record shows a discrepancy because he has signed next to the 9.00am slot and the 12.00pm slot. There is no staff signature next to the 9.00am slot so the assumption is that he signed the wrong line in the first

instance. The hostel log shows that at 11.00am another resident came to inform them of the man's accident. This is followed by an entry that he had gone to hospital so it is not possible for him to have signed in at 12.00pm.

20. The sequence of events is unknown. All that can be determined is that the man left the hostel on his bicycle as he did most days. He had no appointments logged and it is thus assumed that it would have been a normal day on his bike and around the town.
21. It appears from the police investigation and understanding of hostel staff, that when the man came to a corner further down the road from the hostel, he looked back at some pedestrians on the opposite side of the road. He was travelling fast down a hill in damp conditions and approaching a corner. Because he was on a corner, and not watching the road, he cycled across the white line into the path of oncoming traffic, hitting a car head on.
22. The man was taken to a local hospital where he remained in a critical condition. The hostel had daily updates from ward staff and staff visited him on one occasion. Over the following two months, the man's condition was critical but stable, but he was unable to breath for himself.
23. On 9 March, the man was moved from the hospital where he was since time of accident to another hospital closer to his family. The supervision of his case was also transferred to a probation office in the area. The following day, staff at the new probation office received a call from the staff nurse at the hospital who described the man as very poorly and in a vegetative state, unable to breath on his own.
24. A month later, on 7 April 2008, the man died at the hospital. His mother, who was with him when he died, informed the probation staff. The possessions which he had at the hostel were returned to his mother by the probation supervisor who had taken over his supervision when he transferred hospitals.
25. The police have investigated the road traffic accident separately and will submit their report to the Coroner.

ISSUES

26. The man left the hostel on his bicycle in the morning of 18 January 2008, as he did most days. A short distance from the hostel, he collided into an oncoming car. The accident was investigated by the police.
27. My investigations look at the care and treatment a prisoner or resident receives in whichever establishment they may be and to identify areas of learning or good practice. The deceased man was monitored closely by hostel staff and his offender manager. His supervision appointments were regular and he saw staff daily for reporting procedures.
28. The man was diabetic and took medication for his condition, which was also monitored by hostel staff. The man had access to the local doctor and diabetic nurse. I have explained that residents are free to leave the hostel during authorised periods and they would not, as a rule, be seen by staff during this time. It is my view, that there was nothing that the staff at the Approved Premises or the man's offender manager could have done to foresee or prevent his unexpected accident which resulted in his death.

RECOMMENDATIONS

I make no recommendations in this case.