Investigation into the death of a man on 2 August 2005 whilst resident at an Approved Premises managed by the Probation Service.

Report by the Prison and Probation Ombudsman for England and Wales

December 2005

This is the report of an investigation into the death of a man who died in hospital on 2 August 2005, after being taken ill at an Approved premises where he was living. He was 64 years old. The post mortem concluded that the cause of death was heart disease.

The man had been was convicted in 2004 and sentenced to 21 months imprisonment. He was released on licence on 15 April 2005 and was provided with accommodation at the Approved Premises.

This investigation has been undertaken by on of my investigators. I would like to thank the Manager of the Approved Premises, and his staff for their participation in the investigation.

The loss of a loved one is always distressing. I would like to add my personal condolences to those already expressed by one of my Family Liaison Officers on behalf of this office.

I am satisfied that the treatment of the man while a resident at the Approved Premises was appropriate, caring and professional. I consider the healthcare arrangements for residents in partnership with the local NHS medical centre to be an example of good practice.

Stephen Shaw CBE
Prisons and Probation Ombudsman **December 2005**

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ANNEXES

Summary

1. The man was born in 1941 and was 64 years old when he died.

2. The man was sentenced to 21 months imprisonment in 2004. While he was in prison, his wife passed away. Unfortunately, he did not find out about her death until over a month after her funeral had taken place as he was estranged from his family due to his offending behaviour.

3. The man was released on licence from prison on 15 April 2005 and was allocated accommodation at an Approved Premises. The man had previously stayed there 11 months earlier, while he was on bail. On his hostel case file it was noted that he had a number of health problems and these included angina and hypertension. He also had been prescribed a range of medication to control his symptoms.

4. After discovering a lump on his stomach, The man attended an appointment on 13 June with the local doctor's surgery. The doctor informed him that he thought that the man had an abdominal aortic aneurysm (a swollen or dilated blood vessel in the heart), which would need to be operated upon. After the man informed the hostel of the diagnosis, staff immediately decided to move him to a room on the ground floor to minimise any risks to his health.

5. On 2 August around 9:00am, the man was talking to other residents in the television lounge when he was taken ill. One of the residents made the man comfortable. Another resident ran to the hostel office to inform staff about what had happened. The Hostel Supervisor immediately went to the lounge and, after observing the man's condition, she contacted the emergency services. A Probation Service Officer then went into the lounge to assist with the man's care.

6. Within five minutes of the call to the emergency services, a paramedic arrived at the hostel. After the residents had been asked to leave the lounge, the paramedic attempted to resuscitate the man with the Probation Officer and Hostel Supervisor assisting him. After the paramedic's colleagues arrived in an ambulance, a further assessment was carried out and a faint pulse was noted. The three paramedics decided to take the man to a nearby hospital.

7. During the afternoon on 2 August, the staff contacted the hospital to be informed that the man had died on arrival.

8. On 25 August, one of my Family Liaison Officers contacted the man's next of kin. They have not replied, and have not expressed any concerns about the treatment of the man for this investigation to consider.

9. I make one recommendation and identify two examples of good practice.

Background

10. The man was born and raised in the north of England. At the age of 11, his mother died and he was subsequently cared for by his older sister. His father passed away when he was 17.

11. The man left school at 15 and quickly found employment as a labourer at a local timber merchant and he remained there for 26 years. He later worked as a civil engineer until he had to retire in 1999 as a result of heart disease. His hobby was woodwork.

12. The man married his wife when he was 30 years of age and they had four children. His wife later developed cancer and died while the man was in custody. However, due to the man being estranged from his family he did not learn of his wife's death until after the funeral had taken place.

13. On 2 August 2005, the man collapsed in the television lounge at the Approved Premises. He was taken to hospital where he was pronounced dead on arrival.

The Approved Premises

14. The premises opened as a probation and bail hostel (now approved premises) in April 1990. It has both single and double rooms and can accommodate up to 12 residents.

15. All residents are either on licence, bail or Community Orders, with a condition to reside on the premises. The residents are in the main considered to be at medium to very high risk of harm to the public. The hostel operates a curfew for the majority of residents from 11:00pm to 6:00am.

16. The hostel is staffed 24 hours a day and enjoys a close working relationship with the local Police Community Safety Bureau. The local NHS medical centre provides comprehensive health checks on all residents along with ongoing health care. I commend this arrangement for residents as an example of good practice.

17. Residents have a key worker from the hostel whom they see on a fortnightly basis. The key worker acts as a conduit between the residents and their Case Manager. Key workers liaise with other relevant bodies, help residents to identify suitable alternative accommodation and discuss day to day issues which may be hindering a resident's progress towards effective resettlement. Residents undergo a full assessment with their Case Manager and are required to tackle the causes of their offending as part of the conditions of their residency.

Conduct of the investigation

18. My investigator contacted the Hostel Manager who briefed him about the circumstances of the man's death and forwarded all the relevant probation records relating to him. These included the man's personal file, statements from staff and copies of log book entries.

19. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation and to request a copy of the Post Mortem report. Upon completion, this report will be sent to the Coroner to assist him in his enquiries into the man's death.

20. One of my Family Liaison Officers the man's family by letter. They have not responded to raise any concerns about his treatment whilst a resident at the Approved Premises.

21. My investigator attended the hostel on 25 August and was met by the Deputy Manager who showed him around the accommodation. My investigator also discussed aspects of the man's treatment and the circumstances surrounding his death with staff and residents.

Key findings

22. The man arrived at the Approved Premises on 15 April 2005, after being released on licence from prison. Whist in prison, the man was informed that his wife had passed away. Unfortunately, as he was estranged from his family, this information was not given to either the prison or the man until after her funeral had taken place. The man had a number of health problems including angina and hypertension, for which he had been prescribed medication.

23. On 18 May 2005, the man met his brother in law who informed him that the man's sister had passed away and that her funeral had already taken place.

24. On 6 June, the man told a fellow resident that he had found a lump in his stomach. The resident encouraged him to see a doctor, and he also informed staff of the conversation. The man made an appointment to see a doctor on 10 June, but he did not attend. A further appointment was made for 13 June, which the man did attend. The following day, he informed staff that the doctor thought that he had an abdominal aortic aneurysm which would need to be operated upon. The hostel immediately decided to move the man to a single room on the ground floor to minimise any risks to his health.

25. On 2 August around 8:15am, a Probation Officer saw The man and handed him his medication. When interviewed, the Probation Officer recalled that the man appeared stable, and they had engaged in their usual banter. The Probation Service Officer was the man's key worker - so he had developed a good rapport with the man during his time at the Approved Premises.

26. Around 8:55am, the man had a cup of tea and was chatting with another resident, in the television lounge. The man was sitting in one of the armchairs in the lounge and he asked for a cigarette, which the fellow resident gave to him. The man finished drinking his tea and, after he extinguished his cigarette, started coughing and his head dropped back. In his interview, the resident stated he automatically knew what was happening as he had seen people have heart attacks before. The resident moved the coffee table that was in front of the man's armchair and lifted him onto the floor. He then put the man into the recovery position and checked his airways were clear. While the resident made the man comfortable, another resident ran to the hostel office to inform staff what had happened.

27. Around 9:00am, the Hostel Supervisor was in the hostel office, when she was approached by a resident who informed her that the man had been taken ill in the lounge. When the Hostel Supervisor entered the lounge she discovered that the man was already into the recovery position. The Hostel Supervisor returned to the hostel office and rang the emergency services while a Probation Officer attended to the man.

28. The emergency services advised the Hostel Supervisor that the man should be placed on his back to open up his airway and assist his breathing. When the Probation Officer re-entered the office, to collect a ventaid to assist the man with his breathing, the Hostel Supervisor told him what the emergency services had advised. On his return to the lounge, the Probation Officer asked two of the residents to turn the man on to his back. Within five minutes a paramedic had arrived at the hostel, and residents were asked to leave the lounge while he made his assessment of the man's condition.

29. After the paramedic had asked the Probation Officer to collect some equipment from his vehicle, he told the Hostel Supervisor that the man had died and asked for her assistance in his attempt to resuscitate him. The Hostel Supervisor pumped oxygen and the Probation Officer passed the necessary aids to the paramedic. When an ambulance arrived the paramedics began to attempt to resuscitate the man and managed to find a faint pulse. The three medical staff then decided to take the man to hospital . After the paramedics left the hostel the lounge was locked. The hostel staff then returned to the office to inform the Hostel Deputy Manager and the Hostel Manager about what had happened.

30. During the afternoon on 2 August, the hostel contacted the hospital and was informed that the man had died on arrival at the hospital. The hostel immediately informed the police and gave them the contact details for the man's family. The lounge and the man's room were kept locked until the police gave permission for them to be released. Residents were informed by staff of the man's death and both the Hostel Supervisor and the Probation Officer were individually cared for after the incident by the staff.

31. The police in the man's home town informed his family of his death, and the family told them that they wanted no further involvement in the matter. The man's funeral took place in August 2005, but unfortunately the hostel staff and residents were not informed or invited to attend.

32. The post mortem report states that the cause of death was due to natural causes as a consequence of acute ventricular failure (heart failure) due to acute myocardial infarction (heart attack) due to coronary artery atheroma and thrombosis (a degenerative change in the inner and middle coats of the arteries in the heart) and hypertensive heart failure.

33. In summary, the man had a very serious physical health problem. Staff at the hostel were monitoring his condition and he was also being managed by the local hospital. Although there do not appear to be any physical contributory factors which accelerated the man's premature death, the additional personal difficulties and the stress he had encountered in the last months of his life would not have been beneficial to his health.

34. From comments made by staff and residents at the Approved Premises, it seemed that the man was respected and well liked. It would have also appear that he was starting to put behind him the difficulties he had experienced in the past two years and was starting to settle down into his new life.

Recommendations and good practice

35. I would like to commend the actions taken by the residents who went to The man's assistance when he was taken ill. This action meant that the man was immediately being looked after being taken ill. The Hostel Manager should write a formal letter of commendation to the resident who gave assistance.

36. The actions of staff also emerge well from this report. The decision to move the man to the ground floor after the diagnosis of an aneurysm on 13 June was good practice.

37. I consider the Approved premises' arrangements with the local NHS medical centre to provide comprehensive health checks and on-going health care for residents to be especially good practice.