

Investigation into the circumstances surrounding the death of a man in July 2011, at hospital, whilst a resident at Glogan House Approved Premises, Avon & Somerset Probation Trust.

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

February 2012

This report investigates the death of a man. He had been admitted to hospital in July with stomach pains, where he remained until his death. He was 56 years of age. Her Majesty's Coroner for Avon and Somerset did not request a post mortem and confirmed that he died of oesophageal carcinoma (cancer of the oesophagus). I extend my condolences to his family and friends.

One of my family liaison officers (FLO) contacted the man's family to inform them about the investigation and to provide them with an opportunity to raise any issues about the care he received whilst resident at Glogan House.

The investigation was carried out by one of my investigators. I would like to take this opportunity to thank staff at Glogan House and Yeovil Probation Office for their cooperation during the investigation.

The man's family raised a number of concerns about his care at Glogan House and it is to be hoped that this investigation provides them with answers to their questions. In essence, the report concludes that the care he received was appropriate. A small number of recommendations are made to ensure that lessons are learned from this sad case, regarding matters such as the payment of funeral costs and staff support.

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.

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Prisons and Probation Ombudsman

February 2012

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SUMMARY

1. The man was released on licence from HMP Exeter on 17 June 2011. He was directed to stay at Glogan House Approved Premises located in the Bridgwater area of Somerset. He had been diagnosed with oesophagus cancer in November 2010. He underwent surgery in March 2011 and had completed several courses of chemotherapy treatment. He continued to take medication, and it was believed that his cancer was in remission.
2. The man arrived at Glogan House and completed an induction programme. He had been prescribed medication that he was not allowed to have in his possession because it was classed as 'toxic', and was required to report to staff daily who would dispense and supervise him taking his medication.
3. During his stay at Glogan House, the man attended a number of medical appointments, including an assessment by a consultant at hospital. He spent a lot of time with his family, although he remained unhappy that he was required to stay at the approved premises. His key worker and offender manager explored alternative accommodation for him in a different area, but this was not secured prior to his death.
4. On 6 July, the man was complaining of having stomach pains and said that he had made an appointment to visit his doctor. Over the next three days, he continued to experience discomfort, believing that he was suffering from indigestion or stomach acid. He reported to hospital on 9 July, and was prescribed painkillers, had further tests and was told to see to his doctor.
5. At 4.30pm on 15 July, the man returned to Glogan House, following a visit to his doctor who advised him to report to the medical assessment unit at hospital. Staff arranged for him to travel there by taxi and upon arrival at the hospital, he was admitted.
6. Over the next 16 days the man underwent various assessments, and it was discovered that his cancer had spread and that his condition was terminal. His condition rapidly declined and he died at 6.30pm on 31 July. Her Majesty's Coroner recorded the cause of death as oesophagus cancer.
7. The investigation focuses on the following:
 - establishing the circumstances and events surrounding the man's death, including the care provided by the Approved Premises service and relevant outside factors
 - examining whether any change in operational methods, policy, practice or management arrangements would help prevent a similar death in future
 - ensuring that the man's family have had the opportunity to raise any concerns they may have and that these are taken into account in the investigation and report

- assisting the Coroner's inquest.

THE INVESTIGATION PROCESS

8. My office was formally notified of the man's death on 1 September. The delay in notification was because Avon & Somerset Probation had the incorrect contact details for this office. An investigator was appointed to investigate the circumstances surrounding the death and notices announcing the investigation and its terms of reference were issued to both staff and residents at Glogan House. The notices were displayed around the approved premises and invited staff and residents to contact the investigator should they wish to do so.
9. The investigator visited Glogan House on 13 September. She obtained all relevant documentation relating to the man's conviction and time at Glogan House and conducted interviews with two staff. No residents wished to speak with her. Later in the investigation, she conducted three telephone interviews with other staff members, including the man's Offender Manager. On 20 September, she provided written feedback to the Chief Officer of Avon & Somerset Probation Trust.
10. The investigator also liaised with HMP Exeter. She obtained copies of the man's clinical notes, which detailed his diagnosis and the treatment he had received prior to his discharge to Glogan House. The clinical notes were comprehensive and included a letter from the prison doctor, which was given to the local GP practice for Glogan House. It was not relevant to the investigation to interview any staff from Exeter.
11. One of the Ombudsman's family liaison officer (FLO) contacted the man's family on 20 September, advising them of the purpose and scope of the investigation. He asked whether they had any questions or concerns about the circumstances of his death. His family raised the following concerns:
 - Why have Glogan House not made an offer of assistance with funeral costs?
 - Why were they not given the opportunity to visit the room where he lived?
 - Was the room that he lived cleaned prior to him arriving (cleanliness was imperative as his immune system was low)?
 - Did he remain in the same room during his stay at Glogan House and what were the reasons for any move?
 - On 20 June 2011, why was he told to go and sign on for Jobseekers allowance and try and find a job at Morrison's (supermarket) just around the corner from Glogan House? The family thought this was totally inappropriate for someone suffering from cancer.
 - When collecting his possessions, they had been placed in refuse sacks and a plastic box, which Glogan House asked them to empty as it belonged to them. Although staff provided some more refuse sacks to transfer his possessions the family felt this was insensitive. Why were his possessions not placed in a box/container that could have been taken away and kept?

- Why were his clothes not available for collection along with his other property and necessitated several phone calls from the family to Glogan House to arrange collection?
- Has his electric razor been located?
- He was granted permission to stay at his brother's house for two nights, to enable him to attend a hospital appointment on 1 July and his son's wedding on 2 July. He was required to return to Glogan House by noon on 3 July. Why was he not granted permission for a longer period of leave, to an approved address, as he was very tired as a result of long days and travelling?
- He had special dietary needs which were well known to those who were responsible for his care both in prison and the approved premises. However, on several occasions, due to unsuitable foods (spicy) he had to purchase his own food. Why, when suffering from cancer of the oesophagus was there a lack of special dietary provision? Did it have any bearing on his admission to hospital?
- When he was advised by his GP to go to hospital, why was he initially told to catch a bus, before Glogan House agreed to pay for a taxi?
- Why did staff at Glogan House only speak to hospital staff each day and not directly to him?
- The family was concerned for his welfare when he was released from prison and moved to the approved premises, as staff at Glogan House may not have fully appreciated or been fully informed of the seriousness of his condition. Why were staff not more alert to the fact he may have been very unwell (he had five doctors' appointments and had been to A&E)?
- Why did he and his family not receive clear information about the reasons and timescale for his stay in an approved premises, which undoubtedly contributed to the stress he endured?
- Why was no contact made to his family by Glogan House?

In response to the family raising these issues, the investigator contacted the managers at Glogan House in writing for their response. A written response was received on 4 October.

The family received a copy of the draft report. Having considered the investigation findings they provided some further written concerns. The investigator has sought to address these. Any concerns not covered in the finalised report are addressed in separate correspondence to the family.

GLOGAN HOUSE APPROVED PREMISES

12. 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 premises is to provide an enhanced level of residential supervision in the community, in a supportive and structured living environment.
13. Glogan House is one of four approved premises in Avon & Somerset, is located near the town of Bridgwater, Taunton and has the capacity to provide accommodation for 16 men (12 single rooms and two double rooms). Approved premises have the following aims:
 - i. protect the public
 - ii. prevent re-offending
 - iii. provide residents with an opportunity to address their problems in a safe, stable environment
 - iv. enable residents to face up to their offending behaviour
 - v. complete the conditions of their order or licence
 - vi. facilitate their resettlement into the community.
14. Glogan House 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. Residents are told about the Approved Premises rules, their expected behaviour and how to register with the local GP.
15. 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 the primary point of contact during the resident's stay and assists in sorting out practical issues. Regular key work sessions also give residents the opportunity to discuss their difficulties 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 Glogan House 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.
16. Whilst at Glogan House, residents are required to pay rent and abide by the rules and regulations which include observing an overnight curfew between the hours of 11.00pm and 6.00am (residents are required to sign a register), which staff are responsible for enforcing. During the day residents are free to leave Glogan House unaccompanied, they are not required to tell staff where they are going. However, depending on their offences, some residents will have additional licence conditions and restrictions. They are required to seek permission for certain activities or contact with particular individuals, to ensure that the risk posed by an individual is appropriately managed. Breakfast and

Previous deaths at Glogan House

17. This is the first death at Glogan House since the Ombudsman took on the responsibility for the investigation of deaths in approved premises in April 2004.

Management structure at Glogan House

18. Approved premises in Avon & Somerset are managed by Middle Managers and the responsibility of an Assistant Chief Officer (ACO). Glogan House has two managers that share this responsibility. One manager is also the area manager for approved premises and is responsible for the line management and supervision of staff.

Multi Agency Public Protection Arrangements (MAPPA)

19. 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. The higher the risk, the higher the level at which the individual is managed. Level 1 offenders are managed by one agency, usually the police or probation service. Level 2 offenders are managed jointly by all the MAPPA agencies (including housing), and level 3 offenders are managed by the Multi-Agency Public Protection Panel (MAPPP) which is made up of senior managers from the MAPPA agencies.

Probation Circulars (PCs) / Probation Instructions (PIs)

20. National guidance for probation staff about various protocols is contained in probation circulars and instructions. Probation Circulars contain mandatory actions, while others purely give guidance. Probation Instructions replaced PCs in August 2009, and stipulate the mandatory actions staff need to observe and outline distinct instructions for staff, although some PCs still remain in force.

KEY EVENTS

21. The man was 56 years old at the time of his death. He was from the Yeovil area of Somerset. He worked as a heavy goods driver. On 17 September 2010, he was convicted for sexual offences and was subsequently sentenced to 18 months' imprisonment at Crown Court. This was his first conviction. In addition to his release licence, a Sexual Offences Prevention Order (SOPO) was also imposed on 17 September 2010 at Crown Court for a period of ten years. This order stipulated that on release he would need to register his address and personal details with the police area where he is resident.
22. The man was released on licence from HMP Exeter on 17 June 2011. On the day of his release, he was given a letter by a prison doctor summarising his health care at the prison, which he was to pass on to his new general practitioner (GP) upon release to Glogan House. In the prison discharge letter, the doctor wrote that the man had been diagnosed with a malignant (cancerous) tumour of the oesophagus whilst in custody, and had subsequently been admitted to hospital where he had surgery on 4 March 2011. He then underwent a course of chemotherapy treatment (the use of anti-cancer (cytotoxic) drugs to destroy cancer cells. The drugs go into the bloodstream and travel throughout the body to treat the cancer cells wherever they are, at hospital.

The prison doctor listed the man's medications on discharge as:

- Capecitabine 150mg is an anti-cancer 'cytotoxic' chemotherapy drug. (Cytotoxic drugs are poisonous to cancer cells. They kill cancer cells or stop them from multiplying).
- Capecitabine 500mg
- Domperidone 10mg (used to suppress nausea)

The man subsequently registered with a Medical Centre who have established links with Glogan House.

23. On his release, the man was assessed as a MAPPA Level 2, and managed by several agencies. A condition of this licence was that he was required to live as directed by the Probation Service and his offender manager had made the necessary referral. He intended to return to live with his wife and young daughter, and was unhappy that he was being released to Glogan House. A number of additional conditions were also imposed on his licence, including no unsupervised contact with any child under the age of 18 years without prior permission, to ensure that the assessed risk was robustly managed. The restrictions on his release licence reflected those that needed to be complied with in line with the SOPO.
24. Probation Instruction 09/2009 'Medication in Approved Premises', gives guidance on the arrangements for the handling of residents' medication. All residents must have a Medicine in Possession (MiP) risk assessment, prior to being allowed prescribed drugs in possession. The man's MiP assessment could not be found by Glogan House and was not available to the investigator. Due to the toxic nature of the drugs he was prescribed, and the advice that

gloves should be worn when handling the medication, the drugs were kept in a locked medicine cabinet and dispensed by staff who observed him each day.

25. During his induction, the man told staff that he needed to eat little and often and required a high fat diet, which was recorded in the induction documents. This information was conveyed to the catering manager for Glogan House. In response to the investigator's question about accommodating his diet, Glogan House responded:

“Catering services at Glogan House are provided by an external private company. They ensure that the weekly menus provided to residents have several choices on them each day, so that all dietary needs are catered for. Residents are asked at their induction to specify any particular dietary needs they have and are also advised to discuss any concerns, including that there is nothing they like on a particular day with the resident chef. It is common practice for the chef to then prepare bespoke meals, whenever possible, to cater for their specific needs. We can confirm that the man did note that he did not like spicy food when he came to Glogan House. The only feedback we are aware he gave to our resident chef was that he could not eat the large size of the meals provided. We are not aware, nor have we received any evidence to indicate that the food at Glogan House was linked to his hospital admission.”

26. Further, the man requested that he be advised of any staff or resident that had a cold or cough in order that he could avoid them due to his weakened immune system following chemotherapy. According to staff interviewed and entries in the electronic contact log, this information was well communicated.

In response to a specific question raised by the family, Glogan House added:

“Cleaning at Glogan House is undertaken by an independent private company. It is standard procedure that every room is thoroughly cleaned after a resident has moved out before the next resident moves in. We can confirm that the man's room was cleaned prior to his arrival and that he made no complaint to the standard of cleanliness then or throughout his stay at Glogan House.”

27. The man was allocated a key worker. Despite his frustration at not being allowed to reside with his wife and daughter, he was generally compliant with the rules of Glogan House and respectful to staff. He did not routinely socialise with other residents, choosing to spend much of his time with his family, with the approval of his offender manager.
28. Initially, the man was located on the ground floor in the lounge area at Glogan House. This room has a sofa bed and is often used by staff to assess a resident. He had sole use of this room and it was not used as a common area for other residents. The investigator was told during interview that they wanted to assess his mobility and were mindful of his health needs. He remained in this room for only a couple of days before he agreed that he was capable of using

the stairs and welcomed the exercise that this would give him. He subsequently moved to room 10, a single room with washing facilities. A bed wedge was purchased for him, this gave him support to sleep sitting up, which helped alleviate his discomfort.

29. The man registered with a Medical Centre on 20 June, when he was assessed by the duty doctor. He told staff at Glogan House that there were no specific concerns except that he had lost some weight. On this day, he was also directed to report to the job centre, which is normal practice for all residents at Glogan House. The reason he was required to attend was to apply for benefits to ensure he received his entitlement. He told staff upon his arrival at Glogan House that he was planning for his future and his key worker had discussions with him around goal setting and planning in relation to employment.
30. On 27 June, Glogan House were advised that the man had an appointment with his consultant at hospital on 1 July, and the necessary arrangements for his travel to attend were agreed by his offender manager. Two days later during his regular key work session, he reported feeling "stronger due to good food, and exercise". He completed his course of prescribed capecitabine medication on 30 June.
31. The man was granted permission by his offender manager to reside at his brother's house for two nights, to allow him to attend a hospital appointment and his son's wedding. Permission to reside at an address, especially soon after release to an approved premises, is only granted for a minimum period of time to ensure the risk posed by him was managed robustly. He attended his hospital appointment as planned on 1 July. There is no record of the outcome of this appointment, although there is no expectation that he needed to discuss his medical issues with staff.
32. During a casual conversation on 6 July with a probation service officer (PSO) at Glogan House, he told him he had stomach pains and had made an appointment to see the GP. The PSO recorded this conversation on IIMS (Integrated Information Management System, the electronic contact records). On 9 July at 11.46pm an entry was made on IIMS by a staff member that says:

"He [the man] has handed in a box of co-codamol and said that he had been down the hospital after suffering severe stomach pains. The painkillers are for cramping. Hospital have done some tests and have noticed that his urine is high on glucose. He said that he has to attend the doctor's on Monday in relation to this but at the moment there are no major concerns for him".
33. Two days later, the PSO has made a further entry on IIMS at 11.54pm:

"[The man] Came to the office at 6.05am for Stomach Acid pills – complaining of very bad acid. Returned to the office at 7.10am for Co-Codamol – has had quite quite (sic) bad stomach cramps. Is going to see GP today to have a look. Awaiting Blood Test – GP has given him pain relief at Surgery".

34. On 13 July, the man reported to a staff member, in the absence of his offender manager, for his regular appointment. During this meeting, it is recorded on IIMS by the staff member that the man discussed having an appointment with the consultant oncologist at hospital. The entry note says:

“He [the man] says, if things continue to get worse medically, he will have to make an earlier appt [appointment]”

Events on 15 July and subsequent admission to hospital

35. A staff member who worked at Glogan House made the following retrospective entry on the man’s IIMS at 11pm on 15 July:

“Bad stomach pains. Declined offer of paramedic. Having seen the GP this PM, he was directed to go to the Medical assessment Unit, at hospital”.

An IIMS entry at 5.03pm by a PSO records that the man was taken by taxi, funded by Avon & Somerset Probation Trust, to hospital. The hospital confirmed at 9.30pm that he would be admitted overnight.

36. Over the next few days, Glogan House staff remained in contact with the hospital to enquire about the man’s health. They were also obliged to ensure that he was observing his licence conditions. On 19 July, his key worker was advised by hospital staff that he would be remaining in hospital, as they had been unable to identify the reason for him vomiting. The next day there is an entry on IIMS by a Glogan House member of staff to say that he was due to have a “procedure” but there are no specific details recorded.

37. On 24 July, a PSO recorded the following on IIMS:

“...he [the man] is currently not at all well, apparently has a swelling to his stomach and having tests done, apparently had a small procedure on the 22nd about possible obstruction. On IV [intravenous – where treatment is given directly into a vein] antibiotics and the nurse said it is unlikely he will show any signs of improvement until at mid week at the earliest.”

38. The following day the PSO recorded on IIMS that hospital staff had told her that the man was “much better today, had a good weekend’ and that he was to undergo further tests. Contact was made each day with the hospital by Glogan House and the offender manager contacted the hospital for an update on 28 July. He recorded his contact on IIMS as follows:

“Asked if any diagnosis and any indications as to whether a return to Glogan will be appropriate. Not able to give me full medical information but stated that the man is not currently well enough to go anywhere. He has deteriorated rapidly in the past few days and medical tests show the ‘worst diagnosis’ – nurse indicating that cancer has spread and that he will be moved to oncology dept [oncology is the non-surgical management of cancer]. Not a good prognosis”.

39. The PSO at Glogan House was contacted at 7.14am on 1 August, by the hospital and was advised that the man died. In the absence of the offender manager, another offender manager contacted the man's family and acted in the role of family liaison officer. She spoke with his sister-in-law who said the man "gave up" as soon as he heard his case was terminal, and that the family were in shock. She made arrangements for his possessions to be collected from Glogan House by his family.

ISSUES

40. The man was released to Glogan House, from Exeter, with prescribed anti-cancer medication. It was believed that his cancer was in remission (that there were no current symptoms or signs that could be identified to indicate the presence of cancer). However, after less than a month, he was admitted to hospital where his condition was diagnosed as terminal and he died.

Clinical Care

41. During his time at Exeter he was diagnosed and treated for oesophagus cancer. He attended all of his outpatient appointments and was examined regularly by prison healthcare staff. A discharge letter was prepared for the day of release, outlining his medical history.
42. The investigator is not clinically qualified and cannot comment on the appropriateness of medical treatment and there is no requirement on the Ombudsman of the relevant Primary Care Trust to commission an independent clinical review. It was the man's responsibility to ensure that he followed medical advice regarding his health, and he was supported by staff in doing this. He registered as required at a Medical Centre and he took his medication as prescribed. The records demonstrate that consideration of his needs was made. Upon arrival at Glogan House on 17 June, he was located in the lounge for the first few days, which is situated on the ground floor. This room has a sofa bed and enabled staff to monitor him and assess his needs, as they were unsure if he would be able to manage the stairs to the living accommodation on the first floor. He was able to demonstrate that he could manage the stairs and he welcomed a move to room 10 on the first floor, as he said this encouraged him to have some exercise. Room 10 is a single room with washing facilities. In addition, his dietary requirements were communicated to the chef and appropriate meals were made available to him and his medication was supervised.
43. The man's family was told by him that he was initially advised by staff to take the bus to hospital. The investigator found no evidence that this was suggested. And it was noted that Avon & Somerset Probation Trust paid for a taxi to take him to hospital and maintained regular contact with the hospital.

Location in Glogan House

44. During his time at Glogan House, the man and his wife tried to find alternative accommodation in the Devon & Cornwall area, which would be approved by the Probation Service. Understandably, they were frustrated that he was unable to return to the family home upon his release.
45. At the point of release, the man's medical condition was being managed and there was no indication that he was terminally ill. Also, his level of risk had been assessed as requiring management at MAPPA Level 2, which meant that he presented a high risk of harm to children in the community. It is a difficult task to balance the needs and wishes of an individual, whilst managing the risk they are

assessed to pose to the community but this appears to have been achieved appropriately.

Family liaison

46. During the time that the man was an inpatient at hospital, staff at Glogan House generally contacted the hospital each day. However, no formal provision was made for liaising with his family, when it was known that his condition was terminal and they have questioned why nobody from Glogan House had spoken to them, or him, directly.
47. Staff at Glogan House were told of the man's death prior to the duty manager starting her shift. The investigator was told that his offender manager was on annual leave at the time of his death. His sister-in-law contacted the offender manager's colleague at the Yeovil Office before staff had the opportunity to discuss family liaison arrangements. Having had contact with the family, the replacement offender manager, in consultation with the duty manager at Glogan House, acted as the liaison officer for the family, to avoid the family having to speak to different people at a very difficult time. Whilst it is typically the manager of an approved premises who would adopt this role, the sensitivities of the family were considered by staff. A letter of condolence was sent the following day by Yeovil Probation Office in addition to a card from the offender manager.

In response to the investigator, Glogan House stated:

"The role of the Probation Service is first and foremost to ensure public protection. We therefore had a responsibility to have contact with the hospital to confirm his [the man's] whereabouts and manage any possible risk situations. We were though also conscious of his emotional needs and his desire to have these fulfilled through the support of his family rather than through a criminal justice agency which does have limitations in the roles it can provide...During his time with us at Glogan House and even when he was initially admitted to hospital, we were not aware as to the gravity of his situation. Once aware we did begin to review our management of his case including starting to plan, with the hospital, for his transfer to more appropriate medical accommodation nearer to his family. Unfortunately given his rapid deterioration this could not be actioned before his death."

Healthcare between a resident of an Approved Premises and a GP remains confidential. If the GP wanted to raise concerns with the manager of Glogan House regarding his placement there, he could have done so.

48. Following contact with the Ombudsman's FLO, the man's family told the PPO's family liaison officer that they were not given the opportunity of visiting the room where he lived. Managers at Glogan House spoke with the replacement offender manager who was acting as the family contact and responded by saying:

“She [the replacement offender manager] assures us that these options were extended to the family via her contact with the man’s sister-in-law with whom she was in telephone contact. It was our understanding that she requested that we pack his belongings and the family would come to Glogan House to collect them, which they subsequently did.”

49. The man’s property was collected by his sister-in-law on 1 August. The replacement offender manager recorded on IIMS that the family had expressed their thanks to her for the help provided. During contact with my FLO, the family raised the issue of how his property was given to them, and that they were asked to transfer his belongings from a box to a refuse sack. Further, that there were some missing items (an electric razor and his clothing). Glogan House have responded by saying:

“We very much appreciate the importance of packing the deceased’s items sensitively. We would like to assure the family that this was discussed with staff who were instructed to put items into plastic boxes that we have on site for such situations. We have checked the ‘Property Storage’ form in relation to his possessions and this clearly notes that his belongings were placed in his own holdall and one plastic box. We also spoke to the staff who were on duty when his family collected his belongings. From this we our (sic) assured that the family were not asked to empty the plastic box.

The man’s ‘Property Storage’ form itemises an electric razor and one of the members of staff who packed his belongings clearly remembers this. Unfortunately the family were not asked to sign for his belongings, which is normal procedure, and as such we cannot confirm whether it was taken with the rest of his belongings. Despite further searches we have not been able to locate his electric razor. As such we will offer compensation but we acknowledge this does not replace the sentimental value of the item and again offer our apologies to the family.

Staff on duty at the time his possessions were initially collected by the family, confirm that his holdall containing items including his suit was not available. They accept that this was an oversight of their part as they did not follow our standard procedure. We are aware that staff did then take action to find the missing item and once located the family were advised. We are aware that staff apologised to the family at the time but we would offer our apologies again now for this oversight as we fully acknowledge that this was not an acceptable level of service and would only have added to the families stress at the time.”

Following the consultation period, the family responded:

“The assurance given that the family were ”not asked to empty the plastic box” is simply not true. The gentleman that met the family members said, albeit politely, “the plastic box belongs to us, I will get you some bags” he returned about five minutes later with two black

refuse sacks. It is not our intention to follow this up as I believe it to have been with good intention, suffice to say; they may appreciate the importance of packing items sensitively and probably did do so at that time, but the actual handover of the property left us with the feeling that [his] whole life had been summed up in a couple of refuse sacks.”

Glogan House confirmed that they have subsequently agreed compensation with the family for the electric razor.

Avon and Somerset Probation Trust should appoint a family liaison officer, at the earliest opportunity, to co-ordinate all contact with a bereaved family.

Staff support

50. Staff were told of the man’s death as they reported for duty on the morning of 1 August. During interview, one manager told my investigator that there was no ‘official’ debrief or staff support offered, as the man had been in hospital for two weeks. He said that he made informal contact with staff over the following days, and made them aware that they could approach him if they felt it necessary. Another manager also reflected that she spent time with staff speaking informally, and recognised the need to ensure staff were able to manage their feelings and had the opportunity to talk.
51. Staff at Glogan House and Yeovil Probation Office were unaware at the time that he died that the man’s death would be subject to a Prisons & Probation Ombudsman (PPO) investigation. This process, in addition to the difficulties in managing the death of a resident, would have been a difficult time for those directly involved. During interview, it was clear to the investigator that staff felt a more formalised approach to support would have been beneficial to them.

Avon & Somerset Probation Trust should ensure that all staff are formally offered support following a death of an approved premises resident and are made aware of the process, and offered support, during the subsequent investigation.

Funeral expenses

52. The man’s family were not offered a contribution to the cost of the funeral. During interview it was apparent that neither manager of Glogan House were aware that this was mandatory, believing that it was dependent upon the family’s circumstances and the fact that the man had died in outside hospital.

In paragraph 23.39 of the Approved Premises Manual 2011, it states:

“Trusts are required to offer to pay reasonable funeral costs of up to £3,000 with the money being paid direct to the funeral director upon receipt of an invoice. The amount paid should cover the cost of the funeral only and not ancillary items such as clothing for those attending, or go towards the cost of a wake, etc”

Glogan House responded to the investigator by stating:

“It was our understanding at the time of the man’s death that offering assistance towards funeral costs was discretionary. After some consideration we felt it would potentially cause the family more upset and distress if this offer was made. This was on the basis that we were conscious that their view of the Approved Premises was quite negative as they did not believe that he should have been placed there in the first instance. We are now aware that our interpretation regarding offering to pay towards funeral costs was incorrect. As such Avon and Somerset Probation Trust will now make contact with the family to offer this assistance should they wish to accept.”

Glogan House subsequently advised the investigator that the man’s family have been reimbursed for the funeral costs.

Avon & Somerset Probation Trust should ensure that funeral expenses are offered in the event of any death of a resident, irrespective of the circumstances of that individual or the place of death.

Residents support

53. The man’s key worker was on duty on the morning of 1 August. He told other residents of the death during the morning briefing and advised them that if they wished to discuss their feelings with staff, they would be available. He said that some residents were shocked and it raised issues around their experience of bereavement, but that the man had kept “himself to himself” at Glogan House and had not established any strong links with other residents.
54. During interview one manager said that he did not consider any form of memorial for the man. He explained that the man had not been resident for very long, had no established links with other residents, choosing to spend much of his time with his family. He did not want other residents to have felt obliged to contribute to a collection or a tribute.
55. However, another manager told the investigator that this decision was much more considered. She said that she had a discussion with staff following notification and that it was agreed that it would be inappropriate, particularly as his family were opposed to Glogan House. She went on to say that the other residents did not approach any member of staff concerning a tribute or card for the family, but had they done so they would have been allowed to pay tribute in an appropriate way.
56. The investigator was satisfied that this situation was adequately managed according to the circumstances and context of the man’s death. The managers broadly followed the guidelines in the Approved Premises Manual 2011, which set out the support that should be offered in the event of a resident’s death.

Notifying the Prisons and Probation Ombudsman (PPO)

57. The PPO was officially notified that the man had died on 1 September. Probation Circular 40/2007 Deaths of Approved Premises Residents and Section 23C-1 of the Approved Premises Manual, outlines the responsibility to notify this office within 24 hours in such circumstances. The investigator interviewed one of the managers who explained that he believed this had been done by another member of staff, and had been assured on separate occasions that notification had been sent. Following this interview he provided the investigator with a copy of the notification form that had been completed on 2 August.

58. Contact details for the PPO have altered to those published in the probation circular and Approved Premises Manual 2011. However, these changes were communicated to the Head of Approved Premises, National Offender Management Service (NOMS) and were disseminated to each probation area and trust. Given that deaths in approved premises are not common, it is likely that the appropriate information had not been updated. In this instance, it is not unreasonable that in such busy environments this information had been overlooked. However, it is to be hoped that any future deaths at an approved premises in Avon & Somerset will be notified in accordance with the new guidelines.

CONCLUSION

59. The man was known to have been diagnosed with oesophagus cancer, which - following several courses of chemotherapy treatment - was believed to be in remission. Upon release from custody to approved premises, he registered with a community doctor and his condition was monitored by specialist consultants.
60. Despite concerns subsequently raised by the man's family, the care that he received whilst resident at Glogan House was generally good. He was supported and encouraged to seek specialist medical advice when he became unwell, which he did. He was admitted to hospital, where he received the prognosis that his condition was terminal.
61. A death in an approved premises is a rare event and it is therefore perhaps understandable that the management response to the man's death was not completely in accordance with guidance. In the light of his tragic case and the investigation by this office, it is to be hoped that the management team at Glogan House approved premises will ensure that their contingency plans in respect of family liaison, staff support and notification to the PPO are updated and regularly reviewed.

RECOMMENDATIONS

1. Avon and Somerset Probation Trust should appoint a family liaison officer, at the earliest opportunity, to co-ordinate all contact with a bereaved family.

Accepted by Avon & Somerset Probation Trust

2. Avon & Somerset Probation Trust should ensure that all staff are formally offered support following a death of an approved premises resident and are made aware of the process, and offered support, during the subsequent investigation.

Accepted by Avon & Somerset Probation Trust

3. Avon & Somerset Probation Trust should ensure that funeral expenses are offered in the event of a death of a resident, irrespective of the circumstances of that individual or the place of death.

Accepted by Avon & Somerset Probation Trust