Circumstances surrounding the death of a resident in Probation Service Approved Premises in September 2004

Report by the Prisons and Probation Ombudsman for England and Wales

February 2005

FOREWORD by STEPHEN SHAW, CBE

This is the report of an investigation into the circumstances of the death of an Approved Premises resident who died on 23 September 2004, from multiple injuries received when he was struck by a bus.

Since 1 April 2004, my office has been responsible for investigating all deaths of Approved Premises residents, including those that occur off the premises. A senior member of my staff, Mrs Morris, conducted the investigation with the assistance of the Manager and Deputy Manager of the Approved Premises. Although no formal statements were taken, I am grateful for the assistance and co-operation that Mrs Morris received from staff at the Approved Premises. A letter was sent to the resident's parents offering them contact but they did not respond and my office has had no contact with them.

A Consultant Forensic Psychiatrist provided confirmation of the resident's condition and treatment.

The loss of their son in such tragic circumstances must have been a great shock to the parents of the deceased man and I extend my condolences to them.

February 2005

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Summary

The resident was a young man of 29 years and was his parents' only child. He appeared at Magistrates' Court in July 2003 charged with several offences of assault in which the victims were his mother and a police officer who came to arrest him at his parents' house. It was said that the offences were directly related to the deceased man's mental illness that had manifested itself for some 4 or 5 years but was unrecognised and untreated at that time. It has also been suggested that he had been drinking alcohol to excess and that this exacerbated the aggressive aspect of his personality.

In relation to the court proceedings, the man underwent psychiatric assessment. There was general agreement that he was suffering a mental illness and a suggestion that it could be schizophrenia but there was no agreed diagnosis. He was granted conditional bail at the Approved Premises and subsequently sentenced to a 3 years' Community Rehabilitation Order with conditions of psychiatric treatment and to reside where directed. The supervising officer considered the Approved Premises to be the most appropriate placement for the man at that time. He settled well and presented no management problems. The man remained at the Approved Premises until his death and had come to look upon it as his home.

On Thursday 23 September the man left the Approved Premises for his regular weekly shopping trip to the City Centre. Members of staff on duty at

the premises were surprised when he failed to return, as this had not happened previously, and the police were informed of his absence. It was not until the following day that the Approved Premises discovered that the man had been killed when, running to catch a bus, he was struck by another bus travelling in the opposite direction

The Investigation found that a high level of care was given to the man by the members of staff at the Approved Premises, who are experienced in the supervision of residents suffering mental ill health. Staff and residents alike were distressed by the unexpected manner of the man's death and paid their respects to him and to his family when several of them attended his funeral.

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The Deceased man

1. During his stay at the Approved Premises the man was seen by a number of mental health professionals. All agreed that he suffered from a mental illness although the exact diagnosis was unclear. It was originally thought that he suffered with schizophrenia but, later, it was suggested that he experienced psychotic incidents. His mental health was reasonably maintained but his condition manifested itself in a persistent and unshakeable belief that people in his past had poisoned him. In particular, he believed that a noxious substance had been placed in his drink some years previously and that his eyes and his body had been contaminated. The man often reported 'black things' floating in his eyes and had been examined by an opthalmic consultant who could find no organic reason for such visions.

2. Although the man was preoccupied by his beliefs, that made him extremely depressed at times, he was able to function well on a day to day basis. He lived with his parents all his life and had no experience of independent living but his personal hygene was good, he could travel around safely and manage his finances well. Staff at the Approved Premises described him as polite, grateful for their help and a pleasant addition to the residents' group. My colleague was told that the man was "a nice lad with not much experience of the Criminal Justice System."

3. The man was treated with a combination of anti-psychotic and anti-depressant medications. He was prescribed:

Fluoxetine 40mg in the morning
Chorophenіramine 4 mg x 2 daily
Quetiapine 200mg in the morning and 400mg at night.

His medication was kept in a locked cupboard at the Approved Premises and dispensed to him by staff as required by paragraphs 5.7 and 5.8 of the Approved Premises Handbook. The man fulfilled the conditions of the Rehabilitation Order by accepting the psychiatric

treatment offered. He had begun to work with a psychologist, as it had become clear that medication alone was not addressing his delusions.

4. The man's illness had made it very difficult for his parents to deal with him and, although they would often talk on the telephone, it was, understandably, some time after the offences before they felt able to see him. He missed his parents and was keen to renew his relationship with them. Prior to his demise, monthly visits had been established and the relationships between parents and son were being rebuilt. It had been decided that family support should be re-established before plans for move on accommodation were considered.

The Approved Premises

5. In its publicity material, the Approved Probation Premises for male offenders describes itself as providing accommodation for mentally ill offenders although it is not recognised as a national specialist resource by the National Probation Directorate. It does, however, benefit from a long-standing partnership with the local Forensic Psychiatry Clinic and is visited several times weekly by a forensic psychiatrist with members of his team. The house has 20 single rooms, two lounges, a games' room, kitchen, dining room and residents' laundry. The Manager is a Senior Probation Officer with a Probation Officer as Deputy Manager. There are waking night care staff and day staff are experienced Probation Service Officers.

Events leading to the resident's death

6. During his time at the Approved Premises it became common practice for the man to go out and about into the City Centre during the daytime. It was also his habit to shop in the late afternoon or early evening each Thursday. My colleague was told that the man would often clean his ears vigorously with cotton wool buds that, from time to time, could not be extracted without a visit to the local Accident and Emergency department. This had occurred about a week before his death and his ear had become badly infected. Since then the man had insisted on keeping cotton wool in his ears and his hearing had been somewhat affected.

7. On 23 September the man had been in and out of the hostel with other residents during the day. He returned around 15.30 and was last seen by members of staff on duty when he went out again, alone, a little later. The man did not return by curfew time and staff members were surprised and worried as this was unlike him. Telephone calls were made to the local police and hospital but there was no news of him that night. The following morning he was reported to the police as having failed to return to the premises as required.

8. Later that morning, the local radio station broadcast details of a man, who had been knocked down by a bus and had not yet been identified. A description was given of the clothes the man was wearing, including a football shirt, and of a tattoo. A member of the Approved Premises staff heard the broadcast and was able to alert police to the possibility that the man was the missing resident. This was confirmed later in the day when the man's fingerprints were identified.

Consideration and conclusions

9. The man was vulnerable by virtue of his mental ill-health but no more vulnerable than many other residents of the Approved Premises. Those who reside in Approved Premises are bound by certain restrictions but their status is very different from those who are held in custody. Although in the care of the state, residents are entitled to come and go as they please within the confines of the Approved Premises rules and the requirements of their supervision. The man participated in offence focussed key work sessions, took his medication regularly, fulfilled the terms of the condition of treatment in his Rehabilitation Order and appeared to be making progress. He was used to travelling the few miles to and from the city centre, he was familiar with the area and there was no reason for hostel staff to suspect that he would be unsafe.

10. Despite the depression that occurred from time to time, the man had not expressed any desire to harm himself. In the days preceding the accident there had been no additional concerns about his condition and the psychologist commented that his mood appeared to be improving. Contact with the mental health professionals and with the Approved Premises staff disclosed nothing to suggest that the man was feeling low and his death appears to have been a tragic accident that affected all those who had known him at the Approved Premises.

11. My colleague was left in no doubt that the Approved Premises provided a supportive environment for the man, within which psychiatric services were available. The investigation found that staff cared for the man well and took appropriate action over his unexpected absence. Indeed, had the member of staff been less vigilant or less familiar with the man's appearance, it could have been some time before his parents knew of his death.

STEPHEN SHAW
OMBUDSMAN **FEBRUARY 2005**