

**Investigation into the circumstances surrounding the  
death of a man, at hospital in September 2010,  
whilst a resident of Chorlton Approved Premises  
in the Greater Manchester Probation Trust**

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

**March 2011**

This is the report of an investigation into the death of a man. He had lived at Chorlton Approved Premises, a hostel managed by Greater Manchester Probation Trust, for nearly three months. He died at hospital in September 2010, having been taken ill earlier that day. He was 43 years old. The cause of his death was recorded as occlusive coronary artery thrombosis (a clot in one of the arteries supplying blood to the heart) due to a coronary artery atheroma (development of fatty lumps within the lining of the artery).

I offer my sincere sympathy and condolences to the man's family and to all who have been affected by his loss.

The investigation was carried out by my colleague. I would like to thank the manager of Chorlton Approved Premises for his assistance in liaising with the investigator. I also thank his colleagues for their cooperation during the investigation.

Although he was receiving treatment for high blood pressure and high cholesterol, the man's death came suddenly and unexpectedly. My investigation finds that staff at Chorlton Approved Premises acted quickly and appropriately when they responded to his collapse. Although I make no recommendations, I encourage the hostel manager to consider whether staff should have paid more attention to whether he had collected his medication.

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.

**Jane Webb**  
**Acting Prisons and Probation Ombudsman**

**March 2011**

## **CONTENTS**

Summary

The investigation process

Chorlton Approved Premises

Key events

Issues

Conclusion

## **SUMMARY**

The man arrived at Chorlton Approved Premises on 25 June 2010, having been released on licence from HMP Wymott earlier that day. He was not taking any medication at the time, and told staff on his induction to the hostel that he had stopped taking an anti-depressant the previous year. He settled into the hostel and got on well with some other residents who he knew from prison and the community.

During his first week at Chorlton, the man told two different members of staff that he had problems with one of his legs. He said that his leg sometimes became numb or paralysed, which meant that he could not walk for several minutes. Both members of staff encouraged him to register with a local doctor to have the problem investigated. He did so, and saw the doctor several times in the following months. He was referred to a consultant vascular surgeon and had an outstanding appointment on 7 September, four days after his death. The post mortem report identified that he had peripheral vascular disease (a narrowing of the arteries that supply blood to the legs). In addition to these investigations, he was prescribed medication for high blood pressure, high cholesterol and depression.

As is standard for all residents, the man was subject to an overnight curfew. On 14 August, he broke his evening curfew and did not return to Chorlton until the early hours of the morning. Once he realised that he had broken the terms of his curfew he feared being sent back to prison and therefore stayed out late. He was not recalled, but was given a final warning about his conduct. Following this incident, he settled in well at Chorlton and arranged a trial period of employment at a local DIY store.

At around 6.35pm on 3 September, the man told a fellow resident that he was unwell. The resident told the staff on duty, who went to his room. They found him sweating and shaking, and immediately called an emergency ambulance. A lone paramedic arrived within ten minutes, while the ambulance arrived shortly afterwards at 6.50pm. Over the following half an hour, the ambulance crew performed various tests, during which time his condition deteriorated. He had a heart attack after being moved to the ambulance and died at around 8.30pm, shortly after arriving at hospital.

The man died suddenly and unexpectedly. The investigation found that the response of staff to his collapse was both timely and appropriate.

## **THE INVESTIGATION PROCESS**

1. The investigation was opened on 7 September 2010 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. One resident came forward as a result.
2. The investigator and his colleague visited Chorlton on 21 September. During the visit they were shown around the hostel, including the room where the man lived. They were given copies of all documentation relating to him. They interviewed one member of staff and two residents during the visit, including the resident who had put himself forward.
3. The Ombudsman's senior family liaison officer telephoned the man's son on 14 September to inform him of the investigation. He said that he had no concerns about the care his father received, although he was not aware that his father had been ill. He received a copy of my draft report as part of the consultation process. He did not make any comments on the content of the draft report.
4. Investigations of deaths in approved premises do not include a review of the resident's clinical care. This is because residents register independently with a general practitioner and the relationship is not part of the care provided by the hostel.

## CHORLTON APPROVED PREMISES

5. The purpose of an approved premise is to provide an advanced level of residential supervision for offenders in the community, within 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. All residents at Chorlton are subject to an overnight curfew from 11.00pm to 6.00am. The man was subject to an extended curfew from 7.00pm to 9.00am and had to sign in at 1.00pm and 5.00pm.
6. There are seven approved premises in the Greater Manchester area, managed by Greater Manchester Probation Trust. Each approved premises has a manager, offender manager and residential support staff.
7. Chorlton Approved Premises is a pair of large Victorian houses which have been joined together, providing accommodation for up to 27 men. The accommodation is a mixture of single and double rooms, communal lounges, dining room and other areas used for group work. The hostel has a number of CCTV cameras covering communal areas.
8. The hostel 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. Each resident is allocated a key worker, who is a member of staff with whom the resident meets to discuss their progress, well being, participation in the regime and group work.
9. A doctor's surgery, on the same road as the hostel, used to register all the residents, for which the surgery received funding. However, the contract with this surgery recently ended. The surgery therefore no longer receives funding and hostel residents are no longer able to register at the practice. New residents now visit the Chorlton Health Centre and are allocated a local surgery from there. Some residents keep their medication in their rooms and some is stored in the staff office to be given to the resident as prescribed. This is decided on an individual basis following a risk assessment. Each resident is responsible for their own health. If they require a consultation with a doctor or visit to hospital then, unless it is an emergency, the onus is on the resident to arrange the appointment. The records held by the doctor are confidential to the patient and hostel staff do not have access to them.
10. This is the fifth death of a resident at Chorlton Approved Premises since April 2004, when the Ombudsman began investigating the deaths in approved premises in England and Wales. The man's was the first which was due to natural causes. The most recent investigation report, following the self-inflicted death of a resident in October 2009, recommended that Greater Manchester Probation Trust ensure staff in approved premises have up to date first aid training. I am pleased to report that all staff have received emergency incident training, comprising an element of general first aid and resuscitation techniques.

## KEY EVENTS

11. The man was born in October 1966 and was 43 years old when he died. He had three sons, all of whom live in the south of England. Around two weeks before his death, he was visited by his sons. This was the first time that he had seen them in several years.
12. The man spent some time working as a lorry driver. In late 2007, he served two months in HMP Forest Bank and HMP Wymott. On 28 March 2008, he was sentenced to three and a half years imprisonment. He initially served eight months at Forest Bank, before transferring to Wymott on 5 December. He was released from prison on 25 June 2010, having been allocated a place at Chorlton Approved Premises.
13. Following his arrival at Chorlton on the afternoon of 25 June, the man was inducted to the hostel by his key worker. The induction involved an explanation of the hostel rules and expectations and a tour of the building. He did not bring any medication from prison with him, and she asked if he had taken any recently. He replied that he had been prescribed anti-depressants in 2007 but had stopped taking them in 2009 and had not taken any medication since. He initially shared a room with another resident, who he knew from prison.
14. The man settled well into the hostel, although on his second day he told his keyworker that he found it “strange” being in a new environment. He attended a meeting on 29 June with the hostel’s offender manager. The purpose of the meeting was to discuss his future plan. She told him about courses he was required to attend and that he would be monitored for drug or alcohol misuse during his time at the hostel.
15. During the meeting, the man said he had problems with his mobility and that his leg sometimes became “paralysed” which left him “unable to walk for several minutes”. He said this meant he was in “constant pain”. He added that he suffered from depression and had been prescribed medication, but had stopped taking it a year previously. She advised him to register with a local doctor in order to discuss these matters further.
16. The following day, the man spoke to his keyworker about his leg. He explained that it sometimes went numb and gave him difficulty walking. He went on to say that this affected his chances of future employment as he was concerned that he would not be able to get to work if he had to walk or go on public transport. She advised him to consult a doctor about his leg. She also explained how he could attend courses via Manchester College to improve his future employment prospects. At a meeting with a visiting offender manager on 5 July, he said he was now “in the process” of registering with a local doctor’s surgery.
17. The man saw a local doctor the following day (6 July) and was signed as unfit for work for four weeks due to “musculoskeletal pain”.  
(Musculoskeletal disorders are a group of numerous conditions that affect

the body's muscles, joints, tendons, ligaments and nerves.) At his next appointment with the visiting offender manager, on 12 July, he told him that the doctor was waiting to receive his prison health records before making a diagnosis. He said that his mobility was continuing to deteriorate and again expressed concern that it might harm his future employment prospects.

18. At his next appointment with the local doctor, on 20 July, the man was prescribed simvastatin (to lower cholesterol) and metronidazole (an antibiotic). He handed the medication in at the hostel office on the same day. (It was determined that his medication should be kept in the hostel office for him to collect each day.) The doctor also advised that he should go to hospital for a physiotherapy session. An appointment was subsequently made for the afternoon of 23 July. His signing in times were amended for the day so that he could attend.
19. Three days later, on 23 July, the offender manager visited the hostel for his next scheduled appointment with the man. He said his mobility was still restricted. He explained that the doctor was unsure whether he had a blocked artery or arthritis in his leg and investigations were ongoing.
20. On 29 July, it was noted that the man had not collected his medication since he handed it in nine days previously and so he was encouraged to do so. (There is no indication why he had not taken his medication.) He saw his keyworker the following day and said that he was "frustrated" with the signing times and curfew on his licence conditions. She advised him to speak with the offender manager next time she was on duty. (There is no indication from the notes that he did so.) In the first two weeks of August, however, he attended various courses and hostel activities, and was reported as working well.
21. On the evening of 14 August, the man did not return to the hostel by his 7.00pm curfew. After several attempts, a member of staff was able to speak to him on his mobile telephone at around 10.00pm. He said he had drunk alcohol and did not want to return to the hostel for fear of being recalled to prison. Shortly afterwards, he ended the call.
22. Six and a half hours later, the man telephoned another resident with whom he was friendly. The resident passed his telephone to the member of staff, who spoke with him. He said that he had not returned because a recent visit from his sons had brought back memories of family bereavements but he now wished to return. He arrived back at the hostel at 5.15am, having been collected by a police patrol.
23. The following day (16 August), the man had a meeting with the offender manager to discuss these events. He told her that he had felt depressed recently on account of his poor mobility and the recent death of his father and brother. He said that he would consider taking anti-depressant medication again and agreed to visit the doctor that day. (Later entries indicate that he was prescribed an anti-depressant, sertraline, by his

- doctor. He was also prescribed amlodipine, for high blood pressure.) He added that he had received an appointment to see a consultant at the hospital in September for an examination of his legs. (Staff at the approved premises later told the investigator that this appointment was scheduled for 7 September, four days after his death.) The offender manager agreed with him that he should no longer consume alcohol and that he would be referred to the local Alcohol and Drugs Service.
24. On 18 August, the man had a meeting with the visiting offender manager in which they discussed his recent absence from the hostel. He said the visit from his sons had gone very well, but he felt lonely when they went home. He therefore went out for a couple of drinks and soon realised that he was out beyond his curfew, which increased his anxiety. The offender manager reiterated that his actions were a breach of his licence conditions. He was formally given a final warning about his conduct and it was highlighted that another breach would result in recall to prison. He was described as remorseful for his actions and thankful to have another opportunity to remain at the hostel.
  25. The man's next appointment with the visiting offender manager was on 23 August. He told him that he was still experiencing pain in his leg and limited mobility, but was happy to have been referred to the consultant. He said he now felt more secure in life at the hostel since the events of the previous week. Three days later, he told the offender manager that his mood had recently improved significantly.
  26. On the morning of 2 September, the man had an appointment with his doctor. He later told the offender manager that he was feeling "more positive about life" and the anti-depressant he had recently been prescribed was working well. On the same day, he was offered a trial period of employment at a DIY store in Timperley (around five miles from the hostel). The trial was due to start on 8 September. It was agreed that his curfew and sign in times would be amended to allow him to take advantage of this opportunity.
  27. The following morning (3 September), the man spent around an hour on a computer at the hostel with his keyworker. They looked for a bus route that he could take to Timperley to ensure that he arrived at work on time. The man's keyworker told the investigator that he was keen on DIY and had worked on his sister's house in the past.
  28. At lunchtime, the man went for a walk with another resident. The resident recalled that they bought a sandwich and passed some time sitting on a bench. He added that the man gave no indication of feeling unwell while they were out. After eating their evening meal at the hostel, they sat outside in the garden from around 5.30pm. The man said he had been experiencing "palpitations" and "pins and needles in his right wrist". The resident told the investigator that his assumption at the time was that he had indigestion, and he therefore advised him to rest in his room. He went to his room at around 6.00pm.

29. The hostel's closed circuit television (CCTV) system shows that the man left his room, on the top floor, at 6.24pm. He went into the toilet on the same floor. Although it is not clear from the footage, he appeared to be holding his chest when he went to the toilet.
30. Around ten minutes later, another resident heard the man shouting from the toilet. (The resident's room is next to the top floor toilet.) He told the investigator that he came out of his room to check on the man. He recalled that the man "did not look good". Although he thought the man was breathing normally, he described him as "sweaty" and said the man's "eyes were rolling". The hostel's CCTV shows that the resident went downstairs at 6.35pm. He went to the staff office (on the ground floor) and told a hostel worker what had happened. She picked up the hostel's response bag (containing items including a mouth guard for resuscitation and a mobile telephone) and went upstairs via the kitchen, where she told the keyworker about the events.
31. The CCTV footage shows that the man left the toilet at 6.37pm and returned to his room. Shortly afterwards (also at 6.37pm) the hostel worker and keyworker arrived at his room. The keyworker told the investigator that the man was shaking, covered in sweat and said he could not feel his leg. He was able to speak and breathe normally. The hostel worker telephoned for an emergency ambulance as soon as she saw the man. The keyworker said that the man's condition did not change prior to the arrival of the paramedic, other than when his eyes briefly "rolled to the back of his head". She said that she "shouted" at the man and he began to talk to her again.
32. At 6.46pm, a lone paramedic arrived in a car and was escorted to the man's room. On her arrival, the man began to complain of pain in his groin and a tight chest. Shortly afterwards he was violently sick. He apologised and was reassured by the staff.
33. The ambulance arrived very soon afterwards, just after 6.50pm, and the crew were escorted upstairs by the keyworker. The paramedics spent around half an hour examining the man and performing various tests, during which time he deteriorated further. At 7.25pm, the man was taken downstairs to the ambulance. He had a heart attack in the ambulance and the paramedics spent around 20 minutes performing cardio-pulmonary resuscitation. The ambulance left for the hospital at around 7.55pm.
34. The man died at around 8.30pm, shortly after arriving at hospital. Staff at the hospital telephoned his son to break the news of his death, having been given his contact details earlier by the keyworker. A post mortem later recorded the cause of his death as occlusive coronary artery thrombosis (a clot in one of the arteries supplying blood to the heart) due to a coronary artery atheroma (development of fatty lumps within the lining of the artery).

35. The hostel manager was told of the events over the telephone and came into the hostel that evening. He broke the news of the man's death to the residents during a meeting at 8.45pm. Both the keyworker and hostel worker were offered time off work and said they felt supported by colleagues in the aftermath.
36. The man's sons visited the hostel following his death, and his property was returned to them. His funeral was held on 12 September and the hostel manager attended to represent the hostel.

## ISSUES

### The man's health

37. Residents of approved premises are responsible for their own health. If they require a consultation with a doctor or visit to hospital then, unless it is an emergency, it is the responsibility of the resident to arrange the appointment. Staff should, however, be expected to help any resident who has difficulty registering with a doctor or arranging an appointment.
38. The man did not have any prescribed medication when he arrived at Chorlton from HMP Wymott on 25 June 2010. He told his keyworker on his induction that he had previously been prescribed anti-depressants but had decided to stop taking them in 2009. He first mentioned the problems he experienced with his legs during a meeting with the hostel's offender manager on 29 June. The man said that his leg sometimes became "paralysed", which left him "unable to walk for several minutes". The offender manager appropriately advised him to register with a local doctor to discuss the matter further.
39. The following day, the man told his key worker that his leg sometimes went "quite numb" and gave him difficulty walking. She also advised him to register with a local doctor. The man duly registered, and first saw a doctor on 6 July. The doctor signed him as unfit for work for four weeks on account of "musculoskeletal pain". The man was later sent to a local hospital for physiotherapy and was referred by his doctor to a consultant vascular surgeon at the hospital. This appointment was scheduled for 7 September, four days after he died.
40. The post mortem report identified that the man had peripheral vascular disease. This is a narrowing of the arteries (blood vessels) and mainly occurs in arteries that supply blood to the legs. It is caused by the development of fatty patches inside the lining of the arteries (a process known as atheroma). Symptoms of peripheral vascular disease include pain in the calves when walking or exercising.
41. As well as peripheral vascular disease, the post mortem report highlights that the man suffered high blood pressure, high cholesterol and depression. He was prescribed medication to treat each of these latter conditions by his doctor in the community. Hostel records show that he did not initially take his medication when it was prescribed. This was not highlighted in his records until nine days after the medication was prescribed, and could have been noticed earlier. In response to my draft report, staff at the premises said that they did mention to the man that he had not taken his medication over the period 23-29 July. However, this was not recorded on either the case recording system or local logs.
42. Although residents are responsible for their own health, by deciding to hold their medication, I think that hostel staff should play some part in monitoring whether it has been collected. The hostel manager and his

colleagues at Greater Manchester Probation Trust should consider amending their medication policy so that residents are reminded if they fail to collect their medication after an agreed period. I will draw my remarks to the attention of the National Offender Management Service in order that consideration can be given to whether the national guidance on handling medication should be amended.

43. Nevertheless, with encouragement, the man began to take his medication more frequently from the end of July onwards and I do not think that the lapse had a bearing on his death six weeks later. Shortly before he died, he told the staff that he thought his anti-depressant was working well.
44. The post mortem report concludes that the man collapsed and died "suddenly and unexpectedly". I am satisfied that staff at the approved premises did all that is reasonable to encourage him to seek treatment for his medical conditions and symptoms.

### **Emergency response**

45. The events following the man's collapse on 3 September 2010 are outlined in paragraphs 29-34 of this report. I am satisfied that the hostel worker and the keyworker responded immediately and appropriately when they were alerted that he had been taken ill. They took the emergency response bag to his room with them and made a telephone call for an emergency ambulance as soon as they had seen him and ascertained his condition.
46. Following the death of a resident in 2009, all staff at Chorlton received emergency incident training. This included an element of general first aid and resuscitation techniques. As the man did not stop breathing until his heart attack in the ambulance, the hostel worker and keyworker were not required to practice these techniques. Nonetheless, it is important that staff receive regular refresher training to ensure that they are in a position to confidently apply the most up to date techniques should the situation arise.
47. There is currently no defibrillator at Chorlton Approved Premises. Whilst this would not have made a difference in the man's case, as he did not have his heart attack until the ambulance crew had arrived, such a device might be important in future incidents. Defibrillators are now widely installed in public places like shopping centres and railway stations. They give automated instructions to the resuscitator on how to treat a patient, with little prior training required.
48. Following the death of a resident at a different approved premise in 2008, my predecessor recommended that National Offender Management Services (NOMS) review the costs and benefits of providing defibrillators in all approved premises. Their conclusion was that the cost was not justifiable given that very few deaths of residents might have been prevented had a defibrillator been in place. NOMS will, however, re-

review the matter as necessary. I encourage them to do so in the light of the man's death.

## **CONCLUSION**

49. The man had some difficulties at Chorlton Approved Premises. He suffered anxiety and depression and, on one occasion, absconded from the hostel for most of the night. He had also made some considerable progress, however, and had seen his sons for the first time in many years as well as obtaining the offer of a job at a local DIY store.
50. Although the man saw his doctor on several occasions during his time at Chorlton, and had an outstanding appointment with a consultant vascular surgeon, his death was sudden and unexpected. I am satisfied that the staff who responded to his collapse acted promptly and appropriately.