

**Investigation into the circumstances surrounding the  
death of a man, a resident  
at Plas-Y-Wern Approved Premises,  
North Wales Probation Trust, in January 2011**

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

**March 2012**

This is the report of an investigation into the death of a man, who died unexpectedly at Plas Y Wern Approved Premises, in Wrexham North Wales, in January 2011. He was 34 years old when he died of a heart attack. I offer my condolences to his family and friends for their loss.

An investigator carried out the investigation on my behalf. I would like to thank the manager and staff at Plas Y Wern for their full co-operation and support during the investigation. No one else has died at the hostel since 2004 when my office became responsible for investigating deaths at approved premises.

The man appeared to be a healthy 34 year old man who had no history of heart or any other serious medical problems. However, after he died, his partner told a member of staff that he had mentioned chest pain the week before his death. His mother also informed us that he said he had collapsed in his room before Christmas. He did not report this to any staff member and it is not clear whether he told his doctor.

The man used the gym regularly, both when he was in prison and when he first moved to the approved premises. However, on 15 January, after lapsing for a few weeks he did a gentle work out with a member of staff. Half an hour later, staff found him outside the hostel in discomfort. An ambulance was called but resuscitation was unsuccessful and he subsequently died en route to the hospital.

Staff at the approved premises had been trained in first aid and had recently completed refresher courses. They acted professionally and competently and managers supported those who were involved in the resuscitation attempt.

I am satisfied that on the information available to staff, the man's death could not have been prevented and I make no formal recommendations in respect of this investigation. However, I ask the Chief Executive of North Wales Probation Trust to consider appointing a trained family liaison officer following a death in an Approved Premises.

I am impressed with the arrangements made for the support of staff and residents as well the commemorative memorials which were provided.

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

**Thea Walton**  
**Acting Deputy Ombudsman**

**March 2012**

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## SUMMARY

1. The man was released on licence on 19 November 2010, to Plas Y Wern Approved Premises, after completing a three year nine month custodial sentence at HMP Risley. He had previously been a drug user but provided negative tests whilst he lived at the approved premises.
2. When the man arrived at the approved premises, he told staff that he was healthy and had no illnesses. He was not taking any prescribed medication and he had been using the prison gym to keep fit. He subsequently completed the induction to use the gym at the approved premises and started training, often with one of the staff. However, over a period of time, he gradually reduced his time in the gym and he had not trained for a few weeks until just before he died.
3. On 15 January, the man decided to start training again and he had what was described as a gentle gym session with one of the staff. He completed the session without any problems and, when the staff member left him in the gym at 3.30pm, he was not in any obvious pain or discomfort.
4. Just after his gym session, at 4.00pm, staff found the man outside the front of the building in discomfort and clutching his chest. A staff member telephoned for an ambulance and, as the paramedic arrived, he collapsed. Both the staff member and the paramedic performed cardio pulmonary resuscitation until a second ambulance arrived. The paramedics initially used the defibrillator to try and stabilise the rhythm of his heart and then took him to hospital. He died during the journey.
5. The staff member telephoned the man's next of kin to tell her that he was being taken to hospital. She immediately made her way to the hospital but, on arrival, she was met by the police liaison officer, who told her that he had died on the way to hospital. The post mortem found that he died of a heart attack.
6. I make no formal recommendations as a result of this investigation. However, I ask that consideration be given to appointing a family liaison officer in the event of future deaths. I also note the spiritual and emotional support provided to staff and residents and the provision of commemorative memorials.
7. The man's nominated next of kin, his partner, was contacted and asked if she would like the opportunity to raise any concerns. She raised no concerns at the time and was given the opportunity to receive a copy of the draft report.
8. Following the end of the draft consultation period the man's mother contacted the PPO and explained that she had not known of the investigation and had not received any communication from our office. She explained that she wished to be involved in the process and given an opportunity to view and comment on the draft report. She and her family were provided with a copy of the draft report and raised a number of concerns for consideration.

## **THE INVESTIGATION PROCESS**

9. The man died in January 2011. My investigator opened the investigation on 21 January, when she visited Plas Y Wern Approved Premises. The manager of the approved premises showed my investigator around the hostel, including the gym, and gave her copies of all the man's probation records.
10. Notices were issued to staff and residents informing them of the investigation and inviting anyone who had relevant information to contact the investigator. No one contacted my investigator.
11. My investigator returned to the hostel on 1 March 2011, to interview three members of staff. Unfortunately, one staff member was ill and so she was not interviewed. However the other two staff were able to provide the details needed for the investigation in their interviews. She also spoke to the man's offender manager by telephone.
12. One of my family liaison officers contacted the man's partner, as his named next of kin, to explain the purpose and scope of the investigation and invited her to ask any questions or raise any issues for consideration. She raised no concerns or issues during the investigation. She was offered an opportunity to receive and comment on the draft report, however, to date has chosen not to do so.
13. The man's mother contacted the PPO at the end of the draft consultation period, having been notified of our investigation by HM Coroner. The family was subsequently given extra time to read and comment on the draft report. The investigator has considered the issues raised and has, where appropriate amended the report to reflect their comments. It was felt some of the issues raised would be more appropriately addressed outside of this report and this has been in separate correspondence.
14. We would like to apologise to the man's family for not contacting them at the outset of our investigation and hope that the findings of this investigation answer any questions they may have.

### **Post mortem**

15. The coroner for Wrexham stated that the cause of the man's death was "massive heart attack". It is suspected that it was brought on by his previous substance abuse and possible previous anabolic steroid use. There was no indication of any current drug use.

## PLAS Y WERN APPROVED PREMISES

16. Approved premises (formerly known as probation or bail hostels) provide controlled accommodation for offenders under the supervision of the Probation Service. These are usually ex-prisoners on licence in the community who have been assessed as presenting a high risk of harm and requiring a greater degree of supervision than is possible in other forms of housing. The level of supervision is intended to reduce the risk of harm to the public. Residents follow a structured regime, which includes an overnight curfew. There is 24 hour supervision by staff whose role is to provide support and to ensure that residents comply with the rules and licence or bail conditions.
17. Plas Y Wern is one of two approved premises in the North Wales area and is located in Wrexham. Both approved premises provide a resource to the North Wales Courts and have the following aims:
  - i. protect the public
  - ii. prevent re-offending
  - iii. provide residents with an opportunity to address their problems in a safe, stable environment
  - iv. enable residents to face up to their offending behaviour
  - v. complete the conditions of their order or licence
  - vi. facilitate their resettlement into the community.
18. Plas Y Wern accommodates 23 adult men, the majority of whom are supervised on licence. The property has a closed circuit television system installed in the main areas of the building. The video images are recorded 24 hours a day, every day of the year. Recorded images are kept for a short period of time and, if required, give an accurate timed account of movement in and out of the premises, as well as internally.
19. When residents arrive at Plas Y Wern, they take part in an induction process in which they are required to read, agree and sign the North Wales Probation Area 'Approved Premises Conditions of Acceptance' document. By signing the document, residents confirm they understand the rules and agree to abide by them. Failure to comply with any of the listed rules means the resident can be returned to the court for a possible breach of their licence conditions, which could result in a return to prison. Every resident is allocated a key worker who is a member of staff with whom the resident meets to discuss their progress, well being, participation in the activities and group work.
20. All approved premises have strict rules regarding alcohol and illegal drugs. The possession of alcohol, solvents and controlled drugs is not allowed. This is reinforced by random but regular room searches. New residents are advised about a local surgery who will accept registration to a general practitioner (GP). It is the resident's responsibility, however, to register with the practice. The contact between the resident and their doctor is confidential from hostel staff.

21. Plas Y Wern hostel has a small, equipped gym. All residents are required to complete a gym induction session before using the equipment. Two members of the hostel staff are qualified to carry out these assessments which consist of the member of staff explaining to the resident how to use every piece of equipment safely. The staff member signs to say that resident has completed the induction and then the resident may use the gym. The form is also signed by the resident to say that they agree that they are fit and well and have no underlying medical conditions. There is a closed circuit television in the gym, which is linked to the administration office in the hostel. Residents who wish to use the gym have to go to the office and ask for the key, so staff are aware of who is using the gym. Only three residents are allowed to use the gym at the same time.

## KEY EVENTS

22. The man was released on licence on 19 November 2010, after serving a sentence of three years and nine months at HMP Risley. Once released on licence, a prisoner can be recalled to prison at any time if they breach their licence. One of the conditions of his licence was that he must live at Plas Y Wern Approved Premises until directed otherwise by his offender manager.
23. On arrival at Plas y Wern, the man completed an induction interview in which the rules of the hostel were explained to him. He agreed to the rules and signed the relevant forms. At the same time, he completed a number of forms about his health. Staff recorded in his case record that he was of “medium athletic build” and he said he was not taking any prescribed any medication. His health record states that prior to his term of imprisonment he had used drugs and alcohol. There is no further information about any health issues and he agreed to register at the local doctor’s surgery.
24. The man had previously been using the gym in prison and he wanted to continue to do so at the hostel. He attended an induction session with a Residential Service Officer (RSO) A on 21 November. The RSO told my investigator that the man did not tell him of any previous chest pains or any heart complaints when he carried out the induction and he signed the form to this effect.
25. RSO B told my investigator that the man used the gym regularly when he first arrived at the hostel and they often trained together. He said that, over a period of time, he gradually stopped using the gym, especially when he had some home leave and spent less time at the hostel.
26. Just before his death, the man said that he wanted to get fit again. RSO B said that he had a good relationship with him and they planned to re-start training together on 15 January. He told my investigator that he was unaware of any health problems or chest problems and the man did not mention anything about any illness.
27. On 15 January, the man used the gym for the first time in a few weeks. At about 2.30pm, both he and RSO B did a warm up together. The RSO said that the heater was on and the man was walking on the treadmill. He said that the man kept saying “I don’t want to do too much because I just want to start getting back into it”. They therefore did a little upper body and leg work then some tricep work.
28. The RSO said that “It was nothing over the top, no heavy weights you know” and they made arrangements to train three times a week. The man had put on some weight and they discussed the best diet to “bulk up”. (Bulking up is when someone eats a particular low fat, high protein diet, whilst using weights, in order to increase muscle and lose body fat.) The RSO said that they trained together for about one hour and 20 minutes and, during that time he had no worries about the man’s health at all.

29. After they finished training at around 3.30pm, the RSO left the man in the gym, with another resident, to lock up and went for a shower. He came down to the main office around 4.00pm, because RSO A was due to finish work.
30. RSO A left the office to go home but returned very quickly. He told the other RSO that the man was at the front entrance of the hostel and seemed to be in a lot of pain. They both returned to him, who was sitting against the wall with his arm holding his chest. RSO B said that he looked very uncomfortable. Meanwhile, another member of staff arrived at the hostel and he asked her to sit with him while he rang an ambulance.
31. The ambulance control officer asked the RSO if there was any aspirin on the premises and whether he knew if the man was allergic to it or not. She advised him to give aspirin to him, but not to do so if he was unsure about allergy. The RSO asked the man and he said he was not. He was aware where the aspirin was kept at Plas y Wern but chose not to give the aspirin to him because he was worried about what might happen. The man's family have raised concerns about this.
32. The RSO said that it seemed to take a long time for an ambulance to arrive at the hostel. It seemed to take a lot longer than five minutes and when it arrived there was only one paramedic. By that time, the man had moved position and had vomited. He said that he felt better and "joked" that he had not cried like that since he was 16 years old and had a little chuckle.
33. The paramedic asked the man to move inside the building so that he could do some tests. He moved to the nearest office and the paramedic carried out an electrocardiogram. (An electrocardiogram is a test that records the electrical activity of the heart.) RSO B said that when the paramedic looked at the results of the ECG he asked for emergency back up over his radio.
34. Soon after this, the man fell to the floor and made what the RSO described as strange noises. The paramedic examined him and realised he had stopped breathing. He told the RSO to start cardio pulmonary resuscitation (CPR) and give chest compressions, whilst he sorted out the oxygen. My investigator asked about the number of compressions but the RSO said that the paramedic just told him to keep going, so he did not count.
35. The paramedic then attached a defibrillator to the man and gave him two shocks. (A defibrillator is a machine which delivers an electrical current to the heart which enables the heart's natural pacemaker to regain control and establish a normal rhythm.) The second ambulance arrived and the paramedics jointly continued to treat him and shocked him again with the defibrillator. It appeared to the RSO that he was not responding. The paramedics then moved him to the ambulance where they treated him for some time, before setting off to hospital. Later that night the local police informed the hostel staff that he had died.
36. When the man was in the ambulance, RSO B telephoned the man's partner, his nominated next of kin and explained that he had been taken ill and was on

the way to hospital by ambulance. After the telephone call, the man's partner went straight to the hospital but was told that he had died en route in the ambulance. The hospital police liaison officer met her at the hospital to explain what had happened. She subsequently went to the hostel to collect his property after the coroner confirmed that she could have it, on 19 January. No official family liaison officer was nominated by North Wales Probation Trust. However the manager of the approved premises liaised with the man's next of kin throughout the period.

37. RSO B said that he was a fully qualified first aider and had completed his refresher course the previous week. He felt well supported by his manager and said that all staff who were involved attended a debrief and group counselling session, with an opportunity for individual sessions provided by Vie Life Counselling Services.
38. The manager spoke to the residents that evening to break the news of the man's death. She also arranged for the prison chaplain from HMP Altcourse to come to the approved premises to provide a spiritual element of support for the residents. Staff and residents were invited to the funeral by his next of kin and about eight residents and staff, including the manager, attended. She also arranged a plaque in memory of him to be made and put up at the hostel and one of the residents is currently making a bench in memory of him. My investigator was told that when this is completed, his next of kin will be invited back to the hostel. Staff plan to put the bench outside, near to the pond in the gardens of the hostel.

## **ISSUES**

### **Medical history**

39. The man disclosed no serious pre-existing medical conditions or use of prescribed medications when he first moved into the approved premises. However, it was recorded that he had a history of drug and alcohol use. After his death, his partner mentioned to one of the staff that he had complained of a chest pain and not feeling well a week before. His mother commented that he had not been well and told her that he had collapsed in his room before Christmas. However, neither he nor his family told staff at the time. In an approved premises residents are expected to register at the local doctors and, apart from not holding certain prescribed controlled drugs, their health care is their own responsibility as it would be with anyone living in the community

### **Use of the gym**

40. The man became ill shortly after using the gym with a member of staff, after a period of not using it for a few weeks. I am satisfied that the necessary induction for using the gym was carried out appropriately by qualified staff and that he had the appropriate knowledge about the equipment and how to train safely. Health and Safety checks had been carried out on the machines and staff were present whilst he was using the gym on this occasion.

### **Response to ambulance control**

41. When RSO B rang the ambulance service he was asked to give the man aspirin, provided that he was not allergic to it. Although he said that he was not allergic to aspirin, the RSO was worried that he was not medically trained and was concerned about the consequences of giving medication at that stage. The man's mother was concerned that the RSO did not administer the aspirin. I share her concern but think that this is understandable in the circumstances and was unlikely to have changed the outcome.

### **Family liaison**

42. Whilst the manager of the hostel liaised appropriately with the man's next of kin it would have been preferable for a designated and suitably trained family liaison officer to be appointed to carry out this duty. This ensures that, in the event of a death, a standardised process is followed and there is a defined point of call for relatives. Although I make no formal recommendation in this respect, the Chief Executive of North Wales Probation Trust may wish to consider appointing a trained family liaison officer when there is a death at an approved premises. I appreciate that Plas-Y-Wern has not experienced a death at the hostel before the man died. Hostel staff may find it helpful to consider the reports which I have published following deaths at other approved premises and consider whether there are any other lessons to be learned.

43. Probation Circular 35/2006 outlines that an approved premises “may wish to consider the planting of a tree or shrub or installing another form of memorial in the grounds to commemorate deceased former residents”. Although this is not a mandatory requirement, the manager arranged for a plaque to be put up in the hostel in memory of him and has encouraged another resident to make a bench, which will be used by hostel residents and staff.

#### **Support for staff and residents**

44. Staff and residents were fully supported throughout the period following the man’s death. I am particularly pleased to note that she arranged for both spiritual input and practical counselling for those affected and commend her for arranging for the chaplain from HMP Altcourse to come to the premises. Regrettably a prison chaplain may well have had more experience of responding to deaths of offenders and the other residents may well have known him. This was an imaginative arrangement which I expect was of value to residents and staff alike.

## **CONCLUSION**

45. The man lived at the approved premises for less than two months before his death and was expected to leave shortly had he not died. He had spent time in the gym in prison custody and when he first arrived at Plas Y Wern. He was aware of how to use the equipment safely and how important it was to disclose any health problems. He signed the necessary documentation and was given a full induction to the gym at Plas Y Wern.
46. Although the man seemed to be a fit and healthy man and was not taking any medication or being treated for any illnesses, it seems from the post mortem that his previous drug abuse had underlying and unknown effects on his health. It is sad that these health problems had not been diagnosed and treated earlier however, without this knowledge, it would have been impossible for staff or others to have taken steps which would have changed the outcome, or prevented his death.
47. I am satisfied that staff acted appropriately when the man became ill. I am impressed with the spiritual and emotional support provided for the staff and residents after his death and the steps taken to commemorate his death.

### **Feedback from National Offender Management Service (NOMS)**

NOMS have responded that they were satisfied with the report and they welcome the suggestion about appointing a trained family liaison officer, which will be taken forward.