

**Investigation into the circumstances surrounding the
death in January 2007 of a former resident of
an Approved Premises
in the Essex Probation Area**

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

September 2007

This is a report into the death of a man who died in hospital in January 2007, whilst a resident of an Approved Premises. The man, who was 55, had lived at the Approved Premises for seven months before he died. He was disabled and used a wheelchair, having received a spinal injury during an earlier operation. The post mortem report shows he died from natural causes.

One of my Family Liaison Officers contacted the man's family to inform them of my investigation and offer the opportunity to raise any concerns. I would like to extend my condolences to all members of the family.

The investigation has been carried out by two of my investigators. I would like to thank the Approved Premises staff and the man's supervising probation officer for their assistance and co-operation. A clinical review into the man's care was carried out on behalf of South West Essex Primary Care Trust (PCT) and I must also thank the clinical reviewer for his comprehensive account.

It was a condition of the man's licence following his release from HMP Norwich that he must reside in Approved Premises. However, because the disabled accommodation in his home county of Suffolk was already occupied, he was allocated a place at an Approved Premises in Essex. As soon as he arrived, staff there were concerned about their lack of equipment and training to deal appropriately with his needs. It was their first experience of a resident with such severe needs and their concerns were immediately raised with local social services. Six months of concerted efforts by Essex Probation staff failed to find the man more suitable accommodation until, just as the matter was resolved, he passed away in hospital.

It is my view that the Approved Premises was not the appropriate place for the man as his medical and social care needs could not be fully met. Much of the extra care he required was given by staff and residents out of goodwill and because of their commitment to decency and dignity. They deserve both thanks and praise. I also commend the man's probation officer for her valiant efforts to negotiate with the health and social care authorities. I repeat the clinical reviewer's concluding comment in his review that, whilst organisations such as local authorities have objectives to meet, they occasionally lose sight of the individual. I have drawn my concerns to the attention of the two local authorities concerned.

Approved Premises have a specific function, namely to protect the public through monitoring residents' behaviour. They are not equipped to care for people with complex or specialist health needs. Many of the issues in this case repeat those in another of my recent reports, which may be indicative of a national trend towards the housing of older residents. I therefore repeat my observations, together with my recommendation calling for a review of the Approved Premises estate and a more inclusive approach to medical and social care of residents.

Although probation staff emerge well, this is a dismal story of how a seriously ill person should not be treated.

Stephen Shaw CBE
Prisons and Probation Ombudsman

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SUMMARY

The man who died came from the Ipswich area of Suffolk. He used a wheelchair because his spine had been injured during a back operation some years earlier.

On 15 August 2005, the man was sentenced to 12 months imprisonment with 18 months extended licence. A condition of the licence was that he must reside as directed by his supervising officer. He was directed to live at an Approved Premises (a hostel run by or contracted to the Probation Service). However, as none of the local hostels had rooms available for people with disabilities, his home probation officer referred him to a hostel in Essex. The probation officer did not visit him in prison, and provided scant information in the referral.

The man was released on licence from HMP Norwich on 2 June 2006 and taken to the hostel in a town in Essex, a town with which he had no other connections. He was allocated a suitable room on the ground floor. His needs were immediately apparent as he had to be lifted out of the car and taken inside, even though he still had some independent use of his upper body. The hostel staff did not consider that they had received full information and were therefore unprepared for the extent of his needs.

Over the six months from June to December 2006, the man's health deteriorated rapidly. He lost much of his independence, and staff and residents had to help him eat, drink and go to the toilet. Eventually Essex Social Services provided a care package for him through a private home care agency. Initially they provided one carer for half an hour every morning. This was subsequently increased to two carers for half an hour in the morning and again in the evening. The man would never eat much, often just having a cup of tea and a biscuit all day, and he lost a lot of weight.

It was the opinion of the staff and the appointed general practitioner (GP) that staff and residents, however willing, were unable to meet the man's needs and that he needed 24 hour nursing care in a nursing home or hospital. Many attempts were made to arrange more suitable accommodation or care. The problem seems to have been that neither the Social Services Department in Essex nor that in Suffolk would accept responsibility.

On 17 December 2006, the man had trouble breathing and was admitted to the local hospital. Whilst he was a patient, the manager of the hostel withdrew his place, hoping that it would force either of the two Social Services Departments to arrange an alternative. A suitable nursing bed became available in the first week of January 2007, but sadly the man died in hospital before the move took place.

The post mortem records the cause of death as being due to 1) Chronic Obstructive Pulmonary Disease (COPD) which is chronic bronchitis and emphysema, usually as a result of smoking, and 2) under nourishment.

THE INVESTIGATION PROCESS

1. A letter and notices were sent to the hostel when my office was notified of the man's death. These notices told staff and residents of my investigation and invited them to contact the investigators if they had relevant information. In this case, no-one other than the staff identified by my investigators came forward.
2. My investigators visited the hostel and were given unrestricted access to the man's probation files. They interviewed the senior probation officer (SPO), the man's keyworker and his supervising probation officer. One of my investigators also had a telephone conversation with the man's previous probation officer in Suffolk.
3. During initial discussions with the SPO, and after receiving the man's probation files, my investigators became concerned about his medical and social care. It is not the usual practice for my office to ask for a clinical review when a resident dies in Approved Premises. However, in light of our concerns, the local South West Essex PCT agreed to carry out a clinical review. HMP Norwich supplied the relevant prison medical records. Since receiving the clinical review, I have written to each local authority to ask for their views.
4. The man had listed his son as his next of kin. However, as the boy is still a juvenile, my Family Liaison Officer contacted the man's former wife (the boy's mother) to inform her of the investigation and ask what level of involvement the family would like to have. She did not raise any concerns for the investigation to consider. It was agreed that my final report would be provided to the social worker in case the man's son wishes to see it when he is older.

APPROVED PREMISES

8. Approved Premises were formally known as Probation and Bail Hostels. They are approved by the Secretary of State within section 9 of the Criminal Justice Act 2000. Approved Premises provide a supportive, structured environment in the community for high risk and difficult to manage offenders. The management of those accommodated in Approved Premises is governed by the National Standards for Supervision of Offenders and the guidance contained in the National Approved Premises Handbook.
9. The purpose of Approved Premises is to provide an enhanced level of supervision for some of the most difficult and high-risk offenders in the community. They are not principally an accommodation resource, and they are not equipped to provide social or nursing care.
10. It is Approved Premises procedure that, in the event of a death at the premises, the police are called. The Approved Premises staff will notify the police of next of kin details and the police are responsible for informing the next of kin.

The Approved Premises in Essex

11. This hostel has capacity for 26 residents. There are 23 bedrooms, 2 of which are doubles. One room, for those with physical disabilities, is on the ground floor and has an en-suite toilet and shower. The room has an emergency call alarm and separate back door, which is alarmed so that it is not used inappropriately. There is now a ramp outside the door, but this was not the case when the man, at the centre of this report, first arrived. In the case of an emergency such as a fire, he would have had to go out through the hostel and rely on help from others. The hostel is staffed 24 hours a day, with a minimum of two staff on duty at all times.
12. This hostel is a catered premises, providing breakfast and one cooked meal a day. The accommodation charge payable by residents is £21 per week for residents aged over 25. This includes daily supplies of tea, coffee, bread and jam.
13. There is a curfew from 11.00pm to 7.00am, when staff physically check all rooms to ensure that residents are present and well. Ad-hoc checks are also carried out to ensure that rooms are used properly and that no banned items are being held in possession.
14. Residents' medication is securely stored within the office and is handed to residents according to the medication instructions. Each resident has a drug dispensing chart which is signed when the medication is dispensed. The Approved Premises Handbook states that it remains the residents' responsibility to collect and take the medication. The hostel has a contract with a local general practitioner, who attends the hostel each Tuesday afternoon for confidential appointments with residents who ask to see him. The GP is not involved in sentence planning or any other decisions about residents, and staff do not generally seek his advice.

15. Each resident has a dedicated keyworker to assist with their individual needs, and with whom they hold regular one-to-one meetings. Keyworkers also liaise with other agencies and the resident's probation officer regarding their reintegration back into the community and to address specific needs such as accommodation. In Essex, probation officers are referred to as Assessment Offender Managers (AOMs).

Release on Licence

16. All prisoners sentenced to more than 12 months imprisonment are released on licence, which means they are supervised by the Probation Service until the licence expiry date. In general terms, the expiry date falls three quarters of the way through a released prisoner's sentence. There are standard conditions for all licences, which include:

- keeping in touch with the probation officer in accordance with any instructions that may be given
- residing at an address approved by the supervising officer
- being well behaved, not committing any offence and not doing anything that could undermine the purposes of supervision, which are to protect the public, prevent re-offending and help successful resettlement into the community.

17. Further conditions can be added by the Secretary of State if they are deemed necessary to manage a person's risk.

Multi-Agency Public Protection Arrangements (MAPPA)

18. The MAPPA is a formal partnership between police, probation, prisons and other statutory and non-statutory agencies that assesses and manages offenders in order to minimise the risk of serious harm they may pose to the public. There are four core functions:

- identification of offenders with the potential to commit serious violent and sexual offences
- sharing relevant information between agencies
- assessing the risk of serious harm
- managing that risk.

KEY FINDINGS

19. The man was sentenced to 12 months imprisonment in August 2005, followed by 18 months extended licence with a condition of to reside as directed by his supervising probation officer. Parole was refused in March 2006 because he was not considered to have addressed his offending behaviour.
20. A MAPPA meeting was held to discuss the man's release plan, and he was not allowed to return to the area where he lived in order to protect the victim of his offence. The man was at risk of being homeless, and so the Probation Service explored various options for housing. In the meantime, the MAPPA meeting decided that he should be released to an Approved Premises, and needed facilities suitable for someone with disabilities. A referral had been made to the local Ipswich hostel, but the suitable room was already occupied and arrangements were made to find another Approved Premises.
21. The man's probation officer in Suffolk made a referral to the hostel in Essex on 15 May, simply stating that he "needs disabled room". My investigator spoke to the probation officer to find out what she knew about the extent of the man's disability and needs, and she said that she struggled to get consistent information. She said that HMP Norwich and one of the man's relatives both told her that his disabilities were not as bad as he said. She did not visit him whilst he was in prison because he had made threats against her, and she was advised not to meet him. She recalled that her probation colleagues in the prison were reluctant to speak to him on her behalf, recording that he refused to co-operate with them.
22. The man was conditionally discharged from HMP Norwich on 2 June 2006. It is suffice to say that the hostel staff were neither aware, nor prepared, for the eventual extent of his needs.
23. The keyworker assigned to the man, told my investigators that she was shocked when he arrived as the deputy manager had to lift him out of the car. The keyworker added that the man had been able to do a few things for himself, such as eating and drinking, when he first arrived.
24. An assessment offender manager (AOM) in Essex took over as the man's supervising officer and, due to the extent of his disability, their regular supervision sessions were held at the hostel. In accordance with probation national standards, the AOM visited the man every week for 16 weeks and then fortnightly. She told my investigators that, when he first arrived at the hostel, he had some independence and could open a door, eat and go to the toilet by himself. She said that initially he stayed in his room and did not like coming out. Both the AOM and the keyworker told my investigators that the man had liked doing jigsaw puzzles and crosswords. Sometimes he would go to the communal lounge to watch television. The keyworker talked of times when she played cards with him to try and encourage him to interact more.
25. Shortly after the man arrived at the hostel, a locum consultant forensic psychiatrist saw him to assess his mental health. The psychiatrist had been told

that the man had a history of mental illness, although he denied it. The psychiatrist concluded that there was some unexplained aggressive behaviour in the man's past, but there did not seem to be any past psychiatric history and no further action was necessary.

26. Essex Social Services (ESS) assessed the man's needs on 9 June 2006. Hostel staff recorded in his file that, "it looks as if Social Services in this area will not be taking responsibility as providers of care". This is the start of what was clearly a difficult and frustrating time for the man and the hostel staff. There are many entries in the man's file for the rest of June detailing staff efforts to find out what care was available for him. Matters were not helped initially by the man's refusal of any assistance with his personal care, although plans were made to order a shower chair and a hoist to help him in and out of bed. At a three-way discussion with his AOM and keyworker on 16 June, the man agreed that he was unable to do tasks such as shaving and washing and he consented to help from a Social Services carer.
27. Hostel staff remained concerned about the appropriateness of the man residing in a hostel. It was clear that they were not equipped to adequately deal with his needs. The man had apparently also been experiencing blackouts (the AOM had expressed her concern about this during their supervisions sessions). However, she told my investigators that the man was quite "blasé" about them and would not seek medical help. My investigators asked if the doctor had been informed and the AOM said she had had a conversation with the doctor one day when they were both at the hostel. The problem they faced was that the man would not consent to going to a hospital as he claimed to have a fear of them. Without his consent, the staff and doctor were powerless.
28. The AOM completed an information exchange form for the MAPPA on 22 June and outlined her concerns about the man's suitability to be living at the hostel. She noted that he was unable to leave his room unassisted and the hostel was not equipped to offer him appropriate support. She reiterated that the man had no connection to the Essex area and was keen to return to his home town in Suffolk.
29. Also on 22 June, a second community assessment was carried out by ESS. My investigators have not found any assessment documentation in the man's file for this date, but there is a plan which was agreed in part on 28 June by the care-coordinator's team manager and subsequently by the Social Service Department's county panel on 3 July. It requested that a male carer visit the man for 30 minutes at 10.00am every day to assist with his personal care and domestic hygiene. The assessment also noted that staff at the hostel were meeting the man's nutritional and fluid needs but no other needs. It also recognised that he was not living near any friends or family and so had no extra support. A private company called London Care was commissioned by ESS to be the providers of the man's care.
30. A client care co-ordinator visited the man on 11 July and advised him that there would be a carer coming to visit him daily at 10.00am for half an hour starting the following day.

31. The AOM visited the man on 14 July and noted the changes Social Services had made to his room. These included the chair for his shower and bars on the bed. In her contact log, the AOM noted that the man felt everything was "good" and that he was socialising more.
32. Unfortunately, on 18 July, the hostel received a telephone call from London Care to say that ESS had only funded one carer to attend the man's needs. As a result, they could not help him shower as one person was not permitted to lift a client on their own. The agency was going to request further funding for a second carer and suggested that the hostel also spoke to ESS to support the request.
33. The keyworker telephoned ESS on 24 July to tell them that the man had not had a shower for a considerable period of time and to raise her concern that his carer only stayed for part of the half hour allocated. She was told that ESS would enquire with London Care.
34. The man had another social care visit on 8 August. His keyworker recorded that a hoist was to be ordered as he was having trouble getting in and out of bed. She also logged that he was not eating very much, despite staff encouragement.
35. Two days later, the AOM and the man had a supervision session in which he told her that he had had many blackouts since arriving at the hostel. He still refused to see the doctor, saying he would rather wait until he returned to Suffolk. He told his AOM that he had been dealing with the blackouts since he was ten years old. When she visited him four days later, she recorded that he had been shaking. When she asked if he was okay, he replied that this was usual and he was fine to continue with the session. He told her about the hoist to help him get in and out of bed, and said he was waiting to be shown how to use it.
36. ESS visited the man on 22 August. They agreed that he needed two carers to visit for half an hour in the morning to get him out of bed and attended to his hygiene needs, and again for half an hour at night to get him changed and back into bed. The hostel had managed to obtain a higher bed which made the use of the hoist easier.
37. The man's AOM tried to contact ESS on 23 August to reiterate that the man's health was deteriorating. She felt that supported housing was needed and left a message asking the care co-ordinator to telephone her back. Her call was returned the following day. In her contact log, the AOM recorded that she had told the care co-ordinator about the decline in the man's mobility. They discussed residential or nursing care which would mean him being transferred back to the Ipswich area. The co-ordinator felt that he needed an orthopaedic or neurological assessment, but the man was reluctant to accept any help. The co-ordinator agreed to complete a nursing assessment, and pass the necessary information to Suffolk Social Services, but anticipated problems with funding.
38. The AOM agreed to make a referral to Ipswich Social Services (ISS), which she then discussed with the office's housing liaison officer. She contacted ISS who

told her that, as the man already had a social worker in Essex, they should make the transfer request. The AOM hence contacted ESS again and asked them to make the referral. She reported that the man was not looking after himself in terms of eating or caring about his health.

39. A letter from ESS dated 25 August informed the man that, after the support care assessment on 22 August, he would be receiving extra support from 23 August, two days earlier than the letter was written.
40. Also on 25 August, a three-way meeting between the man, the AOM and the keyworker took place. At the meeting the man said he was "okay", but accepted that his health had deteriorated. His supervisors recorded that he was still reluctant to accept help from anyone and wanted to maintain his independence. They also spoke about his medication and asked why he would rather be in pain, but he would not answer other than saying that he had coped with it for seven years. The supervisors felt that the man was under the impression he would cope in his own house. They pointed out that it would be difficult for him to cook and use the toilet without assistance, and reminded him of a recent occasion when he was unable to grip a cup properly and had spilt water over himself. They also told him there would be more positives than negatives in supported housing. In the end, the man agreed to accept it.
41. Four days later, a member of staff at the hostel emailed the AOM to tell her that, during evening checks, she had found the man slumped half over the toilet and half over his wheelchair. She had managed to get him to respond and he was eventually able to sit up, but slumped again before his carers arrived about 45 minutes later. His carers were able to move him enough to use the hoist and get him from the bathroom to his bed. The member of staff recorded that, had they not been able to use the hoist, they would not have been allowed to lift the man manually due to health and safety concerns. An ambulance would have had to have been called.
42. The following day, the man's AOM contacted the Essex care co-ordinator who said she had made a nursing needs assessment referral which could take a couple of weeks. She also said that she was in the process of making a referral to Social Services in Suffolk. In the meantime, the AOM was also going to make a referral to Suffolk council as a back-up.
43. The local GP saw the man on 30 August. After her supervision session with the man, the AOM asked to see the GP. She recorded that the doctor also felt the man's condition had deteriorated and that his problems were neurological. He too believed the hostel was not the right environment, and told the AOM that he could progress the case if the man attended the hospital for an orthopaedic appointment.
44. A nursing needs assessment on 11 September noted that the man was immobile, incontinent when he had no assistance to get to the toilet, and underweight and malnourished. The box was ticked to say that the man was able to be in his "own home with care package and district nurse support". This was despite

protestations from the hostel that they were unable to provide appropriate care and that the hostel was not his own home.

45. On 11 and 12 September, the man's AOM left messages for the care co-ordinator for an update on the progress of their referrals to Social Services in Suffolk. She visited the man on 13 September and recorded that he was slumped on his bed and in pain. He made very little eye contact and she believed he had given up hope. He refused to have a blood test, telling her that he did not like the way he was treated last time he had one. The frequency of the man's supervision sessions reduced to once a fortnight, in line with national probation standards, and the AOM let him know this.
46. The keyworker noted on 14 September that the man was happy with his new mattress and chair cushion. He told her that the carers had been quite rough the night before and had hurt him when he was in the hoist. The keyworker recorded that he had eaten a reasonable dinner for the first time in several days, although he had needed some help. She was due to go on holiday and so arranged for some residents to help him while she was away.
47. The assessment form regarding the man's extra support needs (dated 23 August, the date that ESS told him the extra care would begin) is in his file. On the top of the form is a handwritten note saying that the increase in support would begin on 18 September. It is unclear what indeed did happen between 23 August and 18 September.
48. Another letter from ESS dated 3 October told the man that his care package would be increased by an extra three and a half hours per week, giving him a new total of 14 hours per week. This is somewhat confusing as the care packages written for August and September showed the new total already to be 14 hours per week.
49. Over the next few weeks, the man appeared to have been more content. He came out of his room a bit more and his appetite was better. He spoke to his son on the telephone more often and the keyworker felt this might have helped. However, another hostel worker had cause to contact London Care on 9 October. He expressed his concern that the man's carers had spent less than ten minutes with him on the previous Saturday and Sunday evenings, and had apparently (accidentally) let him fall out of his hoist. London Care promised to investigate this as soon as possible.
50. In the meantime, the man's AOM continued trying to find suitable accommodation for him. On 10 October she contacted the charity Shelter for advice on the situation. She also contacted ISS again to ask for a homelessness application. When she visited the man the following day, she noticed an improvement in his state of mind. He had a new machine which helped alleviate some of the pain he was experiencing. Hostel staff told the AOM that he had been incontinent the previous day and a resident friend had helped him clean himself. There was also mention of the weekend carers not being as careful with him as the regular carers, but this was being monitored by the keyworker. At the meeting, the man and his AOM discussed his plans for moving from the hostel. He still believed he

would be able to cope in his own accommodation and did not need supportive housing.

51. In an email from the to the care co-ordinator (Essex) on 16 October, she asked for an update on the referral to ISS. The co-ordinator responded that they had not officially picked up her referral as they needed the housing application to evidence the man's intention to move back to Ipswich first. She added that, while he wished to move back to Suffolk, neither the local council nor ESS would take responsibility for finding an alternative permanent residence in Essex. The co-ordinator also referred to the recent nursing needs assessment which had indicated that the man could be supported in his own accommodation with a care package.
52. In light of this information, the AOM contacted ISS the following day to get a homelessness application faxed to her for the man. She was told that the only way to complete such a form was for the applicant to attend their offices in person. When she explained that this was not practical given the man's health and the distance, they were unable to provide an alternative. The AOM asked if the man could fill out an application with the local area and then transfer the information. This was also not possible. After further liaison with the care co-ordinator and ISS, a general rather than homelessness application was sent to the AOM on the grounds that the man was a former resident.
53. The forms arrived on 19 October and the AOM arranged to take them to the man the following day. The meeting went well until the man became aware that, as per his licence, there were exclusion zones where he could not live. He became aggressive because he was adamant that his son would be coming to live with him and his school was in one of the exclusion zones. The AOM continued the application on the grounds that he was to live as directed on his licence. With guidance from Shelter, she also drafted a letter to the homelessness department in Ipswich, outlining the man's health needs and their duty to consider his application in a way other than in person.
54. The probation housing liaison officer (PHLO) received a telephone call from ISS on 23 October. He was told that they would consider the man's application if he had an eviction date. To try to ensure that the authorities took responsibility for the man, the hostel wrote a notice of eviction giving an eviction date of 20 November 2006. The letter was forwarded to ISS who responded to say that the man had been allocated a case worker to deal with him.
55. When the AOM telephoned the case worker three days later to give more information about the man, she was told that the best way forward would be for him to attend their office so that they could assess him and give him some options. The PHLO and AOM had already discussed the option of driving the man to Ipswich themselves, and she told the case worker this. However, the case worker informed her that due to the man's offence it might be decided that he had "made himself intentionally homeless" and therefore they might not be able to help. After further discussion about his needs, and the fact that the homelessness team were unlikely to be able to help, the AOM persuaded the case worker to enquire about local supported housing. The visit to the

homelessness team was scheduled for 2 November. Unfortunately, due to no suitable vehicle being available, it had to be postponed.

56. During the rest of November, little changed regarding the man's circumstances. He had a blackout and paramedics were called to see him, but he still refused to go to hospital. The keyworker managed to persuade him to see the GP on 27 November, and she accompanied him at the appointment. She told the doctor that the man was in pain and often cried himself to sleep. The doctor changed the man's medication and recommended a chest x-ray. Although the man agreed to have tests, there is no evidence to confirm whether they happened or not.
57. He became ill five days later on 2 December. He was unable to breathe and the paramedics were called and arrived just after 7.00pm. The man was taken to the local Accident and Emergency (A&E) department with a suspected collapsed lung. Hostel staff contacted A&E at 11.30pm to check on his progress. They were told that test results were awaited and no information could be disclosed. The man was brought back to the hostel by hospital staff at 4.45am the next day.
58. The hostel manager also contacted the housing case worker in Ipswich on 4 December, and agreed that the man would be taken to the housing meeting a week later. The manager then telephoned the Essex care co-ordinator to express his concerns about the man's health and well-being. Matters became further complicated when the co-ordinator told the hostel manager that, when she had visited the man the previous week (there is no log of the visit in the hostel file), he refused to consider residential care. The man said that he was settled at the hostel and would only move back to Ipswich where his son and stepdaughter would look after him. The manager reiterated that the hostel was not the right environment for the man's needs. Neither was it appropriate for staff to provide personal care which they were not trained to deliver. The hostel manager also explained that he thought that the son and stepdaughter were too young to look after their father.
59. The hostel manager followed up the conversation with a fax to the co-ordinator to request a district nurse assessment, a hospital bed, a wheelchair with support and a reclining chair. He also asked for help transporting the man to Ipswich on 11 December.
60. Later that day, the hostel manager spoke to the GP about the man's welfare. The doctor agreed to write to Social Services to say that the man needed a 24 hour residential nursing home.
61. In what appears to be a response to the manager's fax, a district nurse visited the man on 6 December to assess his district nursing needs. She could not understand why there had been no previous district nurse involvement and, after hearing the hostel's concerns, contacted the community specialist practitioner (CSP) for advice. In fact, the CSP was the same person who had signed the nursing needs assessment on 11 September and so should have been aware of situation. The CSP contacted ISS and made a case for residential care to be considered.

62. The next day (7 December), the doctor wrote a letter addressed “to whom it may concern”, detailing his knowledge of the man’s situation. He described how, on the first occasion he had seen the man, he was bed and wheelchair bound and had no power in the right side of his body. The doctor said he had referred the man to a Consultant Orthopaedic Surgeon in the local hospital and to a Neurologist for further investigations. He explained that the man had recently collapsed and been admitted to hospital. He had developed a pressure sore on his lower spine and the doctor said that the man was underweight and poorly nourished. The letter is quite clear that (in the doctor’s view) the man should have been being cared for in a residential nursing home or a hospital bed, not at the hostel. He strongly recommended that urgent action was taken to meet the man’s needs or “the consequences may be disastrous”.
63. In the meantime, the hostel manager contacted the ESS team leader. His record shows that he found the conversation to have been very unhelpful. When he said that his staff should not be lifting and moving the man to the toilet, he was told that the man should wear incontinence pads. The manager knew that the man was continent, and knew when he needed to go to the toilet, but could not physically get himself there without help.
64. The housing meeting at Ipswich Council went ahead on Monday 11 December, and was attended by the man and two probation staff. They travelled in a taxi, arranged and paid for by the hostel. The housing officer suggested that the man move into bed and breakfast accommodation as an interim arrangement, but it was noted that he would still require Social Services support as he could not feed himself. The issue of the man’s offence and whether he might be deemed to have made himself ‘intentionally homeless’ was raised again. The housing case worker was going to try and arrange a move for the following Friday, although hostel staff did not think that it was likely. The PHLO suggested to his colleagues later in the day that, if the man moved to an Ipswich bed and breakfast, his supervision could be transferred to Suffolk Probation who would be in a stronger position to negotiate appropriate accommodation.
65. Ipswich Social Services telephoned the hostel on Friday 15 December. They said that the man had been assessed as eligible for nursing care and would be transferred to a nursing home the following week. The home was in Ipswich and was outside the exclusion zone in the man’s licence. Unfortunately, later that day, the Social Services Department mislaid his care needs assessment and could not progress his application until it was traced.
66. The man experienced respiratory problems on 17 December and was again taken to A&E at the local hospital. The hostel manager decided to force the hand of the social care providers and withdraw the man’s place at the hostel. His decision provoked some disagreement with the hospital who wanted to discharge the man back to the hostel. The hostel manager visited the man and explained his decision, saying that he would ensure that his personal possessions would be kept safe until necessary.

67. On 20 December, ISS told the hostel manager that the nursing home space had gone and was no longer available. During the conversation, the hostel manager managed to persuade the member of staff that the department would accept responsibility for the man's social care, although legal advice was to be obtained before it could be confirmed in writing.
68. The keyworker visited the man in hospital on 22 December and recorded that he was eating regularly and had fortified drinks to supplement his diet. His medication had been increased and he appeared relatively happy. The man told his keyworker that his stepdaughter had telephoned and said she had moved in with her father.
69. The man's stepdaughter visited him in hospital on 27 December. He was intending to discharge himself and return with her to Ipswich so that she could look after him. The hostel manager reminded the man of the licence condition that he must live at an address approved by his probation officer. He also explained that negotiations for suitable accommodation were at an advanced stage. The manager also explained the consequences to the man's stepdaughter.
70. The final entry regarding the man's move was made on 28 December when Ipswich Social Services confirmed that he was on their priority list for moving. Sadly, the next entry in the contact log is on 5 January 2007. This recorded that the man had passed away in the early hours of the morning.

ISSUES

Communication, responsibility and case management

71. When the man was referred to the Approved Premises in Essex, little information about the extent of his disability and care needs was provided by either HMP Norwich or the referring probation officer in Ipswich. The probation officer said that she could not provide full details as she had been threatened by the man and did not see him for herself. Probation colleagues seconded to HMP Norwich did not take steps to gather information either from the man or from the prison.
72. The clinical reviewer has found that the relationship between the prison, probation and health and social care agencies was unclear. He questions the extent of the liaison between them before the man's release from prison.

I recommend that the National Offender Management Service (NOMS) considers how prison and probation services can best provide full information before releasing a prisoner to Approved Premises, especially when they have complex medical needs.

73. Essex probation staff dealing with the man who died soon realised that they were unable to provide appropriate care and support for his health needs. They immediately tried to obtain appropriate support, but neither Suffolk nor Essex Social Services appeared to take any responsibility other than providing limited personal care and equipment.
74. The clinical reviewer comments that there was a lack of ownership of the man's case by the local agencies. There was much debate between the two Social Services Departments but no-one co-ordinating his overall needs. Probation staff had not met such complex issues previously and lacked the knowledge to steer them. The reviewer comments that a care manager within the appropriate authority should have helped move the man to an appropriate setting sooner, and that a more pragmatic approach to establishing who was responsible for commissioning his care would have helped.
75. The relevant services seemed to consider the hostel to be the same as the man's own home, and misunderstood the purpose of Approved Premises. My investigators found that the staff involved with the man were understandably frustrated by their attempts to explain that they were not equipped, staffed or trained to deal with the man's needs.

I recommend that the PCT in liaison with NOMS ensures that Approved Premises staff are included in case conferences where medical care of residents is discussed.

The placement at the hostel

76. The man's health deteriorated significantly during the six months he was at the hostel. It is clear from what probation staff, including the hostel manager and probation officer, told my investigators that they did not feel equipped to deal with his health needs.
77. Nursing needs assessments for the man were carried out and concluded that he could 'live at home with some care support', but the assessors referred to the hostel as equivalent to a person's private home. I have already explained that the Approved Premises provide an enhanced level of supervision for offenders in the community. They are not principally an accommodation resource. They are certainly not a care home. Staff are trained to deal with supervising and monitoring risk of re-offending, and not to provide for health and personal care needs. Approved Premises are not resourced or equipped to deliver such care to residents. The clinical reviewer has also commented in his report that it is apparent that a man with complex needs should not have been admitted to somewhere like the hostel which lacked the necessary equipment and resources.
78. I am pleased that hostel staff and the man's AOM vigorously pursued his application for more suitable accommodation. The hostel was clearly an inappropriate place for him. I believe that it was the goodwill of staff and residents that afforded him some quality of life and dignity during his last months.
79. In a similar recent case, I questioned whether Approved Premises are able to meet the needs of ageing and ailing residents. With the current trend for longer prison sentences, it is likely that the resident profile will continue to change and include older released prisoners, some with complex illnesses and severe disabilities. Although this man was not an elderly man, his health needs were complex and his disabilities extensive. NOMS needs to consider how these changes will affect the Approved Premises estate and I therefore reiterate the recommendation from my previous report.

I recommend that NOMS should conduct a review of the Approved Premises estate to assess its ability to meet the needs of frail, elderly residents and those with complex health needs. Local initiatives suggestive of good practice should be shared across the estate.

80. Like many residents in Approved Premises, this man was required to live away from his home area whilst he was on licence. In his case, it was because of the shortage of a suitably adapted room. Many other residents move because of conditions to stay away from the location of their offence. The housing and social care agencies in Essex and Suffolk did not seem to understand the specific needs of residents, and their responses did not reflect this man's individual circumstances.

I recommend that the Chief Officers in the Essex and Suffolk probation areas draw my report to the attention of their local housing and social care authorities, and develop a multi disciplinary approach to offenders' individual needs.

General Practitioner input

81. Like many approved premises, this hostel in Essex has a long established link with a named general practitioner, and residents enjoy the facility of a weekly clinic within the hostel. However, it is questionable whether the doctor's services were used for the man's full benefit. Out of respect for medical confidentiality, and because of the man's own reluctance to accept treatment, hostel staff did not seek the doctor's advice. My investigators were concerned that the doctor was unaware of the man's housing and social care needs until December, some six months after his arrival at the hostel. Extending the doctor's contract to include general health advice for staff might have encouraged the manager and key worker to have approached him at an earlier date.

I recommend that the Chief Officer of the Essex probation area and the hostel doctor should consider how staff can best seek medical advice about a resident's needs.

Malnourishment

82. Insufficient nutrition contributed to the man's death, and it is a matter of great concern that he ate very little when he was at the hostel. Staff and residents tried to encourage him to look after himself, and often helped him to eat. He apparently had a small appetite, often saying he was full after a biscuit and cup of tea. It was not possible for hostel staff to force him to eat, and my investigators were satisfied that meals were available for the man if he desired them. The clinical reviewer has commented that nutrition is not a social care issue. A nursing needs assessment in September highlighted that the man was malnourished, and hospital staff were also concerned when he was admitted to hospital in December and provided him with food supplements.

83. It is pleasing that the man was so well supported at the hostel. But more should have been done by health and social care professionals to ensure that all his needs were met by those appropriately trained and experienced.

CONCLUSION

84. The man's AOM and the staff at the hostel would be the first to say that they were not trained or equipped to deal with his complex health needs. They faced constant obstacles in their efforts to obtain for him the appropriate accommodation and care. In some instances the man himself made it difficult by refusing treatment and help. But the shifting of responsibility between the two Social Services Departments was clearly the reason he was not given the right care sooner.
85. Whilst it might not be best practice to withdraw beds from residents on the grounds of their severe and complex health and social care needs, it demonstrates the lengths probation staff had to resort to. It is sad that that passed away before he was able to move back to a familiar area and be near his family, but I cannot criticise the efforts or support offered by the Essex Probation staff involved with his case. Without exception, they went beyond their formal duty of reducing the risk of re-offending, and maintaining national standards for number of contacts. All identified their responsibility to promote the man's quality of life and did whatever they could to provide suitable care.
86. The clinical reviewer concludes that it is difficult to make a direct link between the lack of suitable care and accommodation and the cause of the man's death. However, I share his view that the hostel was not the appropriate setting for a man with such health problems. I find it difficult to conclude other than that the man was the victim of a game of bureaucratic pass the parcel.

RECOMMENDATIONS

Since the publication of my draft report, I am pleased to learn that Essex Probation Area has accepted all of the following recommendations and is preparing an action plan to address them.

- 1. I recommend that the National Offender Management Service (NOMS) consider how prison and probation services can best provide full information before releasing a prisoner to Approved Premises, especially when they have complex medical needs.**
- 2. I recommend that the PCT in liaison with NOMS ensures that Approved Premises staff are included in case conferences where medical care of residents is discussed.**
- 3. I recommend that NOMS should conduct a review of the Approved Premises estate to assess its ability to meet the needs of frail, elderly residents and those with complex health needs. Local initiatives suggestive of good practice should be shared across the estate.**
- 4. I recommend that the Chief Officers in the Essex and Suffolk probation areas draw my report to the attention of their local housing and social care authorities, and develop a multi disciplinary approach to offenders' individual needs.**
- 5. I recommend that the Chief Officer of the Essex probation area and the hostel doctor should consider how staff can best seek medical advice about a resident's needs.**