

**Investigation into the circumstances
surrounding the death in a hospital of a resident
of a Probation Service Approved Premises, in
June 2005**

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

October 2005

This is the report of an investigation into the death of a resident of an Approved Premises. The man died during surgery to repair a ruptured abdominal aortic aneurysm.

My office investigates the deaths of all residents in probation hostels, including those due to apparent natural causes. In this case, the investigation was carried out by one of my investigators.

Due to the nature of his offences, the man had not had contact with his family for a number of years before his death. Nevertheless, I would like to offer my condolences to all his relations and friends. I know that the staff and residents of the approved premises who knew the man would wish to do the same.

I am grateful to the Manager of the Approved Premises and her staff for their assistance during the investigation.

I was concerned about one aspect of the man's care: his alleged lack of care at the hands of an ambulance crew. This is not a matter directly within my remit but I have recommended that a copy of this report be sent to the relevant Ambulance Service NHS Trust for their attention.

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Prisons and Probation Ombudsman

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Summary

1. The man was born on in 1946. In 1990, he was imprisoned for offences against members of his family and contact with his family ceased. In July 2004, further offences came to light. As a result, on 13 January 2004, he appeared in court and was bailed with a condition of residence at an Approved Premises. He lived in the hostel, at first on bail, then as a condition of a Community Rehabilitation Order, until he was admitted to hospital on in May 2005.
2. The man conformed to the hostel rules, and was a very popular resident both with the staff and other residents. He participated in the programmes run by the hostel and the Probation Service and worked well with his probation officer. However, it was known that he had serious health problems that required him to walk with a crutch.
3. In late May, he was in a great deal of pain and staff called an ambulance which took him to the local hospital. The hospital staff prescribed medication for a urinary tract infection. The man returned to the hostel, and told staff that he had lost his medicine. The pain continued, so again an ambulance was called to take him to the hospital. The man found his medication there and returned to the hostel. The following day, the doctor who serves the Approved Premises visited him and prescribed stronger drugs. The man improved slightly.
4. Two days later, the pain again increased and the man was admitted to hospital where tests were carried out. Four days later, a scan revealed that he had an abdominal aortic aneurysm. The following day, the aneurysm ruptured and he underwent emergency surgery to try to repair it. Sadly, this was not successful and he died during the operation.
5. My investigation has found that the man who died was well cared for whilst he was at Approved Premises. Staff ensured that he received medical attention when he needed it, and kept it touch with him while he was in hospital.
6. I make one recommendation.

The investigation process

7. My investigator visited the Approved Premises on 9 June 2005. She spoke to staff at the end of their team meeting and explained my office's role and the investigative process.
8. My investigator also spoke about the specific circumstances of the man's death to the hostel manager, to two other members of staff and to one of the residents. The man's roommate showed her the room they had shared and she was shown around the hostel. She was given copies of all the hostel's records relating to the man who died.
9. The investigator also spoke to the man's probation officer, by telephone and discussed the work he was undertaking with him.

Background

The man who died

10. When he arrived at the hostel, he had a number of health problems, including severe osteo-arthritis, that meant he walked with crutches. For the six months he was resident in the hostel, he participated in hostel life as fully as his health allowed. He went to a local college four times a week where he took certificated courses in computing, maths and English. He also attended the 'Living Here, Moving On' course that was run by the local Probation Area. He attended meetings with his probation officer and was working at addressing his offending behaviour. The local Probation staff were also trying to find suitable accommodation for the man to move to once he left the hostel. This was likely to have been a warden-assisted flat.
11. In spite of his limited mobility, the man was able to go shopping and on car trips into the countryside. Other residents with cars were very good and gave him lifts in their vehicles. While he was in the hostel, he was officially registered as disabled and applied to buy a car from Motability, a charity that helps disabled people finance cars, scooters and wheelchairs. This was agreed but, by the time his car was ready, he was in hospital.
12. Staff at the hostel spoke highly of him and said that his death had left a gap in the hostel. They admired the way the man coped with the constant pain and limited mobility he suffered, and his use of humour, which was often at his own expense.

The Approved Premises

13. The Approved Premises is a hostel with 32 beds. It has both single and double rooms. At present, approximately a quarter to a third of residents are on bail, but increasingly the residents are those who have been convicted of serious offences.
14. There is a CCTV system for monitoring purposes. However, staff are also expected to have regular and close contact with residents. The residents are also subject to a curfew and staff carry out a series of checks to ensure that this is complied with.

Key Findings

15. The man who died was arrested in July 2004 and charged with offences against members of his family committed in the 1980s. In January 2005, he was bailed and was sent to an Approved Premises. In February, he was sentenced to a three-year community rehabilitation order and continued to stay at the hostel as a condition of the order.
16. When he arrived at the hostel, he was in poor health. He had severe osteo-arthritis, problems with his hips and walked with two elbow crutches. He also took medication for stomach problems. He was allocated a shared room on the first floor, as there were no ground floor bedrooms. Staff were concerned that he would be unable to manage the stairs. They discussed this with him and suggested that he transfer to a hostel with ground floor bedrooms. The man said he wanted to remain at that hostel, and staff agreed to this. However, they appropriately monitored his ability to cope with the stairs.
17. On an afternoon in late May, the man told staff that he was in severe pain and they made a doctor's appointment for him for the following day. An hour later, he again called staff and asked that either a doctor visit him or for an ambulance to be called. Staff spoke to the doctor and then called an ambulance.
18. The ambulance arrived at 4:55pm. The crew used a wheelchair to carry the man down the stairs and into the ambulance. They left at 5:15pm and took him to a local hospital. At the Accident and Emergency Department he was assessed and given medication for a urinary tract infection. At 9:10pm, the man returned to the hostel by taxi. He told staff that he had lost the pills he was prescribed and they telephoned the hospital to check the name of the drug.
19. At 11:30pm, staff checked the man. He said that he had vomited shortly after returning to the hostel. Staff rang the emergency doctor number and spoke to a nurse. She said that she would consult the doctor and call them back. At 12:40am the next morning, the doctor called and recommended that the man return to the hospital as his condition might worsen without medication. An ambulance was again called.
20. The ambulance arrived at 12:50am. The crew did not use a wheelchair as the first crew had done. The man who died was forced to walk, which he did with great difficulty, and I am told it took him 40 minutes to make his way to the ambulance. Once the ambulance left, hostel staff rang the hospital and updated staff there about the man's condition. They also gave nursing staff the hostel telephone number in case they needed further information.

21. At 4:40am, the man telephoned the hostel and told staff that he had found the medication he had lost during his previous time in the hospital. He had not yet been treated and did not want to wait any longer as he was in a great deal of pain. He returned to the hostel by taxi where staff helped him to his room and gave him his medication. The hostel log records that, as they tended him, the man told staff that he was upset at his treatment by the second ambulance crew. The next morning, when they checked him at 7:15am, he again said how upset he was.
22. The man was still in discomfort and asked staff to arrange a home visit from the General Practitioner who serves the hostel. The doctor arrived at 12:30pm and prescribed stronger medication. He said that, if the man was still in pain after taking the new medicine, they should contact him again. By 11:00pm, when staff checked him, he was feeling a bit better.
23. Unfortunately, during the following night, he was again in so much pain that staff once more called an ambulance for him. He was admitted to the same hospital as before and sent for x-rays. On the next afternoon he called the hostel and told staff that he might have a kidney or water infection or a kidney stone. The hostel manager visited him that evening and some residents went to see him on the following day which was a Sunday. They all thought that he looked quite a bit better.
24. However, the following Tuesday, the man's condition deteriorated and a scan revealed that he had an abdominal aortic aneurysm. (An aneurysm is a bulge in the wall of an artery, in this case, the aortic artery leading to the heart.) The following day, the aneurysm ruptured and the man underwent emergency surgery. Sadly, this was not successful and he died during the operation.
25. Nursing staff informed staff at the hostel of his death. They also said that a post mortem would not be held and there would not be an inquest. The man had given the hostel as his next-of-kin, when he was admitted to hospital. After his death, staff at the hostel made contact with one of the man's relatives, but he did not want to be involved. Because the man who died had no contact with family members, the Bereavement Centre at the hospital arranged the funeral which was held later that month. Four members of staff and six residents attended the service and took with them flowers from the residents and a wreath from the staff. The residents also placed a plaque in the hostel garden engraved with "In memory of ..." (the man's first name).

Conclusions

The man who died was well cared for whilst he was at the approved premises. Staff were aware of his poor health and monitored his ability to cope with the stairs. They called an ambulance for him three times when he became very unwell. On the second occasion, they tried to persuade the crew to use a wheelchair rather than require the man to walk to the ambulance. When my investigator spoke to staff, they were still angry about this and at how it had upset the man.

Overall, staff at the hostel ensured that the man received medical attention when he needed it, and kept in touch with him while he was in hospital.

Recommendations

I recommend that the Probation Area sends a copy of this report to the Ambulance Service NHS Trust suggesting that they enquire into the actions and attitude of the second ambulance crew when attending to the man at 12:50am on 26 May 2005.