

**Circumstances surrounding the death of a resident in Probation Service
Approved Premises in June 2004.**

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

August 2004

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FOREWORD

My office undertook this investigation into the death, apparently from natural causes, of a resident of an Approved Premises while on bail awaiting trial for an offence of arson. The purpose of my investigation was to establish the circumstances and events surrounding the man's death, including the quality of care provided by the Probation Service, and to ascertain whether there are any lessons to be learned about operational methods, policy, practice or management arrangements that might help prevent such occurrences in future.

I also wanted to ensure that the man's family had the opportunity to raise any concerns they had so as to take these into account in the investigation and report.

A senior member of staff from my office carried out the investigation with the co-operation of the Probation Area. I am grateful for all the assistance that

my Investigator received from the Manager and members of staff at the Approved Premises.

Although the investigator was not able to meet with the man's family, his wife and stepson spoke to her on the telephone. I am most grateful to them for doing so and for providing helpful information at what was a very difficult and distressing time for them. The wife spoke positively about the attitude and kindness of staff at the hostel. I hope that this report will answer her questions and may assist her in her efforts to come to terms with her feelings. I offer the man's wife and her family my sincere condolences.

The Investigator conducted formal interviews with the Manager and Deputy Manager of the Approved Premises, and with a member of the hostel staff. The interviews were not recorded but the Investigating Officer's notes were agreed, and signed by interviewees. Another member of staff spoke with the Investigator on the telephone and provided a written statement.

The Investigator also examined a variety of documents readily provided by the Probation Area. She spoke on the telephone to the man's solicitor, who provided copies of the psychiatric reports prepared at the solicitors' request, together with details of injuries that the man sustained.

**STEPHEN SHAW
PRISONS AND PROBATION OMBUDSMAN**

SUMMARY

The resident was a 55 year old married man who was separated from his wife but who retained regular contact with her. He had a history of heavy alcohol consumption that had affected his health and he had previously suffered a stroke.

He was charged with an offence of reckless arson and was remanded on bail to await trial, with a condition of residence at an Approved Premises. The circumstances of the alleged offence were unusual and a psychiatric report was commissioned by his solicitor. He was known to be in poor health when he was admitted to the hostel and was placed in a room with an emergency call system.

The resident was perceived as an intelligent but demanding man who kept himself somewhat aloof from other hostel residents, but generally abided by the hostel rules and did not present a management problem.

During his stay at the hostel he was admitted to hospital for surgery to an injured hand and again when he became unwell at the hostel. On that occasion he discharged himself but was returned to the hospital by the Hostel Manager under threat of breach.

Whilst on leave of absence for a weekend with his wife, in May 2004, the resident suffered a stroke. He was an in-patient at hospital for some three weeks before returning to the hostel on 9 June. Although he remained poorly, he had a day out with his wife on 15 June and complained of no significant problems until Saturday 19 June when he was unwell and stayed in bed throughout the day.

His ill health continued into Sunday 20 June and Monday 21 June but, despite the exhortations of various members of the hostel staff, the resident refused to see a doctor or to have an ambulance called for him. At this time it was discovered that the emergency alarm cord over the bed was missing.

During the afternoon of Monday 21 June, when a worker took him his medication, the resident's condition appeared to have improved a little but, sadly, some three hours later when he was next checked, he had passed away.

My investigation has identified one area where procedures for reporting and monitoring essential maintenance work could be improved and my recommendation can be found in Part 2, Section 2.

PART ONE

Background information

Section 1 - The deceased

The man was 55 years of age when he died. He had two children from his first marriage although the marriage lasted only a few years. He was married to his second wife for some 33 years and, although they had no children, her son said that the subject of this report had brought him up as his own from when he was aged seven. The deceased appears to have been an intelligent man who had worked hard to educate himself to a high standard; both his wife and the Hostel Manager described him as an intellectual.

The man had been in poor health for some time and was in receipt of sickness benefit. He told the doctor that he had always been a heavy drinker of alcohol and his stepson confirmed to my investigator that this was so. His drinking sometimes resulted in short term memory loss and he believed it had a significant effect upon his physical well being. The doctor's report indicates that the man said he suffered with arterial disease that led to a stroke in his early 50s, from which he recovered after some three weeks in hospital. He had high blood pressure and his wife believes that the long term use of alcohol took its toll on her husband's health.

Unfortunately, his consumption of alcohol and its effects upon him also made the man's relationship with his wife difficult. She cared for her husband but

found his behaviour increasingly wearing. After 33 years together she came to the end of her tether and they separated. The man lived in a flat near the marital home and his wife did all she could to be supportive to him. She felt that she could not completely abandon him and remained loyal to him throughout his life.

However, the man was unhappy with his accommodation, a flat on an estate where he perceived problems with crime and general nuisance. He felt unsafe and had trouble sleeping so sought alternative accommodation. On 2 January 2004 he moved into accommodation on the first floor of a property comprised of five flats with a communal kitchen and a ground floor occupied by the owners.

During the night of 2/3 January, there was a fire in the premises. The owners and other occupants were awakened by the fire alarm, smoke and the sound of breaking glass from the man's flat. He jumped out of his bedroom window, injuring his hand on broken glass.

When interviewed by police, the man said that he had been confused and frightened. He thought he had heard various sounds and snippets of conversation that led him to believe there were people trying to force their way into his room to shoot him. He said that, being frightened, he decided to escape by jumping out of the window but, before doing so, he set fire to his mattress to prevent entry to the room and, he said, to give others a chance to escape. His wife was mystified by his actions and could only believe that they occurred as a result of his illness.

He was taken by ambulance to hospital where the injuries to his hand were examined, assessed and cleaned. His wife said that her husband contacted the police because he was frightened and wanted their protection. He readily explained that he had caused the fire. On the same day he was transferred to another hospital where he had surgery to his hand. He was discharged into police custody on 9 January and, on 12 January, he was bailed from Court to the Approved Premises.

Background Information

Section 2 –The Approved Premises

Probation Approved Premises, formerly known as Probation and Bail Hostels, are approved by the Secretary of State, within Section 9 of the Criminal Justice and Court Services Act 2000. Their purpose is to provide accommodation for persons granted bail in criminal proceedings and in connection with the supervision and rehabilitation of persons convicted of offences. Hostels can provide a supportive, structured environment in the community for high risk and difficult to manage offenders. The supervision of offenders accommodated in Approved Premises is governed by the National Standards for the Supervision of Offenders.

Approved Premises operate on each day of every year with 24 hour staff cover on a rota basis. This hostel is a large, pleasant house set in attractive

grounds. The hostel has 29 places and is managed by a Senior Probation Officer. There is a Deputy Manager and a team of nine staff members, responsible for the daily management of residents.

The Approved Premises has an open admissions policy based on assessment of risk. Potential residents are refused only if significant risk is identified to the community, to other residents or to staff, or if a proper assessment cannot be made due to lack of information. Where potential residents are charged with violent or dangerous offences such as arson, the facts of the case and information about the individual are considered carefully before a decision is taken. In this man's case, there were no indications of violence other than the index offence and he had no history of serious offending. Therefore, despite the index offence, he was not considered to be high risk.

Residents are required to pay rent and to ensure that the hostel can obtain payment, if necessary, directly from benefit. The hostel provides a programme of activities and groups, in which all residents are expected to participate. As required by directions in the Approved Premises Handbook, the hostel retains all prescribed medication and dispenses it to residents at the required intervals to ensure that there is no misuse. The man handed in his medication on arrival and it was administered in this way.

Residents are allocated key workers who are expected to meet with them regularly, to identify any issues of concern and to assist where possible. There is also an expectation that information will be shared regularly with probation officers in the field who are Case Managers. However, in this man's case there was no Case Manager as he was on bail, awaiting sentence, not subject to a community penalty. All residents must be in the hostel between the hours of 11.00pm and 7.00am the next morning unless a Court has imposed an alternative curfew. The man was subject to further conditions, to comply with random drug testing as required and not to consume alcohol on or off the premises.

PART TWO

Events leading to the death

Section 1 – The resident's time at the Approved Premises

The man arrived at the Approved Premises in January 2004. He received a full induction, which included the provision of health and safety information, expectations of behaviour and requirements of the hostel rules. The following day he was registered with the hostel G.P. The referral form had not included an assessment of potential self-harm and no completed self-harm forms accompanied him to the hostel.

Nevertheless, it was noted that he was a mature man, in poor health, lightly convicted, estranged from his family and probably facing a heavy sentence,

all of which could lead to depression. He was allocated an en-suite room, at the end of a corridor, opposite a CCTV camera.

Hostel staff particularly noticed the condition of his injured hand as the wound seemed to be dirty and ill dressed, although he was not complaining of it at that time. His overall standard of hygiene was not good and concern was expressed that perhaps he was neglecting himself.

A few days later, it was noted in the hostel record of contact, that the wound to the man's hand continued to bleed and, on 21 January he was sent to the injuries unit at a local hospital from where he was transferred to a larger hospital and admitted for further treatment. He remained there for some days until he was discharged back to the hostel.

Hostel records indicate that the man appeared settled at the hostel although staff noted that he could be belligerent in his attitude at times and that he was not used to doing things for himself. My Investigator was told of one occasion when the man had an altercation with the hostel G.P's receptionist and left the surgery without having a required blood test. Hostel staff had to persuade him to return after the doctor had telephoned to say the test was vital.

The man's wife continued to visit him regularly and he told her that he could not relate to other residents, most of who were quite different to him. She said that while she wanted to support him as much as possible, she did not wish him to be under any illusions about returning to live with her as this was not going to happen.

No further problems were identified until 27 April when the man complained of feeling unwell. It was noted that he spent most of the next three days in bed and, on 1 May, after an ambulance was called, he was admitted to hospital. Three days later, on 4 May, he arrived back at the hostel still with a 'junction point' for needles attached to his arm. The Manager ascertained that he had discharged himself and he was sent straight back to the hospital. He was reminded that, if he discharged himself again without the hospital's approval, it was hostel policy that his place could be withdrawn and he would be returned to Court, as the hostel could not be responsible for any risk to his health.

On his return to the hostel, the man sought permission to spend a weekend away with his wife. This was thought to be in his best interests as an opportunity to rest and recuperate. His bail conditions were varied by a Judge in Chambers and, on Friday 21 May, he went with his wife to a hotel in another town. The wife told my investigator that her husband spent most of the weekend in his room as he was unwell. She said that he was worried as he found it difficult to keep his balance at times. Unfortunately, on the return journey he became unwell again and, on 24 May, the hostel received a telephone call from a hospital informing them that he had been admitted with a suspected stroke. It was said that he was 'very poorly' and could neither walk nor speak.

The hostel log indicates that there were nightly calls made to the hospital during his stay, to check his condition and to confirm that he remained an inpatient. On 7 June, his wife telephoned the hostel to say how concerned she was for her husband and she spoke of her intention to talk to his solicitor about the possibility of having him stay with her temporarily.

However, on 9 June, the man was discharged from hospital and returned to the hostel. At that time his medication was noted as follows:

Metformin 500 mg (1 in morning)
Ramipril 5 mg (1 in morning)
Propranolol 80 mg (1 in morning)
Omeprazole 20mg (1 in morning)
Atorvastatin (1 at night)
Caliden D3 Forte (2 daily)
Aspirin 75mg (1 in morning)

Two days later he was complaining that he still felt most unwell and the log records him as saying that, if the quality of his life did not improve within two weeks, he would contemplate doing away with himself. There was a request for staff to remain extra vigilant. Despite this, he spent the day out with his wife again on 15 June and returned without mishap or complaint.

Events leading up to the resident's death

Section 2 – The events of 21 June 2004

All seemed well until Saturday 19 June when it was noted that the man did not collect his medication. He was checked at noon and reported that he had been vomiting during the night and still felt unwell. His medication was brought to him in his room. However, it is recorded that when he was checked again after an hour, he told the member of staff he was feeling a lot better.

The following day, Sunday 20 June, the resident remained in bed but when staff checked on him, he said he felt slightly better but was tired. He took his medication and indicated that he wished to remain where he was.

On the morning of Monday 21 June, the Weekend Probation Residential Officer (WPRO) who had been on duty the previous night, went to the resident's room to call him for breakfast. The resident indicated that he did not wish to eat but would like a cup of tea. The WPRO tried to persuade him to join other residents for breakfast but he did not wish to do so. When the WPRO returned with his tea a few minutes later he discovered that the resident had vomited and felt dizzy. The WPRO said he expressed concern and suggested calling an ambulance but the resident was adamant that all would be well when he had taken his medication. He drank the tea but was unable to take his two large tablets saying he would try again in a short while.

The WPRO said that when he tried to persuade the resident to have the doctor called, he became quite angry saying that he knew what he needed and the WPRO should not interfere. The WPRO then reminded the resident that he was aware of what he (the resident) had said two weeks previously about possibly killing himself but the resident calmed down and assured the WPRO that he had no such intentions. He is reported as having said, "No I haven't taken anything, honest it's just my illness. It's the same as last time I was ill and the doctor just gave me some tablets for it."

The WPRO accepted what the resident said and, as he was about to go off duty, he told him that a colleague would check on him later. He advised the resident to pull the emergency cord by his bed if he got into difficulties but, at that point, both men noticed that the cord was missing. This was recorded in the log and the entry was subsequently signed by the Deputy Manager as having been noted for action.

I recommend that the Probation Area should review the procedures for monitoring and checking that required maintenance work is undertaken within a reasonable time scale and consider whether improvements can be made.

The WPRO told the Deputy Manager and the colleague who came on duty of his concerns about the resident and it was noted that there was a general ongoing concern about his health. He said that he had wanted to get a doctor for the resident but that he (the resident) had refused.

In his statement, the WRPO said that he had shared his concerns about the resident with the Deputy Manager, in the duty office. The Deputy Manager's recall was slightly different. He remembered the WRPO's expressions of concern but said that these were relayed to him as general rather than specific. He also said that the WRPO had not come into the Assistant Manager's office - which would have raised his concerns - but had spoken to him in the general melee of a busy Monday morning.

The Probation Residential Officer (PRO) who came on duty that morning knew the resident quite well. She said that she, and others, had sometimes found him to be a very negative, chauvinistic man but that she was able to talk with him about her perceptions in a straightforward manner which, she believed, he appreciated. She checked on him before lunch when he again did not take his medication and refused an ambulance. At lunchtime she said he seemed better; he was sitting up, asked for his pills and took them. During the afternoon she checked again and the resident asked for a cup of tea that she took to him around 3.30.

She told the resident that his wife had telephoned, concerned that she had been calling him on his mobile phone and he had not answered. The PRO said that the resident was rather short with her and disparaging about his wife's concern for him but, as she left the room, he relented and said that if his wife telephoned again he would speak to her. When the PRO went off duty

around 5pm, she reminded her colleague to check the resident and persuade him to take his medication.

Shortly after 6.40 that evening, the PRO went to the resident's room to remind him about his medication. He found the resident on the floor between the bed and the washroom, unconscious and cold. He immediately called his colleague and went quickly to call an ambulance. In the meantime, the colleague had checked the resident and was unable to locate a pulse. Sadly, when the paramedics arrived they confirmed the resident's death.

PART THREE

Consideration and conclusions

It was my role to consider the adequacy of care provided for the resident at the hostel. In doing so, I also considered whether hostel procedures were clear to staff and commensurate with the requirements for all such hostels as defined in the Approved Premises Handbook.

The handbook requires residents to be registered with a G.P. and the evidence is that the hostel complied with this requirement by identifying a G.P. who was willing to take all the residents of the hostel allocating specific times for them to be seen at the surgery. There is a good relationship between the hostel and the G.P. that was illustrated in this resident's case by the liaison over necessary tests.

There is also a requirement for significant events to be recorded and there are clear procedures in place at the hostel for daily events of note to be recorded in the hostel log. The members of staff interviewed were familiar with these procedures and ensured that entries were kept up to date. The daily hand over procedures enable colleagues to share information and ensure that their assessments of situations are made known in addition to the events themselves.

From interviews with staff, it was clear to my Investigator that they were aware of the resident's ill health from the outset and did their best to ensure that he received adequate treatment. On the occasion when he discharged himself from hospital, the threat to withdraw his place was appropriately used to persuade him to return. I note that a similar sanction was not used during the weekend prior to his death, to persuade him to seek medical attention, although it clearly would have been in his best interests if a doctor had been consulted.

It was known that the resident was inclined to neglect himself and two weeks previously the log had recorded his dissatisfaction with the quality of his life. On the other hand, each time he was seen, the resident said that his condition was improving and maintained that he did not need medical attention. He told the WRPO that if a doctor was called, he would not co-operate. On the afternoon of his death, he was conscious, talking, sitting up in bed and had taken medication. Neither my Investigator, nor the members of hostel staff on

duty that day, are medically trained but it did not appear that his condition was immediately life threatening. It was a fine judgement as to whether to call a doctor, notwithstanding the resident's own views. I can imagine that in similar circumstances, some hostel staff would have done so.

Residential staff in hostels are required to work closely with residents on a daily basis to provide assistance and advice whilst encouraging those same residents to take responsibility for themselves. The question that I have to consider is whether the resident's right to choose should have been overruled by the hostel's duty of care. In this case, decisions were taken to respect the man's wishes while his condition was monitored. Although, as I have noted, other staff might have taken a different view, in all the circumstances, I do not consider that the decisions that were made were unreasonable.

However, I wish to draw the attention of the Probation Area and the National Probation Directorate to the missing alarm cord. Because of his ill health, the resident was allocated a room where he was able to summon aid if necessary by means of emergency alarm cords situated above the bed and in the toilet area. My Investigator was told that the system is checked each time a new resident occupies the room but, thereafter, no checks are made as the resident would be expected to report any faults. It is unclear for how long the alarm cord had been missing.

Maintenance requirements, for example faulty locks or failed light bulbs, are recorded in a manual that is checked weekly by a representative of the maintenance contractor. If the fault can be rectified, it is noted in the manual that the job has been completed. If not, the representative will report it to the maintenance contractor. Although staff may check the manual to ascertain if the necessary work has been undertaken, there is not a recognised procedure and no identified responsibility for doing so.

A fused light bulb or a faulty lock may not have far reaching consequences, but they are likely to be noticed, reported and dealt with more quickly than an alarm cord that will only be required in an emergency. This may be particularly so when the occupant of the room from which the alarm cord is missing is someone known to neglect himself. I cannot say whether this resident would have used the alarm had he been able to do so, nor whether its availability could have changed the outcome, but the question would not have arisen if there had been a formalised system of checking whether the missing cord had been reported and replaced.

That said, my Investigator formed the view that members of staff work hard to ensure that residents are treated as individuals with care and consideration. She was satisfied that the overall quality of care provided by the hostel to this resident was good. There was no evidence to indicate that his sad death could have been prevented by changes in either management procedures or policy.

RECOMMENDATION

I recommend that the Probation Area should review the procedures for monitoring and checking that required maintenance work is undertaken within a reasonable time scale and consider whether improvements can be made.

**STEPHEN SHAW
PRISONS AND PROBATION OMBUDSMAN**

August 2004

IMPLEMENTATION

On 3 November 2004, the Probation Area notified the Ombudsman that his recommendation has been implemented. Existing arrangements have been reviewed, improvements have been put in place and communicated to Approved Premises staff.