Investigation into the death of a man whilst a resident at Ty Newydd Approved Premises in North Wales Probation Trust in September 2010

Report by the Prisons and Probation Ombudsman for England and Wales

January 2012

This is the report of an investigation into the death of the man. The man was found in his room at Ty Newydd approved premises in September 2010. It is thought that he had been dead for a number of hours when his body was discovered. A post mortem report concluded that he died of coronary artery thrombosis (a blood clot in the heart). I extend my condolences to his family and friends. I trust that our report answers many of their questions regarding his death.

One of the office's family liaison officers (FLO) contacted the man's mother to inform her about the investigation and to provide her with an opportunity to raise any issues about the care the man received whilst resident at Ty Newydd approved premises.

The investigation was carried out by one of the office's senior investigators. We would also like to take this opportunity to thank all of the staff at Ty Newydd approved premises for their cooperation during the investigation.

We also thank Healthcare Inspectorate of Wales (HIW) for appointing the clinical review to review the man's clinical care. As the man died from natural causes, the findings of the clinical review were essential to our own conclusions. The review concludes that the standard of care the man received was comparable to that which he could have expected in the community. HIW's clinical review is the first annex to this investigation report.

Several areas of concern were identified during the investigation. These included opportunities to have discovered the man sooner, due to a lack of curfew checks. And concern that the man had access to the internet, breaking his licence conditions. The Approved Premises conducted an internal review that covered these and other concerns, and I make a recommendation regarding the implementation of their findings. We make one further recommendation relating to the enforcement of his licence conditions.

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 prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **January 2012**

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SUMMARY

1. The man was released on licence from HMP Wymott on 14 September 2009. (A licence sets rules and guidance to which a prisoner must adhere to whilst living in the community. The licence is supervised by the Probation Service.) Initially, he was resident at Plas Y Wern approved premises located in the Wrexham area, but moved to Ty Newydd approved premises on 31 August 2010, whilst suitable accommodation was sought. He had a known heart condition, for which he took medication.

2. During his induction at Ty Newydd, the man told staff he felt "low in mood" and had suicidal thoughts. Although he said he did not intend to act upon these thoughts, he was not allowed to have his prescribed medication in possession. The man was required to report to staff daily who dispensed his medication and supervised him taking it. He signed a disclaimer that he understood it was his responsibility to collect his medication and that it was not the staff's responsibility to ensure that he did.

3. During his stay at Ty Newydd, the man attended a number of medical appointments, but mainly stayed in the approved premises as he told staff he was fearful of meeting former colleagues who knew about his offending. During his time at Ty Newydd his key worker and offender manager continued to explore alternative accommodation arrangements for him.

4. On 14 September, an ambulance was requested by staff after the man complained of experiencing chest pains. Following assessment by paramedics, from the Welsh Ambulance Service, the man was told to report to staff if his symptoms persisted and the paramedics did not take any further action. The man later visited his doctor, who amended his medication. Over the next ten days he was encouraged by staff to discuss any concerns about his health with his doctor. During this time the man enquired about his accommodation situation, and regularly reported to take his medication.

5. At 5.55pm on Friday in September, the man collected his medication for the last time. Staff had not observed any change in his physical or emotional health. They were aware that he used to go to his room early most evenings, but when he failed to report to collect his medications, they did not check on his whereabouts. During the investigation it became apparent that a number of staff were returning from periods of time off, and were not familiar with all of the new residents, including him. It became apparent that policies on roll checks and room searches were not being followed. As a result, there were a number of missed opportunities to check on him.

6. On the morning of Sunday 26 September, over 38 hours after the man was last seen by staff, another resident brought his absence to their attention. He was consequently found in his room, it was apparent that he had been dead for some time and had been viewing indecent images of children at the time of his death. A post mortem concluded that he died from coronary artery thrombosis, coronary artery disease and hypertensive heart disease.

THE INVESTIGATION PROCESS

7. An investigator was appointed to investigate the circumstances surrounding the man's death at Ty Newydd approved premises. Notices announcing the investigation and its terms of reference were issued to both staff and residents at Ty Newydd. The notices were displayed around the approved premises and invited staff and residents to contact the investigator should they wish to do so. No residents came forward in response to these notices.

8. The investigator obtained documentation relating to the man's time at Ty Newydd approved premises and opened the investigation. He conducted a number of interviews with staff who had contact with the man on 6 and 7 October 2010. During the course of the investigation the investigator provided verbal and written feedback to the manager at Ty Newydd where the man was a resident

9. Healthcare Inspectorate Wales (HIW) conducted a review of the man's clinical care whilst a resident at Ty Newydd. HIW's findings are summarised in this report and the full clinical review is included as the first annex.

10. The investigator also liaised with Detective Inspector (DI) of North Wales Police, who is acting on behalf of the Coroner. The Ombudsman is grateful to him for his and his colleagues' assistance. The investigator has also been in contact with the coroner's office and a copy of this report will be sent to Her Majesty's Coroner for North West Wales District, to assist him with his enquiries. A copy will also be sent to the National Offender Management Service.

11. One of the office's family liaison officers (FLO), contacted the man's mother in writing on 22 October, advising her of the purpose and scope of the investigation and to give her the opportunity to raise any questions or concerns about her son's death. On 25 October, he had a lengthy conversation with her when she raised a number of issues, including

    - What times during the day was the man checked by approved premises staff?

    - What was the cause of the man's death?

    - Why have some of the man's possessions not yet been returned to the family? (This issue was discussed with the family during the investigation and does not form part of the report.)

12. Additionally the man's mother asked if her son was on a low fat diet during his time at the approved premises. My investigation has established that whilst at Ty Newydd the man, as with all approved residents, would have been responsible for his own diet. Had his doctor raised any concerns about his diet with him it would have been for him, as an adult, to have addressed these issues. There is no evidence to suggest that his doctor raised any concern about his diet. In exceptional circumstances an approved premises may be officially advised of dietary requirements from a GP, for instance if a resident had a particular allergy. The investigation could find no evidence to suggest that the approved premises

had been notified that the man should be in receipt of a particular diet.

13. The man's mother also asked if the man have any psychiatric and mental health support whilst at Ty Newydd. However, staff at approved premises play no role in providing health care, or healthcare advice to residents. Medical matters between an approved premises resident and their doctor are confidential. In some circumstances an offender manager may either be informed of, or make a referral for, a resident to mental health and psychiatric services. The investigation has found no evidence to suggest that this was the case with the man.

14. On 4 November, the office's family liaison officer also contacted one of the man's brothers. He raised no further issues.

TY NEWYDD APPROVED PREMISES

15. Approved premises, (formerly known as probation and bail hostels), are approved by the Secretary for State within section 9 of the Criminal Justice Act and Court Services Act 2000. They provide a structured, supportive environment in the community for high risk offenders, many of whom have been released from prison as part of a supervision plan agreed with the person's offender manager (formerly probation officer). The purpose of an approved premise is to provide an enhanced level of residential supervision in the community in a supportive and structured living environment.

16. Ty Newydd is one of two approved premises in which the man stayed in North Wales. It is located near the town of Bangor. Both approved premises have the following aims:

    - protect the public
    - prevent re-offending
    - provide residents with an opportunity to address their problems in a safe, stable environment
    - enable residents to face up to their offending behaviour
    - complete the conditions of their order or licence
    - facilitate their resettlement into the community.

17. Ty Newydd has an established routine for inducting all new residents. The induction is carried out by the member of staff who is on duty at the time a new resident arrives. During the process residents are told about the local house rules and their expected behaviour. Ty Newydd has a strict policy on alcohol and drug use, the possession of which is strictly forbidden. Breakfast and dinner is provided to all residents.

18. As well as having their own offender manager (probation officer), in the community, each resident is also allocated a key worker at the approved premises. This member of staff acts as their primary point of contact during their stay and assists residents in sorting out practical issues. Regular key work sessions also give residents the opportunity to discuss any difficulties they may have in depth. Although the sessions are not governed by a set agenda, issues such as benefits, health and future accommodation are routinely discussed. Residents at Ty Newydd are all asked to register with a local general practitioner (GP). Approved premises do not provide healthcare and a resident's medical treatment is a confidential matter between them and their doctor.

19. Whilst at Ty Newydd, residents are required to pay rent and abide by the rules and regulations, which include observing an overnight curfew between the hours of 9.00pm and 12.00 noon, which staff are responsible for enforcing. (Residents are allowed to leave the approved premises earlier than midday if they have a doctor's appointment, have employment or other authorised appointments.) During the afternoon residents are free to leave Ty Newydd unaccompanied and are not required to tell staff where they are going. When leaving the premises residents are required to sign out, in a register, and sign back in on their return. Some additional licence restrictions, dependent on a person's offence, can be

imposed such as the removal of certain items like mobile telephones and any electrical device with internet capability.

Previous deaths at Ty Newydd

20. This is the second death due to natural causes at Ty Newydd since the Ombudsman took on the responsibility for the investigation of deaths in approved premises in April 2004. There are no similarities between this previous death and that of the man.

Management structure at Ty Newydd and Plas Y Wern

21. Both approved premises in North Wales are managed by a Senior Probation Officer (SPO) under the responsibility of an Assistant Chief Officer (ACO). The manager of both approved premises at the time of the man's death was SPO A. Each of the premises has its own manager. In addition, full and part-time Residential Support Officers (RSO), Probation Support Officers (PSO) and a Business Administrator (BA) staffed the approved premises and assisted in the running of the accommodation and implementation of rules. Relief staff were sometimes used at Ty Newydd to cover some shifts.

Multi Agency Public Protection Arrangements (MAPPA)

22. Offenders who come within the Multi Agency Public Protection Arrangements (MAPPA) remit are classified according to the type of offence, nature of the risk and its management. MAPPA members are convened, usually prior to a high risk prisoner's release, and comprise of local agencies, including the police, probation, social services, health, and / or other agencies, where appropriate, to assess and manage the risk they may pose on release.

    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.

KEY EVENTS

23. The man was 45 years old at the time of his death. He was convicted on 7 December 2007, for the making and possession of indecent images of children and was subsequently sentenced in total to a five year extended sentence (two years imprisonment and three years on licence) at Caernarfon Crown Court on 14 January 2008.

24. The man was released on licence from HMP Wymott on 14 September 2009, and he was assessed as a MAPPA Level 2 offender. A condition of his licence was that he was required to live as directed by the Probation Service and was released to Plas Y Wern approved premises in Wrexham. In addition to the standard licence conditions, a number of additional conditions were also imposed, including:

> "Must not use a computer or other electronic device for the purpose of accessing the internet or have access to instant messaging services or any other on line message board/forum or community without the prior approval of your supervising officer."
>
> and
>
> "Must not own or use any computer without the prior approval of your supervising officer."

25. In addition to his release licence, an indefinite Sexual Offences Prevention Order (SOPO) had been imposed at the time of his sentencing at Caernarfon Crown Court. This order stipulated that, on release, the man needed to register his address and personal details with the police in the area he was resident. He was also prohibited from accessing, viewing or downloading pornography and indecent images of any kind and of installing onto a computer any software or hardware that could wipe the computer hard drive or hide his identity.

26. On 14 September, the man was given a letter by a prison nurse (name illegible) which summarised his health care in prison, which he was to pass on to his new general practitioner (GP) upon release to Plas Y Wern. He subsequently registered with a doctor in Wrexham. In the prison discharge letter the nurse recorded that the man had had a heart attack in April 2007, and had subsequently been admitted to hospital with chest pains in 2008. Further, in August 2008 he had also seen a consultant urologist for urinary problems and that he had last had an attack of angina on 8 September 2009. (If an artery becomes too narrow, it can prevent the heart muscle from receiving enough oxygen-containing blood. This can cause severe chest pain and discomfort, known as angina)

27. The nurse listed the man's medications as:

- Simvastatin (to reduce cholesterol)
- Biosoprolol (to treat high blood pressure)
- Isosorbide mononitrate (to prevent angina attacks)

- Omerprazole (to decrease the production of stomach acid)
- Cetrizine (to prevent or treat allergies, such as hay-fever or other upper respiratory allergies)
- Candesartan (to treat high blood pressure)
- Aspirin (to reduce the 'stickiness' of platelets in the blood which helps to prevent blood clots forming)
- GTN spray (glyceryl trinitrate is for the management of angina)

28. On 14 September, the man's offender manager, noted in the probation services case record and management system, (CRAMS – an electronic system used to record contact with offenders), that he had requested a mobile telephone, television and games console. She agreed that the man could have a mobile telephone:

> "… as long as it [the mobile telephone] is a basic one with no internet access, picture messaging or camera … the games console will need to be looked at more closely as I am not aware as to what kind of game it is at the moment and it may have internet access on it."

29. There is no further record of any discussion about suitability of games consoles and games the man had requested to have in his possession, or what decision was made in regards to this request. Following a visit to his GP the same day, he was examined and he was signed off sick, unable to work for three months, due to his angina. This was later extended.

30. During a regular room search of the man's room on 13 October, a member of staff, recorded in CRAMS that staff had found a Sony 'walkman' with recording ability, along with numerous discs. The man claimed these items had music on them, but they were taken away from him until permission had been sought from his offender manager. The investigator was unable to establish from the documents provided whether or not permission was granted and if the 'walkman' was returned to the man. There is no record or entry that consideration was given to whether the possession of these items constituted a breach of his licence conditions.

31. Over the next few months, the man had regular contact with staff at the approved premises and with his offender manager. During these contacts he was required to discuss his offending behaviour and discussed with staff his wish to move to be closer to his mother.

32. During a room search on 3 December, (the entry on CRAMS is attributed to an unidentified member of staff.) staff found, amongst other items, two free DVDs from magazines (although one had no corresponding magazine), one empty memory card container in the pocket of a large holdall and some prescribed cetrizine medication dated 9 April 2009. In relation to the memory card container, he told staff that he did not know where it came from, saying that it must have already been in the bag which his mother had given him. There is no record or entry that consideration was given to whether the possession of these items constituted a breach of his licence conditions.

33. The man's case was discussed at a MAPPA meeting on 9 December. The main discussion at this meeting focussed on his request to move area and the associated risk that this may pose. There is no record or evidence of discussion about his request for a games console, television and mobile telephone made on 14 September, or the items confiscated on 13 October. Further, there was no record or discussion regarding the items found in the most recent room search on 3 December, only that he had requested to have an 'x-box' computer console.

34. The man continued to have regular contact with staff over the following months, and his request to move was explored by his offender manager. Initially, a move to an approved premise looked likely to happen. However, he had to wait for the transfer to be agreed by the new area and for an available bed, if accepted.

35. On 6 April 2010, the man attended Wrexham Hospital as a day care patient for a procedure to remove a lipoma (a non-cancerous fatty lump) from his right shoulder. However, due to his health it was decided to keep him in hospital overnight.

36. Ten days later, member of staff A recorded on CRAMS that the wound from the man's recent surgery had started to leak. He was advised to monitor the problem and inform staff if he felt unwell, as an infection could become more problematic due to his heart condition. On 29 April, he was admitted to Wrexham hospital to have this wound treated and the hospital were told of the specific licence conditions he had to comply with. There is no specific entry in CRAMS relating to the date he was discharged back to Plas Y Wern.

37. On 3 May, the man became unwell at Plas Y Wern. The Plas Y Wern's manager recorded in CRAMS:

> "At 8.40am this morning [the man] alerted staff he was suffering from an angina attack. Having tried his GTN spray with no relief. Emergency services called. With the assistance of staff he was given 2 further sprays which did start to alleviate his symptoms. Paramedics decided to take him to the local hospital due to his previous heart condition. After initial checks and blood taken he was allowed back. Appointment to be made with cardio unit at Maelor [Wrexham Hospital] still appears pale and generally looking unwell will request staff keep a close eye on him for the time being"

38. An entry made in CRAMs the following day by the Plas Y Wern's manager:

> "Following his angina attack yesterday the man still complaining of being breathless today. Urgent GP appointment made and his meds have been altered. Due to uncertainty on transfer GP not wishing to investigate the condition as he may well be moving??? Personal alarm issued for his use while in the hostel, should he not be in a position to alert staff of his crisis. Full aware on how to work it. Has been advised to rest as much as possible."

39. The clinical review details that the man was examined by a consultant cardiologist on 2 June. The consultant cardiologist concluded that stress was a factor related to some of the man's symptoms and, following an ECG exercise tolerance test he was assessed as 'not high risk'. (An ECG or Electrocardiogram is a test that records the rhythm and electrical activity of the heart. It is commonly used to detect and assess problems of the heart. This could include heart attack. It can also measure your heart rhythm and detect other abnormalities such as an enlarged heart. A tolerance test shows a pattern of heart activity during exercise which provides a doctor with more information). Further invasive investigations were not considered necessary.

40. Over the next few weeks, the man's offender manager continued to explore the possibility of a move, in order that he could be closer to members of his family. On 3 June, his room was again searched. An unidentified member of staff recorded on CRAMS that staff found a number of inappropriate items including two mobile telephone SIM cards, console games, a second mobile telephone and a Play Station 2 (PS2). The man denied any knowledge of one of the games that caused particular concern. He said that it must have been in his room prior to his arrival at Plas Y Wern. It was noted in CRAMS that the Public Protection Unit were informed. There is no record or entry on CRAMS that consideration was given to whether the possession of these items constituted a breach of his licence conditions or that the computer consoles had been checked for internet capability. The following day, the man showed staff three further PS2 games, which he was allowed to keep in his possession.

41. On 17 June, the Plas Y Wern's manager recorded in CRAMS that there was no update regarding the articles found in the man's room and that "a number of appts [appointments] are in place to see various consultants in regard to different conditions". Six days later, the man was advised by his offender manager that his request to move was still under consideration. A telephone call subsequently made to SPO A on 5 July, confirmed that the area to where he wished to move were not willing to accept transfer of the man, who was told of the decision.

42. Following another episode of chest pain on 18 June, the man was taken to Wrexham hospital where he was given an echocardiogram and was assessed as low risk. (An echocardiogram, also known as an echo, uses sound waves that echo against structures in the heart to build up a detailed picture of the heart.) No invasive treatment was deemed necessary by medical staff.

43. A Medication in Possession (MiP) Risk Assessment was completed on 6 July, although there is no entry as to who completed this form. The assessment is used to determine whether residents in approved premises should have their medication in their own possession. There are three possible outcomes of the assessment; Green (all medications can be MiP), Amber (MiP, with some exception) or Red (no MiP). The man was assessed as Amber as he was not allowed to have co-codamol (used for pain relief) in his possession. The man signed this assessment on 6 July. However, Plas Y Wern's manager did not countersign this form until 13 August, despite the direction,

> "Ensure this assessment is immediately passed to the AP manager or

agreed member of staff for review and documentation and/or referral to key workers if necessary."

44. The man advised his offender manager that he would consider staying in the Wrexham area and, over the next few weeks, his accommodation options were further explored.

45. The Plas Y Wern's manager wrote an entry in CRAMS dated 20 July that the man new mobile telephone was handed back to him as it did not have an internet connection or the ability to take photographs. The man had again asked about obtaining an 'x-box' games console and was told that his offender manager and the public protection unit had not previously granted him permission.

46. On 10 August, the man was issued with a notice to leave Plas Y Wern by 31 August, as he had been resident there for too long. It is a requirement for residents to be relocated to another hostel if they have stayed at the premises for longer than two years. Three days later, the man was recorded as "rather pleased" at receiving this notice and hoped it would help him secure independent accommodation. The same day he had told staff that he had been to Wrexham Hospital and seen the consultant. He said the consultant was pleased that his wound was healing and told him that he also may not have angina as originally diagnosed but a chemical imbalance which would have similar effects. There were no documents available to my investigator to support this information.

47. On 15 August, the man was visited by his mother who brought him an 'old type x-box'. This was retained by staff until a decision was made on whether it was appropriate and did not break the conditions of his licence. The following day, the man's offender manager discussed her concerns with colleagues about securing appropriate accommodation for him and said that she would consider making a transfer referral to the other approved premises in the North Wales area, Ty Newydd, as a short term arrangement. There was no mention of the 'x-box'.

48. A referral to Ty Newydd Approved Premises in Bangor was made on 19 August, by the man's offender manger. She noted in CRAMS that plans to move the man had been ongoing since April, but that the preferred area had refused the planned transfer. The man's offender manager envisaged that the man would be at Ty Newydd for a very short time in order to reacquaint himself with the area and for suitable accommodation to be found, with the assistance of Anglesey Council. The referral was accepted by the Ty Newydd's manager, initially for two weeks.

49. In a meeting on 24 August, the man told his offender manager that his health was suffering as a result of the stress of his forthcoming move. He suggested that if he was to have a heart attack it would be her fault. She also noted in CRAMS his understandable concern that he would be moving away from the area where all of his medical appointments had been made, but that arrangements could be made for transfer to another hospital.

50. The man's offender manager confirmed to the man that he would be moving to Bangor on 31 August. Over the next few days, the man raised concerns about travelling through the exclusion zone, an area in which he was not allowed to visit, noted on his licence, on his journey to Bangor, and that he would not be able to carry all of his possessions. The man was assured that his journey was on a direct train for which he had permission to travel on and that he would be given assistance from probation staff in moving his property to Ty Newydd.

51. The man arrived at Ty Newydd Approved Premises on 31 August. He was given an induction by one of the approved premises key workers. During the induction he signed the approved premises rules, confirming that he would abide by them. The rules included being in the building during standard hours of curfew (9.00pm to 12.00 noon the following day) and allowing staff to search rooms and personal belongings at any time without interference. The man also agreed not to:

> "… bring onto the premises, without the prior written permission of staff, DVD or video recorders/players, combined TV with DVD/video player, personal computers or laptops, cameras or other photographic equipment, games consoles with DVD readability or mobile phones with cameras or internet access."

52. Following his induction, the key worker sent an e-mail to the man's offender manager to advise that the man's medications had been removed from his personal possession, as he had disclosed that he had suicidal thoughts since he had been told he was to move to Ty Newydd. The man told the key worker that although he had thought about taking his life, he would not do so.

53. As a consequence of having his medication kept by the approved premises, the man also signed a resident's medication contract during his induction. By signing the contract the man agreed that it was his responsibility to collect his medication at the appropriate time from approved premises staff and to take it under their supervision. He also agreed that any medication not collected for three days (either in a row or within a 28-day period) would result in the approved premises manager being informed. However, the key worker did not complete a new MiP Risk Assessment outlining the reason why the man was not able to have possession of his medication. During interview, she said "that would have been an oversight on my part".

54. Whilst at Ty Newydd the man was concerned that he might see people that he previously worked with, and was worried how they would react to seeing him. He was told to inform staff of any specific issues or concerns. The man told the key worker that he had previously suffered from a heart attack, used angina spray, was due to attend hospital in Wrexham and had recently experienced increased chest pans. She reassured the man that he could approach any member of staff if he felt unwell and that he would be registered with the approved premises local GP at Bron Derw Medical Centre.

55. On 2 September, the man's offender manager recorded in CRAMS her continued discussions with probation areas regarding moving the man closer to his famiily. One area confirmed that they might be able to accommodate the man at

approved premises. The following day the man was informed that he would remain at Ty Newydd until the transfer had been arranged. He asked if it was possible to move back to Plas Y Wern as it would be easier to attend his hospital appointments and he was told that enquiries would be made.

56. Three days later, a Residential Support Officer (RSO), recorded that he had kept a nylon roped washing line that the man had bought, because he was potentially a risk to himself. The RSO recorded in CRAMS that the man was:

> "Edgy walking around town when he heard someone shouting but had not purchased the rope for any other reasons than repair of his holdall. As a precaution I advised the man to bring the bag downstairs for repair. In addition the man did not have Sunday dinner today. He was a bit subdued and told myself and another member of staff he wasn't up to eating a Sunday lunch."

57. In the approved premises diary, the man was noted as having a doctor's appointment at 10.00am on the morning of 9 September. According to the movement log, he left the premises at 9.20am, returning at 10.30am, suggesting that he did attend, but there are no other details recorded.

58. On 14 September, the man complained of chest pains and staff called an ambulance. Paramedics attended. The man was examined and he told them that he had experienced chest pains due to stress levels, but was not in pain during the assessment. The paramedics completed an ECG, a test to assess the electrical activity of the heart) which was normal and required no action. His blood pressure was recorded as 122/83 and pulse 80 beats per minute which were also within normal limits. The paramedics advised staff to call them again should the man's condition worsen.

59. The following morning, the key worker met with the man and enquired about his health. She encouraged him to see his doctor. She recorded in CRAMS how he claimed that living in Bangor had made his health worse, and that doctors had informed him that they were unable to increase his medication any more. She says that she discussed with the man how he would soon be moving form Ty Newydd. However, the man said he did not believe this, and said this had happened before. He was told to obtain a note from his doctor confirming that his health was suffering due to the ongoing situation with his accommodation.

60. Over the next twelve days, the man generally remained in the approved premises during the day. When he left Ty Newydd it was, on most occasions, for a couple of hours during the afternoon and usually to attend medical appointments. On 20 September, there is an entry in the diary noting that his bisoprol medication (used to treat high blood pressure) had been altered to 10mg each morning (previously it was 5mg in morning and 5mg in the afternoon).

Thursday 23 September

61. During a routine review with RSO B, on 23 September, the man said that being at Ty Newydd made him 'ill' and that his doctor was unable to increase his

medications. RSO C who predominantly worked night shifts, returned to work having been on sick leave for four and a half weeks. During interview, she said that on her return to work there were only three residents that she was familiar with and about ten, including the man, about whom she was not. She was given a detailed verbal handover form her colleague and, over the following two shifts, went through the details of the other residents in order to catch up. RSO C said that she was aware of the details of the man's offence and understood he was not allowed access to the internet or have any unauthorised electronic equipment as detailed on his licence. She said that on Thursday night, sometime after 9.00pm, the man came down to the office and complained about the noise from a television in the next door room. RSO C said she turned the television off as the resident was not in the room.

Friday 24 September

62. RSO C said that she and her colleague, gave the man his medication on Friday morning at 8.30am, before finishing her shift at 9.00am. During interview, RSO C recalled that she tried to engage the man in a conversation, but he didn't want to discuss his medication. He signed for it and then went. This was the last time that she saw the man. RSO C returned to Ty Newydd that evening at 9.00pm to start her evening shift, during interview she confirmed that she did not see the man that night.

63. Ty Newydd's signing in sheets record that the man remained in the approved premises on Friday 24 September. Having collected his medication regularly, three times a day, since his arrival at Ty Newydd, the man collected it from staff for the last time at 5.55pm.

64. RSO D started work at 5.00pm and almost immediately was asked to deal with some disruptive residents. He said that at about 5.50pm he assisted his colleague RSO D, a part time RSO, with the issuing of medications. RSO D started work at 2.00pm, and her shift finished at 9.30pm. RSO D told the investigator that having seen the man when issuing his medication, she did not see him again that evening. RSO D said that the man "seemed fine" and did not express any problems with regard to his health. RSO D said that from the time the man arrived at Ty Newydd to the last time he saw him he did not see any noticeable deterioration in his physical health. RSO D said that it was usual for the man to collect his medications early in the morning and that he would go to bed early. He told the investigator that the man was an early riser and tended to go to his room fairly early in the evenings, finding some of the other residents quite boisterous.

Saturday 25 September

65. RSO D was working a sleeping shift, (members of staff working the sleeping nightshift are permitted to sleep, on the premises, between the hours of midnight and 7.00am, when the shift finishes, but remain on call.) and he slept from midnight through to 7.00am the following morning, when he left Ty Newydd. He was not required to be involved in the morning roll check. Having completed her

shift, RSO C left at 9.00am.

66. RSO F is an RSO responsible for the supervision and delivering of services to the residents of Ty Newydd out of hours and at weekends. He told my investigator that he started work at 7.00am and worked through till 4.00pm. RSO F had just returned from a period of two weeks leave and was given a handover by RSO C. He told the investigator:

> "…she [RSO C] said to me that she'd only just come back after three weeks off. So she wasn't aware of what was really going on other than to just tell me it was quiet night, the previous night and the best thing I could do would be to read the files and bring myself up to speed and she gave me a very brief sort of handover as to the new residents."

67. RSO F said that no specific mention of the man was made during the handover.

68. RSO E said that, although she wasn't expected to work, she returned the following day at 7.45am as she was contacted to cover for a relief worker who was unable to work.

69. On the morning of 25 September, RSO F said that he was testing residents' electrical equipment, in their rooms to ensure its safety. However, having checked two other residents' equipment RSO F was distracted before he checked the equipment in the man's possession.

70. During interview, with regard to the distribution of medication, RSO said that it is the residents' responsibility to come and collect their own medication and that in 16 years he had never gone to look for a resident if they did not collect it. He said that, because of the relaxed regime, he was not immediately concerned that the man had not collected his medication, and thought that he would collect it later in the day.

71. A relief member of staff, started duty at 9.00am and worked to 8.00pm. The relief member of staff confirmed that the man did not collect his medications that morning but could not actually remember whether or not he had been involved in the dispensing of medications that morning. The investigator asked if there was any procedure whereby staff would go and look for a resident who had not collected their medication or for completing a roll check of which residents are in the premises. The relief member of staff said:

> "No and it seems to me anyway that we're never going to find a resident if he hasn't come for his medication… I would say to be honest that since I've been here there hasn't been a procedure to check that. The only procedure really that I've been using and been aware of is the residents' signing in and out book."

72. The relief member of staff confirmed he did not see the man during his shift that day.

73. A second relief member of staff, who was working the sleeping nightshift, arrived on duty at 4.00pm. On her arrival, the second relief member of staff said that she received a handover from the outgoing staff, but the man was not mentioned and described the events of the Saturday evening as “quiet”. She told the investigator that staff did not do a roll check in the evening on a Saturday and that the signing in book was used to check residents were on the premises.

74. RSO C returned to work at 8.00pm and was the night waking shift officer, whose duty starts an hour later during weekends. She told the investigator that during the shift she did not see the man.

75. The man did not pick up his medication on Saturday 25 September and staff did not follow it up.

Sunday 26 September

76. RSO C, who was working the nightshift, was responsible for providing a handover to the staff coming on duty on the morning of Sunday 26 September. RSO F said that he reported for work at 7.00am for his second shift of the weekend. He said during interview, that RSO C provided a handover but had nothing of any significance to report. She said that it had been a quiet evening and night and she did not mention anything about the man.

77. RSO E arrived for her shift and RSO C left Ty Newydd at 8.00am, before the man was found in his room.

78. RSO F said that whilst preparing to dispense the morning mediations with his colleague RSO E, he noticed that the man had not collected his medications at all the previous day. At about the same time, between 8.15am and 8.20am, another resident, knocked on the door and told RSO F and RSO E that he had not seen the man the previous day. He said that he had knocked on his door, but had got no answer. RSO E asked the resident to knock on the man’s door, saying that she and RSO F would watch him via the CCTV system. The resident indicated to the CCTV camera, by shrugging his shoulders, that he had not gained a response from the man, RSO F and RSO E then left the office to go and check the man’s room.

79. When she entered the room RSO E said she thought the man was asleep. She called out his name, and told the investigator that, “something didn’t look right”, and went further into the room. She said that the man was cold to touch and that he was purple in colour. RSO F also entered the room. He too explained that The man was cold, that there was a marbling effect to his skin and that rigor mortis was evident (a recognisable sign of death when the joints and muscles become rigid and unmovable).

80. Both members of staff noticed that there was an indecent image of a child on the screen of the man’s television. RSO F told my investigator that he could also see what he believed to be an internet wireless dongle (a small device connected to a computer via a USB port (Universal Serial Bus connection which allows the transfer of data, including pictures, via a connection to a computer) on the wall

behind the headboard of the bed and that this was connected to a games console which in turn was connected to a couple of speakers and the television. RSO F said he and RSO E left the room, locking it behind them.

81. RSO F contacted the emergency services and the on call duty manager for the approved premises. RSO E spent some time talking to other residents, in particular the resident who had knocked on the man's door, to offer support.

82. We understand that the police broke the news of the man's death to his family. The following day premises manager, contacted the man' family to offer condolences and inviting them to visit Ty Newydd, but they declined.

83. A post mortem was completed on 27 September. It was undertaken who recorded the cause of death as coronary artery thrombosis (a clot in the blood that either blocks, or partially blocks a blood vessel, that could lead to a heart attack), coronary artery disease (when arteries become partially blocked, it can cause chest pain, or if they become completely blocked, it can cause a heart attack) and hypertensive heart disease (high blood pressure associated with heart disease).

ISSUES

84. The man had a history of heart problems, and was prescribed various medications to help manage his condition. Following his move to Ty Newydd, he was assessed as a potential risk to himself, and was not allowed to have his medication in possession. He was responsible for collecting his medication each day, which was dispensed by staff.

85. Following The man death, North Wales Probation Trust completed an internal investigation, resulting in several members of staff, including the manager, being suspended from duty pending further enquiries. An acting manager was appointed. A number of areas were identified as falling below the standard expected within approved premises. Whilst these would not have prevented the man's death, it is probable that he would have been discovered much sooner. However, we are pleased to note that prior to the investigator interviewing staff, policy and procedure had already been reviewed at Ty Newydd and changes had been implemented.

Clinical Care

86. The clinical review, undertaken by Health Inspectorate Wales (HIW), critically examined the systems, processes and quality of healthcare services provided to the man whilst resident at Ty Newydd. HIW concluded that the care the man received was comparable to that which is expected in the general community. HIW writes:

> "The man suffered a sudden and fatal cardiac event despite appropriate secondary prevention measures being undertaken by both his general practice and the hospital cardiology service. Given that he had undergone two reassuring investigations (a low risk exercise stress test and a low risk stress echo) this event could not have been predicted…The medical care provided to the man was of acceptable standards."

HIW goes on to say:

> "That said there are areas of concern in relation to the overall care provided by the approved premises, while these do not seem to have contributed to the man's death they are worth addressing as they concern resident welfare and public safety. These concerns are in the areas of: gaps in communication, handover of care, accountability of residents and enforcement of curfew, policies about room searches and dispensing of medications."

Finally, HIW adds:

> "While we have refrained from making a recommendation in relation to the quality of healthcare records it should be noted that the records reviewed were often illegible, unsigned and brief. Recommendations have been made in previous reports in this regard."

Dispensing of medication

87. Probation Instruction 09/2009 'Medication in Approved Premises', gives guidance on the arrangements for the handling of residents' medication. It includes the need for all residents to have a MiP risk assessment, prior to being allowed prescribed drugs in possession. The man's MiP assessment was reviewed upon transfer to Ty Newydd, and following his disclosure that he had suicidal thoughts. Annex 4 of PI 09/2009 was signed by the man on 31 August, which states:

> "c. It is my responsibility to collect my medication at the appropriate time from AP staff and self-administer it under their supervision."
>
> "h. I understand that any medication not collected for three days (either in a row or within a 28-day period) will result in the AP Manager or senior staff being informed"

88. Despite regularly reporting for his medication, when the man failed to report, staff did not check the reason for his absence. I appreciate that residents are responsible for ensuring they collect their medication. However, I am surprised that staff were not alerted by his absence, especially given he was usually very compliant. The internal investigation undertaken by North Wales Approved Premises also highlighted this as an issue. Appropriately, an action plan was formulated and a new formal process has been implemented to ensure when a resident fails to collect their medication, staff follow up the non-compliance.

Staff handovers

89. During interviews with staff, it was established that there was no formalised method of exchanging information about residents between shifts at the time the man was resident at Ty Newydd. Information was often passed on via ad-hoc conversations, with no written log of significant events. Following the internal investigation by North Wales Approved Premises, a new written handover document has been developed and implemented, whereby each resident is listed, and staff are required to complete this prior to the end of each shift.

Curfew checks

90. In the Approved Premises Handbook published June 2009, Chapter 13 (13.27) 'Recording & Monitoring' states:

> "Accurate completion of the daily register is essential for both monitoring and accountability purposes. Clear instructions for completion are printed on the front page of the register. The register should record whether each resident is present in the building following curfew checks at 11.00pm. The guidance contained within the register form is reproduced at Annex 13C.

91. Preventing Deaths of Approved Premises Residents 35/2006 – Monitoring Residents and Wellbeing Checks - Probation Circular 35/2004 requires residents' movements in and out of premises to be controlled and recorded; where

appropriate this information should be communicated to the offender manager. It is vital for the public protection and risk management reasons that managers and staff on duty know which residents are on the premises at any given time. In addition, 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.

92. The man was not found for some 38 hours after he was last seen. Given that he suffered from a sudden and unpredictable heart attack it is most likely that nothing could have been done to assist him even if he had been discovered earlier. However, this lack of follow up is of considerable concern.

93. It is clear through interviews with staff that no one checked on the man, or indeed other residents, regularly during his time at Ty Newydd and that this had been accepted practice for a number of years. Additionally no checks were made when he did not collect his medication and routine and mandatory checks that staff at the approved premises should have been performing on a regular daily basis as set out in approved premises instructions, were not undertaken. As a result of the internal investigation a register is now taken at various times throughout the day.

Room checks / searches

94. Approved Premises rules outline expectations for residents about their stay. Rule 7 states, "I [the resident] must let staff search my room and personal things." Guidance for staff relating to Rule 7 says, room searches should be conducted on both a random and intelligence-led basis and may require the involvement of the police. The investigator interviewed a number of staff members all of whom appeared unaware of the policy in relation to room searches, the frequency these should happen or how they should be recorded.

95. During the investigation it became apparent that at the time of his death the man had been viewing indecent images of children in his bedroom. As a consequence, North Wales Police removed a number of items including electrical devices and other electrical equipment from the man's room for further examination. These included a mini disc player, games consoles and games as well as a television and a number of assorted connection cables. Upon further forensic examination of these items by the North Wales Police Hi Tech Crime Unit, it was established that the man had been in the possession of over 10,000 indecent images of children and over 70 videos. The images were stored on a small memory card, usually associated with mobile phones, and were of a small physical size. The police concluded:

> "It would appear that new and old technology has been used together in order to achieve the goal of being able to view indecent images of children with internet capability. The small physical size of the memory card and the associated reader would also aide the concealment as they were not visible to staff. They could also be removed by simply unplugging them and concealing them elsewhere in the room… A member of staff checking the equipment would more than likely not be

aware of the potential for displaying indecent images of children or accidentally discover them."

96. The investigation by the police concludes that even if room searches had been completed, it is unlikely that the memory card would have been found. However, the man was in possession of IT cables and internet capable equipment. If room searches had been undertaken, then it is probable that these would have been discovered and appropriate action taken and that procedures have been introduced to ensure that room searches are carried out.

Internal Investigation

97. It became evident during the investigation that the failures raised in this report had been reviewed; action had been taken to rectify these deficiencies and new systems introduced. Given that an internal review was undertaken quickly and thoroughly to address the above areas of concern, formal recommendations in these matters are not made. However, in order to confirm that these changes have been fully implemented the following overarching recommendation is made:

    The manager of Ty Newydd should review the actions taken as a result of the internal review, with regard to dispensing medication, staff handovers, curfew checks and room searches to ensure their full implementation.

Enforcement of licence conditions

98. The man had stringent licence conditions, including that he must not use a computer or other electronic device for the purpose of accessing the internet or without the prior approval of his supervising officer. The man was found to be in possession of items that possibly breached his licence on three separate occasions; 13 October 2009, 3 December 2009 and 3 June 2010. There is no record that consideration was given to issuing a warning notice for breach of licence.

    The manager of Ty Newydd should ensure that a breach of licence is recorded and licence warning notices are issued in line with National Standards.

CONCLUSION

99. Upon release from custody to Plas y Wern approved premises, the man had a known heart condition. He registered with a community GP and his condition was monitored by specialists, and assessed not to be high risk.

100. When the man arrived at Ty Newydd, he told staff that he felt stressed as a result of his move and, as a consequence, he was not allowed his medication in possession, as he was assessed as a potential risk to himself. The man regularly reported to collect his medication, but when he failed to collect it, staff did not follow up the reason for his absence. As a result, there was a significant delay in discovering his death.

101. When he was finally discovered, it was clear that the man had been in contravention of his licence conditions just before his death. Following the police and internal investigation, it is incumbent upon North Wales Approved Premises to take measures to ensure that such conditions are not breached on their premises in future.

102. The man suffered a sudden and unpredictable heart attack. HIW concludes that the medical care that he received whilst resident at both Plas Y Wern and Ty Newydd approved premises was comparable to that which he could have expected in the community.

RECCOMENDATIONS

1. The manager of Ty Newydd should review the actions taken as a result of the internal review, with regard to dispensing medication, staff handovers, curfew checks and room searches to ensure their full implementation.

   Accepted – All systems, including those listed above have been reviewed since the death of the man. They are all audited monthly be the AP manager. A number of changes for each procedure have been implemented. Room searches are now undertaken on a random basis, and targeted room searches are undertaken as and when required. The manager of the AP is confident that any failures to collect medication would be investigated immediately. Timely MIP assessments are now undertaken and countersigned by the AP manager in every instance. They are also audited monthly. Curfew checks are carried out in a timely manner by all staff and handovers are undertaken at each shift change.

2. The manager of Ty Newydd should ensure that a breach of licence is recorded and licence warning notices are issued in line with National Standards.

   Accepted – Licence warnings are issued by the Offender Manager, not by AP staff. However, on a number of occasions since the death of the man, the current AP manager has contacted OMs to discuss non-compliance of AP residents to ensure that appropriate enforcement action is taken. If an acceptable response is not received, the Team Manager is contacted.

   Communication with Police PPU colleagues is proactive under the current AP management, with scheduled regular meetings taking place between the AP manager and PPU officers. These meeting include discussion of all residents being supervised by PPU officers and any restrictions that are in place on these residents. Any restricted items (such as games consoles, mobile phones etc) found in the possession or requested by residents are held by AP staff until the OM and PPU have authorised their possession.

   The recording of all information relating to residents is of an improved quality and a practice direction on Recording of Information has been issued and discussed by all at an event held for all North Wales AP staff. The recording of information is audited monthly by the AP manager.