Investigation into the circumstances surrounding the death of a man at Sycamore Lodge Approved Premises in the West Midlands Probation Area in December 2008

Report by the Prisons and Probation Ombudsman for England and Wales

October 2009

This is a report into the circumstances surrounding the death of a man. He was a resident at Sycamore Lodge Approved Premises in the West Midlands Probation Area and had been there for two months before he died. He was 31 years old. Although it seemed initially that he died of natural causes, the post mortem revealed that this was not the case and his death was due to a number of factors, including the inhaling butane.

I would like to offer my sincere condolences to the man's family on their loss.

I must apologise for the delay in issuing this report. This was due in part to work pressures within the Ombudsman's office, but also because of a delay in obtaining the clinical review which was received in this office on 26 August.

The investigation was undertaken by one of the Ombudsman's investigators. She and I would like to thank the manager of Sycamore Lodge and his staff for their co-operation during this investigation. A clinical reviewer was identified by the local Primary Care Trust to undertake a review of the man's clinical care whilst at Sycamore Lodge. I would like to thank him for his helpful review.

It is clear that the man had some ongoing health problems when he arrived at Sycamore Lodge, in particular back trouble. He took medication for the pain. Staff were aware of this, and also his history of previously harming himself so they decided to monitor him every four hours when he was in the building. This is commendable. However, the standard and level of checks were less satisfactory. I make three recommendations to the manager at Sycamore Lodge. One relates to the standard of checks on residents, the second to first aid and the last concerns the inclusion of information in resident's induction packs.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and residents involved in my investigation.

Jane Webb
Deputy Ombudsman **October 2009**

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SUMMARY

The man was discovered in his room at Sycamore Lodge Approved Premises at approximately 4.40pm in December 2008. Staff were making one of their regular four-hourly checks, because they had concerns about previous attempts to harm himself and the distress he was suffering due to back pain.

He had arrived at Sycamore Lodge on 10 October 2008 after being released on licence from HMP Stocken. He underwent a thorough induction and, after a restless first night, appeared to settle in well. He adopted a routine of regularly working at his family's business and attending meetings with his probation officer and key worker. He seemed to be planning for the future, addressing his past problems and looking forward to a new start after he left Sycamore Lodge. However, his back pain continued to get worse and the medication he was prescribed for this did not seem to help. This appeared to have a devastating effect on him.

On the day the man died, staff recalled seeing him in the morning at about 8.30am. At 12.30pm he was checked in his room by a member of staff, as part of the routine four-hourly check. The staff member said she knocked on his door but, as she received no response, used a master key to open the door. She saw him lying on his back on the bed, but noted nothing out of the ordinary and thought he was asleep.

The next check was at 4.30pm. The same member of staff again knocked on his door, received no reply and let herself into the room. This time she noticed that he appeared to have had a nosebleed. She turned on the light and immediately thought that he had died. She did not check for signs of life, but called for immediate assistance. The second member of staff (who did not make any checks either) also thought that he had died and telephoned for the police and an ambulance to attend.

I make three recommendations. They concern the level and quality of checks carried out by staff for vulnerable residents and the need to check for signs of life when faced with a situation like this. A third recommendation concerns additional helpful information which could be included in the residents' induction pack.

THE INVESTIGATION PROCESS

1. The investigation was conducted by a senior investigator. I am grateful for the assistance she received from the manager and staff at Sycamore Lodge who fully participated in this investigation.

2. The investigator first visited Sycamore Lodge on 22 December when she collected all the available documentation and had a tour of the premises. She returned on 6 March 2009 to conduct recorded interviews with staff. None of the residents came forward with any additional information regarding the man. She also interviewed the man's probation officer on 3 April.

3. The Assistant Director of Corporate Governance at the local Primary Care Trust (PCT) identified a clinical reviewer to carry out a clinical review. He was assisted by two colleagues. I am grateful to him and his colleagues for their thorough and helpful review which was received on 26 August.

4. One of the Ombudsman's Family Liaison Officers (FLO) was assigned to this case. She contacted the man's family on 7 April 2009 to explain the role of the Ombudsman and offer a visit from the investigator. They did not raise any questions at the time. A copy of my report will be sent to the family.

SYCAMORE LODGE

1. Approved premises (formally known as probation and bail hostels) are approved by the Secretary of State to accommodate sentenced offenders and those directed to live there by the courts as a condition of bail, or following release from prison. The purpose is to provide an enhanced level of residential supervision in the community, as well as a supportive and structured environment.

2. Sycamore Lodge is one of 101 Approved Premises in England and Wales and it accommodates 32 residents. The residents are either on licence from prison or have been directed to reside at Sycamore Lodge as part of their bail conditions.

3. There are 32 bedrooms, a communal kitchen and a television room. During the day it is staffed by a senior probation officer (the manager), a probation officer (deputy manager), two probation service officers and administration staff. During the night a probation service officer stays at Sycamore Lodge with a night officer. There is also a duty manager on call. All staff carry personal alarms for emergency situations.

4. Each resident is allocated a key worker soon after arrival, and this member of staff acts as the primary contact for helping to resolve practical issues such as accommodation. Regular key work sessions give residents the opportunity to discuss their difficulties in depth. An offender manager from the local probation area supervises the resident. The key worker and the offender manager work closely together to ensure the resident has a resettlement plan and that the resident behaves appropriately whilst at the approved premises.

5. On arrival, the resident is interviewed by their key worker. They are given information about rules, procedures and expectations during an induction. Details of next of kin, personal information and medical information are recorded and a compact is agreed setting out the standards of behaviour expected of residents.

6. All residents are offered the opportunity to register with the local doctor's surgery. Sycamore Lodge has an arrangement with the surgery to enable all new residents without a doctor of their own to register during their stay. The relationship between the doctor and the resident is a confidential one, and the approved premises is not responsible for a resident's healthcare. All medication prescribed by a doctor must be handed in to staff, where each item is logged and stored safely. Medication is given to residents at appropriate times and this is noted by staff.

7. All staff at Sycamore Lodge are trained in first aid and attend a refresher course every two years. Staff receive other training including

risk assessing, health and safety and self harm and mental health awareness.

8. Staff at Sycamore Lodge have the authority to search residents' rooms at any time if they have cause to suspect a breach of hostel rules or that a resident has been involved in criminal activity. Hostel rules include the requirement to follow the hostel's financial regulations and for residents to pay on time for their stay there. Other rules include giving all prescribed medication to staff and to take medication as prescribed by the doctor, participate in the hostel programme as instructed, including meetings and key working sessions and not to bring onto the premises or have in possession any weapons, dangerous items, alcohol, solvents, illegal drugs or drugs paraphernalia.

9. Staff screen all residents when they arrive for signs that they may harm themselves. The manager or his deputy then decide whether a resident should be placed on monitoring arrangements and the frequency of the monitoring, which can range from every 15 minutes to four hours. The frequency can be adjusted and a review takes place daily. The purpose of the monitoring is to check on the residents' physical well-being and to look for any changes in mood, behaviour or circumstances. The observations are recorded in handover sheets so that all staff are aware of the situation.

KEY FINDINGS

10. The man was born in February 1977 and was 31 years old when he died. He had two brothers who he kept in contact with, along with his mother and father. He had a partner and one child.

11. He was sentenced to six years and six months imprisonment at Crown Court in May 2004. He was initially transferred to HMP Blakenhurst. He then moved to HMP Ashwell in December 2005, HMP Featherstone in 2006, HMP Dovegate, HMP Stafford and finally to HMP Stocken in 2007, where he stayed until October 2008.

12. Throughout his time in prison custody, the man experienced medical and psychiatric problems. In 2006 he was referred by Featherstone to be assessed by a Community Mental Health Nurse who was part of the prison's In-Reach Community Team. She noted that whilst at Blakenhurst, he had been assessed by a Consultant Forensic Psychiatrist who diagnosed "impulsive anti-social personality disorder" (a type of personality disorder), but said that he was not suffering from any mental illness at that time.

13. The man told the nurse that he began harming himself at around the age of 15, and would cut his arms, hands and legs. He said this was to relieve stress and anxiety rather than a real attempt to take his own life. Records show that he was treated at hospital in Wolverhampton on 9 October 2006 as he had cut his chest and needed stitches. He attended again four months later as he had lacerated his abdomen and thumb and then swallowed the blade. There were several other instances of self harm during his time at Featherstone, but no acts reported after February 2007.

14. Most recently in 2008, medical records from Stocken show that the man was known to the mental health team there and diagnosed with a personality disorder. He was prescribed venlafaxine (an anti-depressant) and olanzapine (an anti-psychotic) which he took every day. This medication appeared to stabilise his mood and behaviour. The prescription chart from Stocken shows that, from September to October 2008, he was prescribed tramadol (a pain killer), venlafaxine, olanzapine and diclofenac (an anti-inflammatory drug).

15. The doctor at Stocken expressed concern about the high volume of prescriptions issued to the man for tramadol. (He was involved in a road traffic accident in 2002, and subsequently suffered from back and buttock pain.) The doctor noted that the dosages of tramadol had been consistently raised in response to his demands. The doctor also noted that the man needed a review of his back problems and, that as he was due for release on licence shortly, he should discuss this with his community doctor.

16. Before the man arrived at Sycamore Lodge, West Midlands probation faxed an accommodation referral form to the hostel on 8 September. This form gave details about him and his offence. It said that he would be homeless on his release from the hostel, as the offence for which he was convicted occurred outside his proposed release address, and was deemed unsuitable.

17. The form also gave details of the man's referral plan. The plan included management of his risk to the community and his drug use, build on support from family members, resolve his employment difficulties and address his thinking and behaviour. It was also planned to manage his depression with a referral to a community psychiatrist nurse (CPN).

18. The probation form also contained a section entitled "Health Issues". This indicated that the man had a history of harming himself, but had undergone counselling and felt that the risk of harming himself in the future was minimal. He said that he suffered with seasonal depression which worsened in winter months and would take medication at the start of winter to help with this condition.

19. A copy of Sycamore Lodge's rules was faxed to the man at Stocken, which he signed on 16 September 2008. The rules included a curfew 7.00pm until 7.00am every day.

20. On 10 October, he was released on licence to reside at Sycamore Lodge. His licence was due to expire on 16 May 2009. The licence required that he report immediately to a probation officer at Unity House, keep in touch with the supervising officer there, permanently reside at Sycamore Lodge and undertake work approved by the supervising officer.

21. An induction was given to the man on 10 October. The induction document confirmed that he was shown around, "settled down", had talked about any anxieties relating to his release from prison and told that if he experienced any difficulties he should speak to staff. He said he felt "ok" and did not feel the need to speak to a manager at that point.

22. The induction also included a discussion about his general health. He told the hostel worker that he was prescribed diclofennac sodium, olanazipine, venlafaxine and tramadol. He also said that he had a personality disorder, anxiety, depression and a history of substance abuse (heroin and cannabis). He said that he had a history of harming himself by cutting and burning, and had been prescribed medication to address this.

23. The hostel keeps a 'Record of Contact' which details contacts with residents. On 11 October, it was noted that the man woke up late as he had felt unsettled the night before. He had lunch and met his family

who took him shopping for clothes. He returned to Sycamore Lodge in the early evening.

24. The next day it was noted that he had taken his medication and went out in the afternoon. He returned to the hostel in the evening. It was reported that he had “no issues”.

25. On 13 October, the man’s probation officer visited him at Sycamore Lodge. She wanted to know whether he would be able to collect his medication. He told her that he had a doctor’s appointment the next day.

26. He went to the doctor’s appointment on 14 October and was prescribed medication for depression. This information was e-mailed to his probation officer.

27. The man’s key worker carried out a risk assessment on 15 October. She assessed that his risk of harming himself was “medium” and his risk of re-offending was “medium”. The factors which might increase the risk were failure to comply with licence conditions or hostel rules, depression, contact with past associates, relapse into illegal drug use, lack of family support and boredom. A further review was scheduled for no later than 15 January 2009.

28. The key worker agreed an action plan with him after the assessment. This looked at ways in which any risk factors could be reduced by addressing problems such as drug misuse and his emotional well being. His drug risk was not seen to be an immediate problem, as he had addressed this while attending and completing drug programmes whilst in prison custody.

29. Given that the man had spoken about his previous attempts to harm himself, the key worker and another member of staff decided that he should be subject to a four-hourly watch. This meant he would be checked at four-hourly intervals throughout the day and night.

30. The next day he had another doctor’s appointment as he required cream for a skin complaint.

31. On 17 October, the man arranged a doctor’s appointment as he had a pain in his hip. He asked for a three pound loan for his bus fare to enable him to collect an £80 crisis loan. This was authorised on the understanding that he returned the money later that day, once he had received his crisis loan.

32. Later that day he returned to Sycamore Lodge and staff noticed that he smelt of alcohol. He took his medication in front of staff and then returned to his room. Later, another resident complained that the man had been sick in the toilet on the landing, and had not cleaned up after

himself. Staff asked the man to clean it up, which he did. The four-hourly observations continued.

33. Two days later, he started work in the family business. He left for work every morning and continued taking his medication. The four-hourly checks continued when he was in the hostel.

34. On 26 October, the man took his medication as usual in the morning, but told staff he was in a lot of pain as his hip was hurting. He said he had an appointment at the hospital the following day for a scan. Later that day he told staff he had received a telephone call from his mother to say that his aunt had passed away. He told staff he was “ok”.

35. The next day staff noticed that he was limping. He took his medication as usual and said he was going to the hospital for an x-ray. There is no mention of the outcome of the x-ray in the hostel’s records, although residents are entitled to keep such information confidential. For the next few days he continued to go to work, took his medication at the required time and still complained about his “bad hip”. He continued to be checked every four hours in case he was at risk of harming himself.

36. On 4 November, whilst taking his medication in the morning, the man said he was in too much pain to go to work. He went back to bed and staff continued to check on him. Later that day he took some painkillers for his hip and left the hostel for most of the day.

37. Nine days later, he told staff at the hostel that he had been mugged by two men in an alley way in West Bromwich. He said they had threatened him with a knife. He reported the crime to police and said that they had stolen £35 and his mobile telephone. However, he did not stay to make a statement to the police (the police visited Sycamore Lodge the next day to take a statement). He told staff that he would not be going to work from the next day, as the family business was in difficulty and the shop might have to close.

38. The man went to the doctor on 18 November. He returned to the hostel with his medication, cocodamol (a pain killer) and venlafaxine.

39. Three days later, staff noted that he was sleeping on the floor because of his bad back. He asked for a thinner mattress, but there is no record of whether this was supplied or not. On 27 November he asked for a board to be placed under his mattress and agreed to speak to the hostel manager about it the next day. He had continued to sleep on the floor. (It seems from the records that this issue was resolved by 6 December, when he was seen sleeping on a board.)

40. On 4 December, the man was given a verbal warning for being disruptive and behaving unacceptably the night before, as he was smoking in the television room. It was noted that he had been under

the influence of alcohol. There is nothing else of note in the hostel records after 4 December.

41. The supervisor at Sycamore Lodge was employed at the hostel when the man was there. She knew that he had a personality disorder, no longer took drugs but drank alcohol, and took gabapentin (a pain killer), venlafaxtine, olanzapine and tramadol. She confirmed that he had been observed every four hours because of his depression and his back pain. She came on duty at 7.30am on the morning of 14 December and recalled seeing him at around 8.30am. She said he looked “fit and well”.

42. The supervisor carried out a check (as part of the four-hourly observations) on the man in his room at 12.30pm. She knocked on his door and as there was no answer, let herself in with a master key. She said that he seemed “ok” and appeared to be sleeping on his back. She closed the door and locked it. (During her interview for this investigation, she confirmed that it is not practice to wake up a resident during a check.) She did not see him until her next check at 4.30pm.

43. At 4.30pm, she returned to his room to make the next check. Again she knocked on the door, and again had no answer. When she went into his room she saw that he was still lying on his back in bed. She could see something which looked like blood, coming from his nose. She turned on the light and could see a white substance around his mouth. She then touched his arm which felt cold. She had completed a first aid training course the day before. She did not carry out any checks for signs of life, as she thought he had already died. She immediately pressed her personal alarm to summon assistance and left the room.

44. Another member of staff was alerted to the emergency when his pager went off. He ran upstairs and saw the supervisor standing outside the man’s room. He asked what had happened and she said “I think he is dead”. The member of staff went into the room. He saw that the man’s eyes were half closed, that he had some sort of liquid in his mouth and his nose, and was very still. The member of staff said he did not touch him or check for any signs of life, as he could tell from experience that he had died. He confirmed in interview that he had an up to date first aid qualification.

45. The member of staff ran back downstairs to the office where he telephoned for an emergency ambulance and the police. After that he telephoned the hostel’s deputy manager who was on call that day. The deputy manager spoke very briefly to the member of staff and said he would come to the hostel immediately. The member of staff also called the hostel manager and left a message for him.

46. The paramedics arrived within five minutes and the member of staff took them straight to the man’s room. He went into the room with them

and saw them make some checks for signs of life, including pulse and breathing. Within a minute they confirmed that he had died. The member of staff then left the paramedics in the room and returned to the office.

47. Within another five minutes the police arrived and the member of staff took them to join the paramedics in the man's room. They told him that he did not need to stay as the member of staff said his colleague (the supervisor) needed his support.

48. When the deputy manager arrived shortly afterwards he spoke to the police and the paramedics. He then checked on the supervisor and member of staff and the residents to see how they were feeling. He said that both staff members were shaken, particularly the supervisor, who he drove home. When he arrived back at the hostel the manager had arrived.

49. The manager also spoke to the police and paramedics and also checked on the welfare of staff and other residents. He reminded them of the services of the Employee Assistance Programme (EAP) which gives the opportunity for staff to speak in confidence about what had happened. He also spoke to those residents who were in the hostel at the time to tell them what had happened. (Those he did not see, he spoke to the next day.) He told the residents that they could also speak to someone at the EAP if they wished, or alternatively they could talk to a member of staff. He also contacted his manager in the Probation Service and the Ombudsman's office.

50. A post mortem was conducted on 16 December by a consultant pathologist. He was informed by the police that an empty butane gas canister was found beside the man. (The staff at Sycamore Lodge had not been aware of this, or reported seeing it.) The investigator was also unaware of the presence of the canister until she received a copy of the post mortem. The toxicology report noted that his blood and urine specimens detected morphine-glucuronide metabolites (morphine or heroin), olanzapine, venlafaxine, tramadol and methadone. The concentrations of morphine-glucuronide metabolites were consistent with previous, rather than recent, use and did not indicate recent excessive use or an overdose prior to death.

51. The low concentrations of olanzapine and venlafaxine found in the man's blood were consistent with the therapeutic dosage prescribed for depression and did not indicate that he had taken an overdose. However, the concentrations of tramadol were consistent with relatively recent and excessive use.

52. The consultant pathologist determined that the levels of methadone found in the man's blood could have been consistent with either acute over dosage or chronic therapeutic dosage. However, the additional presence of the high concentration of tramadol in the blood could have

exacerbated any toxic effects resulting from methadone use, such as respiratory depression (decreased rate of breathing).

53. Therefore the consultant pathologist concluded that, in the absence of any other pathological findings, fatal opiod toxicity (a fatal amount of opiates in the body) is a possibility. The cause of death was due to acute cardio-respiratory depression (respiratory inhibition caused by opiates), acute over dosage of methadone and tramadol and butane gas inhalation, multiple drugs abuse and bronchopneumonia. He concluded that the man's death was not due to natural causes.

54. The police told the man's family about his death and despite enquiries made to the police, no further information was given to staff at Sycamore Lodge about his funeral arrangements, or any concerns the family may have had. His property was taken from the hostel by the police (and presumably returned to his family).

ISSUES

Monitoring risk of suicide and self harm

55. It is commendable that staff at Sycamore Lodge identified that the man needed closer supervision due to his back pain, which he found almost unbearable, and history of harming himself. A record was made of these checks and a review of the frequency of the checks made every day. However, although he was checked on in his room at 12.30pm on the day he died, I am not convinced that more than a cursory check was made. In my opinion, without a closer check, it would have been difficult to be satisfied that he was merely sleeping. I understand that it is not practical to waken residents during checks (especially the more frequent ones), but I would suggest that when checks are undertaken, a closer inspection is carried out. Without doing this, staff cannot be certain that a resident has not harmed themselves, which negates the purpose of the checks. Also, staff did not notice the butane gas canister which was lying by the man and they were not aware of this until the investigator told them. (The canister had been removed by the police.)

    When staff are checking residents, they should be unobtrusive, but make sure that they have properly assessed the residents well being.

Checking for signs of life

56. Neither the member of staff who found the man, nor the second member of staff who came to help, checked for signs of life, despite being first aid trained. Both said they thought he had clearly died, and had been dead for some time. Although this does seem likely, I would strongly suggest that in situations such as these it is essential that staff make the appropriate checks to clearly assess a resident’s well being.

    Staff should be reminded to carry out appropriate first aid procedures, in particular to check for signs of life, when faced with an emergency situation such as this.

Samaritans details

57. The manager confirmed that although details of the Samaritans were not included in the residents’ information packs, if they had wanted to speak to them he could have facilitated this. It would be helpful if details, such as Samaritans contact numbers, are included in the induction booklet for residents. I understand that residents are told that they can speak to staff and ask for the telephone numbers if they need to, but some residents may not feel they want to ask.

    Contact details for the Samaritans and other similar organisations should be included in the residents’ induction booklet.

CONCLUSION

58. During his short time at Sycamore Lodge, I believe that staff paid attention to the man's needs and the difficulties that he encountered. Appropriate meetings and contact were made and maintained with his probation officer and key worker. He appeared to have adjusted to living there and was making good progress with work and plans for his future.

59. As the man's back condition appeared to become progressively worse, staff tried to help, for example by providing him with a board to place under his mattress. He took medication for his condition, and staff were aware that he was taking this correctly.

60. Because of his back pain and because of his previous attempts to harm himself it was decided that, while he was in the hostel, he should be checked every four hours. This was appropriate and good practice. However, whilst the checks were recorded appropriately and reviews undertaken daily, the checks were apparently superficial and cursory. Whilst understanding that it would be too intrusive to awake a resident, a more thorough check should have been made.

61. The man was not known to have abused butane previously, and so the circumstances of his death came as a shock to staff at Sycamore Lodge.

RECOMMENDATIONS

1. When staff are checking residents, they should be unobtrusive, but make sure that they have properly assessed the residents well being.

2. Staff should be reminded to carry out appropriate first aid procedures, in particular to check for signs of life, when faced with an emergency situation such as this.

3. Contact details for the Samaritans and other similar organisations should be included in the residents' induction booklet.