Investigation into the circumstances surrounding the death of a man in the Humberside Probation Area in May 2008

Report by the Prisons and Probation Ombudsman for England and Wales

October 2008

This is the report of an investigation into the circumstances surrounding the death of a man who was a resident at an Approved Premises in the Humberside Probation Area. He died in his room in May 2008. He was 54 years old. The cause of death was recorded as myocardial infarction (heart attack).

The man's next of kin is his brother. I offer him my sincere sympathy and condolences, as I do to all of his friends and acquaintances who have been affected by his death.

The investigation was carried out on my behalf by my colleague. I would like to thank the manager of the Approved Premises and all of his staff for their full and ready co-operation during the course of our inquiries.

The man had not been seen for more than 12 hours until he was discovered collapsed in the late afternoon of the day he died. The report makes a recommendation reflecting the importance of checking the welfare of residents if they are not seen during the day. I have made a second recommendation relating to the provision of defibrillators.

Stephen Shaw CBE
Prisons and Probation Ombudsman **October 2008**

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SUMMARY

The man arrived at the Approved Premises on 16 November 2007, having been released from prison the same day. He was suffering from a number of health problems, including severe chronic obstructive pulmonary disease (COPD, the restriction of airflow to the lungs due to the narrowing of airways) which had left him wheelchair bound. As a result, he had been offered a room at the Approved Premises which has facilities to cater for disabled residents.

Through his time at the hostel, the man had some good days and some bad days. He would sometimes feel too ill to leave his room all day, but on other occasions he was well enough to spend time in a local pub with other residents. He settled into the premises well and was popular with both fellow residents and with staff.

At around 5.00pm on 16 May 2008, the man told his keyworker that his legs were slightly swollen. He repeated this to a support worker at 3.30am the following morning when he collected his medication (it was not unusual for him to be awake at this time). On this occasion, the man said that the last time he had swollen legs he had had a heart attack. The support worker asked the man if he was in pain or had any other symptoms, to which he replied in the negative. The support worker also asked the man if he would like him to call an ambulance. He declined.

Two members of staff recalled seeing the man during the day on 17 May. He told both of them that he was “fine”. At around 3.30am the following morning, he collected his medication from the support worker in the office. The support worker asked him about his legs, and the man simply said that he was “fine” once more. The support worker again offered him an ambulance if he required it, but the man said he would see how he was the next day.

It would appear that this was the last time that the man was seen alive. He did not come down for breakfast or lunch the next day, although this was normal for him and the staff on duty were not therefore concerned. At around 4.45pm an assistant warden took the man’s evening meal to his room. (The man always ate meals in his room as part of an agreement that he had made with staff.) He found the man slumped in his wheelchair in the middle of the room. He was cold to the touch and had no pulse. There was no sign that he was breathing.

The assistant warden immediately went to the office to call for an ambulance. As the ambulance station is across the road from the hostel, the paramedics arrived very quickly. They pronounced the man dead at 5.00pm. The cause of death was given as myocardial infarction (heart attack).

Staff in Approved Premises are instructed to check on residents’ whereabouts whilst they are on site. For example, residents’ rooms should be checked if the resident is not seen at mealtimes. Although the man did not come down for breakfast or lunch on 18 May, the staff on duty did not check on him as he

was simply following his usual pattern of behaviour. However, this meant that he was not seen all day.

The report includes a recommendation to the manager, reminding him of the importance of checking the welfare of residents if they are not seen during the day. A second recommendation is directed to National Offender Management Services (NOMS) centrally and relates to the provision of defibrillators in Approved Premises.

THE INVESTIGATION PROCESS

1. The investigation was opened on 27 May 2008 when the investigator issued notices announcing the investigation to staff and residents. The notices included an invitation to those who wished to submit information relating to the man's death to make themselves known to my investigator. No residents came forward as a result.

2. The investigator visited the Approved Premises (AP) on 3 June. During his visit he was shown around the hostel, including the room in which the man lived. He was also given copies of all documentation relating to him. My investigator returned on 7 July when he interviewed four members of staff and spoke to a resident who was friends with the man who died.

3. My senior family liaison officer telephoned the man's brother to inform him of the investigation. He said that the man had experienced difficulty getting his medication from the doctor whilst at the Approved Premises, apparently because "it cost too much". He also said that his brother had told him that he had been refused medication when he was in prison.

THE APPROVED PREMISES

4. The purpose of an Approved Premises is to provide an enhanced level of residential supervision in the community, alongside a supportive and structured environment. Whilst residents have to comply with their individual licence or bail conditions, curfews, and the hostel's 'house rules', they are essentially free to come and go from the building.

5. This AP is one of 101 Approved Premises in England and Wales and one of 13 in the Yorkshire and Humberside Probation Areas. It normally accommodates 19 residents and has one additional emergency bed. It is staffed 24 hours a day by probation employees whose role is to provide support and to ensure that the rules and licence or bail conditions are complied with. A curfew operates from 11.00pm to 6.00am.

6. Information about relevant rules, procedures and expectations whilst a resident at the premises is given during induction. All residents are allocated a key worker. Regular key work sessions take place, giving the resident the opportunity to discuss any issues or difficulties in more depth. The day to day routine at the hostel is relaxed, although residents do have to surrender their room keys on weekdays between 9.00am and 11.30am to allow for cleaning. Key work sessions run during the day and some residents have to attend offender management meetings or appointments with external staff in the Probation Area.

7. Residents are provided with breakfast and an evening meal at the premises. They provide their own lunch. A trolley is put out at around 8.30am with cereals and bread for residents to help themselves. The evening meal is provided at around 5.00pm.

8. On arrival, all residents are offered a tour of the hostel and the opportunity to register with a local doctor's surgery. The AP has an arrangement with the surgery to enable all new residents without a doctor of their own to register during their stay. There is also an arrangement with the surgery and local pharmacy to facilitate the delivery of medication to the premises. All prescription medication must be handed in to the staff at the front office, where each item is logged and stored safely.

9. The AP keeps basic first aid equipment in the main office, including resuscitation face masks. There are also a number of other first aid kits located around the hostel. All staff are fully trained in first aid and attend a comprehensive four day course, with refreshers every two years.

10. Her Majesty's Inspectorate of Probation (HMIP) last inspected the Humberside Probation Area in July 2005. The Area was inspected under the Effective Supervision Inspection programme and did not include Approved Premises.

11. This is the third death to have occurred at the AP since April 2004 when I began investigating all deaths in Approved Premises in England and Wales. My last report, which also involved a resident who died from a heart attack, reflected well on staff and I made no recommendations.

KEY FINDINGS

12. The man was released on licence from HMP Hull on 16 November 2007. He arrived at the AP the same day. He suffered from a number of health problems when he arrived, including rheumatoid arthritis and severe COPD. As a result of the COPD, the man was wheelchair bound. The hostel has facilities for disabled residents and the man lived in one of these rooms. An appointment was made for him to attend his local doctor's surgery on 20 November to discuss his medication. His first batch of medication was delivered by the pharmacy the following day.

13. Due to his breathing difficulties, the man found mealtimes demanding. He told staff at the AP that he was embarrassed about the noise he made and asked if he could eat his meals in his room. This was agreed and he thanked his keyworker when he had his first session on 27 November.

14. At his next keyworker session, on 5 December, the man said that he was pleased with his room and the facilities at the hostel. He cancelled his evening meal on 9 December as he was not feeling well, although reported that he was feeling better the following day. When he saw his keyworker on 13 December, the man said that he had good days and bad days. The keyworker noted that the man had settled well at the AP and interacted well with both staff and other residents.

15. Around Christmas, the man reported feeling unwell for a few days. He recovered though and was well enough to visit the local pub with other residents in the run up to New Year. There was some confusion on 1 January 2008, when the man was noticed to be taking gabapentin (pain relief) more regularly than he had been prescribed. The keyworker was able to confirm the correct dose in a telephone call to the doctor on 3 January.

16. The man's brother visited on 5 January and brought with him a new wheelchair which the man said he was pleased with. When collecting his medication from the office in the evening of 12 January, the man told the keyworker that he was a little short of breath. He added that he thought that he would be okay after he had used his nebuliser (a device used to administer a drug in the form of a fine mist for the patient to inhale). The keyworker asked the man to report to staff if he felt that his condition had deteriorated. The support worker checked on him twice through the night. On both occasions, he noted that the man looked to be alright.

17. On 19 January, the man told the support worker that he had been refused his medication by a member of staff. The support worker replied that they could not stop him from having his medication but "would advise against it if under the influence of a substance". He offered the man the opportunity to come to the office for his medication, but he declined. Later that evening, the man returned to the hostel and was described by a second support worker, as "under the influence of alcohol". The man asked for his medication, and the second support worker advised him to wait for an

hour or so before taking it. Despite this advice, the man took his medication anyway. The second support worker checked later that night, and the man said that he was fine.

18. Three days later, the man fainted whilst eating his evening meal. He told an assistant warden that this happened regularly as he would often choke on his food due to his breathing problems. The then premises manager spoke to him about this on 25 January and asked if he would like staff to check on him during mealtimes. The man said that this would not be necessary as he was used to dealing with his shortness of breath.

19. The man attended a doctor's appointment on 24 January and his medication was changed (the particular change was not mentioned in his record). At a meeting on 26 January, he told the keyworker that he was feeling much better as a result. He repeated this when he was visited by his offender manager on 8 February. The offender manager noted that the man looked well and seemed positive.

20. On 17 February, the man had a mobility scooter delivered which enabled him to get around town much more easily. He purchased a different scooter on 12 March. This one was smaller than the original and could therefore be used inside the hostel too. At a keyworker session on 17 March, he said that he was much happier now that he had his new scooter.

21. Towards the end of March, the man reported that he was not feeling quite so well. On 25 March, he said that he was feeling out of breath and, on 30 March, he said that he was feeling "rough". Staff noted in his record that on both occasions the man played down the problem and just said that it would pass. He saw the doctor on 3 April and was prescribed a course of antibiotics. He said that he was feeling better the following day.

22. Around two weeks later, on 15 April, the man told the keyworker that he was feeling a little under the weather. He later told a probation service officer that he thought he had a chest infection. He continued to feel unwell over the next four days and spent most of this time lying down in his room. On 23 April, he said he was feeling a lot better. However, the following day, after going to the doctor's to collect medication, he spent most of the day in his room again feeling unwell.

23. Over the next fortnight, the man continued to report some good and some bad days. On the morning of 2 May, he said that he was not very well and that he believed that his death "could be imminent and sudden". Later that day, however, he said that he was feeling better than the previous day.

24. Having said on 9 May that he thought that he was getting better and would improve over the summer, the man then spent the following day in bed feeling unwell. He again spent the day in his room feeling unwell on 13 May, coming to the office only to collect his medication. On 15 May, the

man cancelled his evening meal as he was not well, having again spent most of the day in his room.

25. At around 5.00pm on 16 May, the man went to the office to collect his evening medication. He saw the keyworker and told her that his legs were slightly swollen. He showed his ankles to the keyworker who, at interview, described them as “a bit puffy”. The keyworker asked the man if he was in any pain, to which he replied that he was not. She advised him to elevate his legs and said that she would check on him later. Around an hour or two later, he came out of his room and told the keyworker that his legs were a lot better.

26. The man went to the office to collect his next batch of medication at around 3.30am the following morning. It was not unusual for him to be up and about at this time. The support worker was on duty and the man told him that his legs were still swollen. He again said that he was not in pain, and spoke of no other symptoms. The man also said that he had suffered a heart attack the last time that his legs were swollen. He did not say how long ago this was. The support worker advised the man that he could call an ambulance if necessary, but he replied “No, no, I’ll be fine, don’t worry about it,” and “I’ll see how it is tomorrow.”

27. At around 2.20pm on 17 May, the man collected his medication from the assistant warden. He told the assistant warden about his swollen legs, but said that he was not in pain. The assistant warden asked him if he would like an ambulance, but he said that he was “fine”.

28. Another support worker also recalled seeing the man on 17 May, but could not remember the particular circumstances. (the man’s medication record indicates that he collected his evening medication from the support worker at around 7.30pm.) He recalled that he had no concerns about his health. However, at around 11.00pm, the support worker checked on the man in his room. (This was a routine curfew check undertaken by staff to ensure that all residents were in the premises.) He asked the man how he was. The man replied that he was “okay”.

29. On the following morning (18 May 2008), the man again picked up his medication at around 3.30am. He was seen by the same support worker as the previous morning, who again asked him about his swollen legs. He simply said that he was “fine”. The support worker once more stressed that the man could have an ambulance if he required it, but he again said that he would see how he was the next day. It would appear that this was the last time that the man was seen alive.

30. As was usual, the man did not come down for breakfast the following morning. The residents provide their own lunch, but neither of the staff who were on duty on 18 May can recall seeing him around at lunchtime. The assistant warden said that it was not unusual not to see the man as he usually ate his lunch in his room.

31. At around 4.45pm, an assistant warden took the man's evening meal to his room. He found him slumped in his wheelchair in the middle of the room. At interview, the assistant warden said that his first impression was that the man was dead. He checked his pulse but there was none. He was also cold at this time and there was no sign that he was breathing. The assistant warden then went to the office to call an ambulance. He did not consider resuscitating the man, as it was clear to him that he was dead.

32. The ambulance station is across the road from the hostel, so the paramedics arrived within five minutes of the call at around 4.50pm. They pronounced the man dead at 5.00pm. The cause of death was given as myocardial infarction (heart attack).

33. The man's brother was informed of his death that evening by the police. He attended the AP on both 19 May and 20 May to collect his brother's property and to talk to some of the residents. The property that the man's brother did not want was donated to the local British Heart Foundation shop.

ISSUES

The man's health in the last days of his life

34. At around 5.00pm on 16 May, two days before he died, the man told his keyworker that his legs were slightly swollen. He reported no other symptoms. He repeated this complaint to a support worker at around 3.30am the following morning. On this occasion, the man also said that he had had a heart attack the last time his legs were swollen.

35. In retrospect, this is a startling statement given the events of 18 May. However, at the time the man told the support worker that he was not in pain and had no other symptoms. The support worker offered to call an ambulance for the man, but he declined and said that he would be fine.

36. Given that the man had no symptoms other than swollen legs, and was not in pain, I understand the support worker's decision not to call an ambulance at this time. If the man had been in obvious pain or was having increased difficulty in breathing, and given his comment about a previous heart attack, it would have been prudent to have called an ambulance. However, in the circumstances, simply offering him the opportunity of an ambulance was a sensible and appropriate course of action.

37. It appears that the man was last seen alive at around 3.30am on 18 May. He did not come into the kitchen for breakfast that morning. However, staff at the premises said that he never came in for breakfast. He was not seen at lunchtime either, but again staff said that this was not unusual.

38. Probation Circular (PC) 35/2006, regarding the prevention of deaths of AP residents, says:

    > "As part of delivering the duty of care to residents, staff should ensure that residents' whereabouts can be established whilst they are on site, particularly after curfew and at weekends. Approved Premises should, for example, ensure checks are undertaken of residents' rooms if they are not present at mealtimes."

39. The Humberside Area's local strategy on the prevention of self-harm and sudden death in APs also says that "residents' rooms should be checked if they are not present at mealtimes".

40. As I have noted, the man was not normally seen at mealtimes. He had an arrangement with staff that he would eat his meals in his room, as he felt embarrassed eating in front of other people. For this reason, the staff on duty on 18 May did not check on the man when he did not present himself at breakfast or lunch.

41. The instructions in place in PC 35/2006 are there to ensure that all residents are seen regularly during the day so that their welfare and location can be confirmed by staff. If a resident who usually attended for breakfast and lunch was not seen at either meal then staff should immediately check on them. In this case, because of the arrangement that the man ate meals in his room (a thoughtful arrangement initiated to preserve his personal dignity and one that I do not criticise), he did not receive such checks. However, this meant that he was not seen by any member of staff (or, it would appear, by any resident) from 3.30am until he was discovered by the assistant warden at 4.45pm. Given his history of ill health and more recent comments regarding his swollen legs, it would have been prudent for staff to have checked on the man during the day if he was not seen otherwise:

The manager of the Approved Premises should remind all staff of the instructions provided in Probation Circular 35/2006.

Resuscitation

42. The assistant warden said that when he discovered the man slumped in his wheelchair he was "stone cold". He had no pulse and did not appear to be breathing. The assistant warden said that, when he saw the man, he "knew straight away he'd passed away". He did not therefore attempt to resuscitate him. Given the man's condition, as described by the assistant warden, I consider it both reasonable and respectful that he did not attempt to resuscitate.

43. There are not currently any defibrillators at the Approved Premises. Whilst this would not have made a difference in this man's case, as he was beyond resuscitation when found, such a device may be important in future incidents. The manager told my investigator that they are currently considering obtaining defibrillators. I have judged that I do not need to make a formal recommendation on this point, but I hope very much that the manager will be able to obtain this equipment. Defibrillators are now widely installed in public places like shopping centres and railway stations. There is though a wider learning point for probation practice as a whole that I draw to the attention of staff centrally in the National Offender Management Service:

The National Offender Management Service should review the costs and benefits of providing defibrillators in all Approved Premises.

Mobile phones for staff

44. Paragraph 19 of PC 35/2006 provides the following instruction:

> "Summoning assistance immediately on discovery of an incident may be critical to avoiding fatalities. Approved Premises managers should ensure that staff carry personal alarms and other safety equipment such as radios at all times. Mobile phones should be made available

and carried by staff patrolling the premises so that they can summon assistance from the emergency services immediately in the event of an incident."

45. At the time of the man's death, staff at the AP did not carry mobile phones whilst on duty. This meant that the assistant warden had to run to the office to call an ambulance when he discovered him. The man's room was on the ground floor near to the office and the delay was therefore negligible. However, if a resident on an upper floor was found in need of urgent assistance then the time taken to run down to the office to call for emergency medical assistance could be crucial.

46. Following feedback from the investigator, the premises manager has purchased a mobile phone for staff to carry when undertaking room checks. I commend his initiative in so doing.

Family concerns

47. The man's brother told my senior family liaison officer that the man had told him that he had been refused his medication when he was in prison. He also said that he had difficulty getting his medication from the doctor in the local area "because it cost too much".

48. The man had been a resident at the Approved Premises for just over six months when he died. Prior to this he had spent around three and a half years at HMP Hull. A letter to the man dated 21 September 2007 from the modern matron at Hull, gives some insight into his concerns. She notes in the letter that the man experienced a delay in obtaining saline nebulas (to dilute medications so that they may be taken by inhalation). She wrote that this was due to a delay in delivery of the product to the prison's pharmacy, and apologised to the man for the inconvenience. Given the time that had elapsed since this delay, I do not consider that it would have had a bearing on his death.

49. I sympathise for the man if he felt he was not getting the correct medication from his local doctor. However, the surgery in question is a private practice with no links to the Approved Premises other than an agreement that all residents can be registered there. Any issues regarding medication prescribed by doctors at the surgery are entirely outside my remit.

RECOMMENDATIONS

1. The manager of the Approved Premises should remind all staff of the instructions provided in Probation Circular 35/2006.

   Accepted.

2. The National Offender Management Service should review the costs and benefits of providing defibrillators in all Approved Premises.

   Accepted – we will review the costs and benefits of providing defibrillators across the Approved Premises estate.