PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent investigations

Investigation into the circumstances surrounding the death of a man in September 2011 while a resident of Felmores Approved Premises, in the Essex Probation Trust

Report by the Prisons and Probation Ombudsman for England and Wales

February 2014

This is the report of an investigation into the circumstances surrounding the death of a man, aged 73, in September 2011. He died in hospital from stomach cancer, while a resident of a Felmores Approved Premises, in the Essex Probation Trust. I would like to extend my condolences to his family and friends and to all those touched by his death.

I am grateful to the managers and staff at Felmores Approved Premises and the man's offender managers for their co-operation during the course of this investigation. I apologise for the delay in issuing this report.

As a high risk offender, following his release from prison on licence on 4 April 2011, the man was required to reside at Felmores Approved Premises. After a period of declining health, for which he was being treated by his general practitioner and hospital doctors, he was admitted to hospital at the beginning of September, where he remained for just over three weeks until his death. Due to the length of time he had been in hospital a post mortem examination was considered unnecessary.

The investigation concludes that staff at Felmores Approved Premises and the man's offender managers made satisfactory arrangements for his supervision in the community and managed him well. His longstanding medical conditions appear to have been addressed promptly using normal community health services and I am impressed with the efforts of staff to encourage and assist him to seek treatment. Nonetheless, the investigation found that no formal support was offered to either staff or residents following his death and his family were not offered a contribution to the funeral expenses. Recommendations are made accordingly.

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.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **February 2014**

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SUMMARY

1. The man died at hospital in September 2011. He was 73 years old. He had been sentenced to 21 months in prison and, having served a substantial amount of his sentence on remand, he was released on 4 April 2011. He was subject to Multi-Agency Public Protection Arrangements (MAPPA) and was assessed as being in the highest risk category. As part of his re-introduction to life in the community, he was required to live for a period at Felmores Approved Premises in Basildon, Essex. As part of that transition, he was in regular contact with his Probation Service offender managers from early in his imprisonment.

2. The man had a number of health problems in prison, including asthma and angina, for which he was treated. He was a heavy smoker and remained so until his death. He did not always comply with medical advice regarding his medication and sometimes took more than was prescribed for him. He had also made serious attempts at harming himself both in prison and in the community some years before his imprisonment.

3. On arrival at Felmores, because of his previous history of self-harm, staff took action to restrict access to his prescription medication and later also removed sharp implements from his possession. The man agreed with these measures.

4. Felmores' residents manage their own healthcare arrangements and are entitled to maintain confidentiality about their medical conditions. Staff were aware that the man was unwell but were not aware of his specific diagnoses. As part of his induction procedure, he registered with the local general practitioner (GP) surgery. The following day, he was seen for an initial consultation by a doctor at the surgery who referred him to a local hospital for blood tests.

5. The man complained to staff at the Approved Premises about apparently intrusive questioning by a doctor and the investigator found that other residents at Felmores had made similar complaints. The matter is outside this office's remit but it is appropriate that the Approved Premises manager followed up the complaint with the surgery's practice manager, although received no response.

6. During July 2011, the man's health deteriorated and he became progressively unwell which led to several admissions to hospital. Following the first admission, he was referred to clinics specialising in both respiratory and cardiology illnesses. In mid-August, a doctor wrote that he had asthma, diabetes, hypertension (high blood pressure), hyperlipidaemia (high cholesterol), depression and coronary disease and instituted further tests. Throughout August, he continued treatment and had further emergency admissions to hospital.

7. On the morning of 2 September, a staff member thought the man again looked unwell. He contacted the GP practice to advise them and, later in the day, an ambulance was arranged to take him to hospital. Before he was due to leave, he was found collapsed in his room and he was taken by emergency

ambulance to hospital. Felmores' staff and his offender manager made regular checks on his progress. His family also visited him in hospital and kept in touch with Felmores, also updating them on his progress.

8. At this time, the man's prognosis indicated that his death was likely within three months and the hospital wished to discharge him to a hospice or a nursing home for palliative care. An NHS complex case manager was appointed to establish, in consultation with his offender manager, the most suitable placement for him. The hospital allowed him to remain until a suitable move could be arranged.

9. Unfortunately, before the move could be arranged, the man died. Essex Probation Trust was notified of his death and his family later told Felmores' staff that he had suffered from multiple cancers in his stomach and his lungs were constantly being drained of fluid.

10. An Inquest was opened on 7 October and the man's family made arrangements for his funeral, which took place on 10 October.

11. We conclude that the management of the man was sound. However, after his death no formal support was offered to staff or residents of the Approved Premises; neither was funeral expenses offered to his family. Recommendations have been made on these points.

THE INVESTIGATION PROCESS

12. The investigator visited Felmores Approved Premises on 21 October 2011. He was given a full briefing regarding the circumstances leading up to the man's admission to hospital prior to his death by the Approved Premises manager. He was given access to his records and shown around the hostel by the manager.

13. Invitations were extended to staff and residents, inviting anyone who might have information relating to the man's death to make themselves known to the investigator. No residents came forward but the investigator met duty staff. The investigator subsequently interviewed other relevant staff. Evidence relating to the man's time at the Approved Premises and the events leading up to his death is drawn from these interviews as well as Probation Trust records. The delay in issuing this report is due to workload pressures.

14. HM Coroner decided it was not necessary for a post mortem examination to be performed, although an inquest was opened and adjourned on 7 October.

15. One of our family liaison officers contacted the man's next of kin, explained the investigation procedure and invited them to raise any concerns or comments to be considered during the investigation. They raised no issues or concerns.

16. The man's next of kin received a copy of the draft report. They did not make any comments.

FELMORES APPROVED PREMISES

17. Approved Premises were formerly known as Probation and Bail Hostels. Their purpose is to provide an enhanced level of residential supervision in the community, within a supportive and structured environment, for offenders assessed as presenting a high risk of harm. Residents have to comply with their individual licence conditions, curfews and the Approved Premises house rules.

18. Felmores Approved Premises is a 26 bed unit for male offenders. It is one of around 100 Approved Premises in England and Wales. Residents are required to be in the Approved Premises between the hours of 11.00pm and 6.00am. There are at least two members of staff on duty 24 hours a day. Each resident is assigned a key worker who provides ongoing support and is responsible for ensuring that the rules are clear and licence conditions are understood by the resident. Felmores provides offender based group work, recreational facilities both inside and in the grounds, laundry room, kitchen and dining room. There are ground floor rooms which can be allocated to less able residents; because of his age and health, the man was one such resident.

19. Medical services are provided by a local general practitioner (GP) practice where residents register. Residents are treated like any other member of the community and patient confidentiality is maintained between doctor and patient. Emergency health services are provided by the Ambulance Service and the local hospital.

20. As part of the duty to public safety, Trigger Plans are put in place by the Probation Trust so that all agencies involved with the offender know what to do immediately the risk to the public or to a specific person or group of people escalates. Once activated, the Trigger Plan ensures that relevant people are notified of the change. It is specific to the individual to which it refers. In the case of Felmores, the Trigger Plan requires initial notification by telephone and is followed up with a confirmation email, the copies of which act as an auditable trail of actions undertaken.

21. Since 2004, when the Ombudsman was given responsibility for investigating deaths of offenders at Approved Premises, there have been two previous deaths at Felmores Approved Premises, in 2007 and 2009. There are no similarities between the man's and the previous deaths.

Release on licence

22. Offenders serving determinate sentences must be released at the half-way point of their sentence. Those prisoners serving indeterminate sentences (including life) can be kept in custody on risk grounds. They will stay on licence in the community for the rest of the sentence and continue any offending behaviour work started in prison. This means they must report regularly to probation staff and keep to the conditions of their licence, eg not approaching a victim, staying out of a particular area, observing a curfew or living in probation Approved Premises.

THE MAN

23. The man was born in March 1938 and was retired. He was a married, but separated, man with no previous custodial history. He had been diagnosed with asthma, diabetes and angina. He also had alcohol related issues and smoked heavily until his death.

24. The man was convicted on 5 January 2011 of serious sexual and violence offences. He was sentenced to 21 months imprisonment and, on release, to be included in the Sex Offender Register for seven years. Having served a substantial amount of the sentence in custody on remand, he was released from prison on 4 April 2011.

25. Given the nature of his offences, the risk he posed to his victims and others and a diagnosis of borderline personality disorder, the man was subject to the Multi-Agency Public Protection Arrangements (MAPPA). The aim of MAPPA is to ensure that a risk management plan is drawn up for the most serious offenders and benefits from the information, skills and resources provided by the individual agencies co-ordinated through MAPPA. The following indicates the risk levels available within MAPPA:

    - **Level 1:** Normal risk.
    - **Level 2:** A high or very high risk of harm.
    - **Level 3:** Exceptionally high risk of harm.

26. The man was assessed as being in the highest risk category. As a result, when he left prison he was required to live at Felmores Approved Premises in Basildon, Essex as the first step towards release back into the community.

KEY EVENTS

27. During his imprisonment, the man was not compliant with prison rules. He assaulted prison staff and seriously harmed himself on several occasions. He had also self-harmed several years before and was, at that time, subject to compulsory assessment and treatment for a mental health condition under mental health legislation (commonly known as "sectioning"). He was assessed early in his sentence by a forensic psychiatrist, who decided not to section him at the time but diagnosed a borderline personality disorder. In anticipation of his release, he was referred to a community psychiatric nurse.

28. At the initial MAPPA meeting on 23 February 2011, the man was assessed as being a level two risk. Following that meeting, additional information became available to the panel and a further meeting was listed for a level three meeting on 14 March. He was designated a critical public protection case. These are either very high risk offenders or those who might be subject to media attention and therefore require extra resources to manage them. In addition, government ministers have to be briefed about them weekly and their local Member of Parliament is advised of their release into the area. Accommodation for his release was discussed at the meeting and several premises, including Felmores Approved Premises, was subsequently approached for bed availability.

29. The man's offender manager, a probation officer at Essex Probation Trust, became involved in his management in March 2011, before his release from prison. He attended sentence planning meetings with the other agencies involved in managing him and, on his release, jointly managed him with a colleague.

30. The man was released on licence on 4 April, with a requirement to reside at Felmores Approved Premises. He was escorted there and, as part of his supervision, was subject to specific escorting procedures (to be reduced over time), whenever he left the facility. He was described by prison staff and some of those at Felmores as a difficult man with entrenched views who did not acknowledge the need to address the problems that had led to his imprisonment. Other Approved Premises staff also thought him a quiet man who tried hard to be charming but when challenged could become very angry quickly. Both prison and probation staff were known to be concerned about his lack of engagement in addressing his offending behaviour. He also had a very low opinion of doctors and other medical practitioners.

31. On arrival at Felmores Approved Premises, during the early afternoon of 4 April, the man took part in an interview with his supervising offender managers. This concluded in a warning for inappropriate behaviour during the interview. (Subsequently, in the first month of his residence, both offender managers visited him weekly as they were unsure whether he would cope with the journey to their office. Following one offender manager's departure from Essex Probation, the other had sole responsibility for him and saw him monthly.)

32. The man's induction process followed, which included registration with the local general practitioner practice. His completed registration document was faxed to the practice the same day. Explanations of the Approved Premises rules and charges, curfews, area restrictions, fire safety and property disclaimer were given, which he signed as having understood. He was made aware of a standard medication contract. He was also reminded to attend the police station the following day regarding the signing of the Sex Offender Register which he acknowledged. As part of the induction procedure, he took an alcohol and drug test which gave a negative reading for alcohol and a positive reading for amphetamines. A drugs re-test four hours later produced a negative test for amphetamines. No action was taken.

33. The man was also assessed for having his prescription medication in his possession and was allocated a "red" status which meant that he was not allowed medication in his possession. The medication of such residents is held in a locked cabinet within a locked office. The taking of medication is then supervised by staff members who are authorised to stop a resident exceeding or deviating from the prescribed dosage should the need arise. Probation staff are not medically trained or otherwise equipped to deal with residents' health needs.

34. On 5 April, the man went to an appointment at the doctor's surgery where he was prescribed medication for pain relief (co-codamol), asthma (beclometasone and salamol inhalers), angina (amlodipine and a glyceryl inhaler) and cholesterol (simvastatin). These medications were kept in the locked cupboard. He was also was referred for a fasting blood test on 7 April. No outcome from that test is evident from the records available.

35. The man later complained to Approved Premises staff that the locum doctor interviewing him had requested details of the offences that led to him being allocated to the Approved Premises. Staff were aware of similar complaints from other residents about this particular doctor. The matter was raised by the investigator with the Approved Premises Manager while he was at Felmores. The Approved Premises Manager indicated that she had raised the matter with the surgery's practice manager, who had yet to respond to her.

36. Later that day, an Approved Premises officer, who was the man's key worker, had a conversation with him during which they discussed his self-harm. Following that conversation, the key worker discussed the matter with his manager who agreed with him that the removal of his razor blades from his possession was a sensible precaution. He was happy with the arrangement.

37. On 21 April, the man was seen by the prison based community psychiatric nurse (CPN) and the community mental health team (CMHT) in separate meetings at Felmores. Both decided that they would approach their respective consultants and recommend that he be taken off their patient lists, as he had no underlying mental health issues.

38. The man attended a re-arranged hospital appointment on 24 April, at hospital for an ultrasound scan, the reason for which is unclear. After a long wait, he

was told that he would not be seen that day and to re-book the appointment the next day. Approved Premises staff then made many attempts (in excess of twenty telephone calls) to re-book the appointment over the next four days. They finally succeeded in getting an appointment for him on 7 May, at another hospital.

39. On 5 May, the man was found in possession of a packet of promethazine tablets from which sixteen tablets were missing. The drug was registered on his medication record sheet, indicating that each tablet was 25mg and that he should take one nightly. The medication sheet shows that he took one on five consecutive nights from 5 May. There is, however, no indication of how many tablets were originally prescribed. He said that he had shown the medication to a staff member, who had told him to keep them. His key worker noted in the occurrence log that because he was considered at high risk of self-harm, he should not be allowed to keep any medication in possession. No other action was taken.

40. During this period, the man met and socialised outside of the Felmores with his nephew and his family. He was regularly breath tested for alcohol on returning to the Approved Premises and the results of all except one were negative. However, on 1 June, his security escort discovered he was trying to smuggle a bottle of alcohol into the Approved Premises, which led to a bad tempered exchange between him and the staff, ending in him smashing the bottle to the ground outside the building. He was warned about his behaviour and that if he used alcohol he was at risk of being recalled to prison. A final warning letter concerning the incident was issued and a copy sent to Probation Trust senior managers.

41. Following this incident, the man became depressed and angry and refused to speak to his escort for several weeks. As he felt unwell, his key worker made a doctor's appointment for him on Tuesday 7 June. In the meantime, on learning of the events and outcome, his offender manager contacted his community psychiatric nurse via his key worker. She told him of her concerns regarding his heightened risk of self-harm. He made an appointment to see him during the following week. Meanwhile, the key worker put in place a self-harm prevention plan. By 9 June, the man, in an unescorted visit to the offender manager's office, told her that he no longer felt in a low mood.

42. On the morning of 1 July, the man felt unwell, finding it difficult to breathe. At around 10.00am, after consultation with the manager staff called for an ambulance. Paramedics checked his vital signs which seemed all right. However, as he had felt progressively unwell over the previous few days and complained of chest pain, they took him with an escort to the Accident and Emergency Department (A&E) at hospital. Later that day, after tests, he was discharged and returned to Felmores.

43. On 5 July, the man received a letter giving him an appointment on 15 July at the Respiratory Service clinic at hospital. During the intervening days, he reported that he remained unwell and was seen by staff to be struggling for breath. They advised him to seek medical help, either by making a doctor's

appointment or going to the local hospital. On 12 July, an officer noted in the occurrence log that his health was becoming increasingly worrying and that his breathing was laboured but that he consistently and flatly refused to seek medical help, citing his appointment three days later. He did, however, take prescribed steroid tablets for asthma and some antibiotics which then ran out. (Staff at Felmores contacted the doctor's surgery for a repeat prescription.) He continued to undergo daily breath tests for the use of alcohol.

44. The following day, 13 July, the man received a letter to attend an appointment at the Cardiology Department at hospital on 8 August. A doctor saw him on that day and wrote in a letter dated 15 August, that he had diagnosed that he suffered from:

Severe bronchial asthma	Hypertension (high blood pressure)
Hyperlipidaemia (high cholesterol)	Depression
Diabetes	Previous atrial fibrillation AF
Previous coronary disease	

He noted that a previous angiogram (a specialised X-ray test to establish information about the arteries in the heart) had revealed narrowing of a coronary artery. The doctor considered that it would be difficult to arrange a non-invasive investigation because of his irregular heart rhythm and his asthma. He therefore proposed a coronary angiogram for which he made a pre-assessment day patient appointment for 22 August at hospital. He subsequently attended and was given an appointment to undergo the coronary angiogram on 12 September.

45. On 19 July, the manager noted a reminder, for the information of staff dealing with the man, that his move on date was imminent at 25 July and that she would like to issue an eviction notice to him. She asked for comments on progress towards his moving on and the appropriateness of that course of action. The "move on" date is the next stage on from residence at the Approved Premises to more independent living within the community. His two supervising offender managers saw him at their office the following day and explained the impending eviction notice and that he needed to progress his plans for other accommodation. His nephew, who remained closely in touch with Approved Premises staff and his uncle's offender managers, agreed to help in this task. As his health was poor and he was unable to travel to her office, one of his Offender Managers saw him at Felmores on 27 July. She discussed with him his lack of progress in finding suitable accommodation. While there was some move towards a resolution, he continued to live at Felmores until his final admission to hospital.

46. During the late evening of 11 August, the man made a telephone call from his room at the Approved Premises to staff in the front office, telling them that he had a pain in his chest. An Approved Premises officer went to see him and it was evident that he was in pain and distressed. The officer immediately called an emergency ambulance, which arrived about five minutes later. The ambulance crew treated him initially and then took him to hospital where he

was admitted and remained until discharged on 13 August. The officer noted, at that time, that he now had 15 separate medications and was due to collect two more on his return to the hospital on Monday 15 August. On 22 August, he received a follow up appointment to attend hospital on 12 September, regarding his coronary angiogram.

47. The key worker was supervising the man's medication on the morning of 23 August and witnessed him taking tablets in excess of the prescribed dosage, two tablets instead of one. He challenged him about the matter, who responded that the doctor had sanctioned the increase. The key worker contacted the doctor's surgery who confirmed that the medication dosage should be a single tablet. The man's reaction was to become angry and abusive, re-iterating that he thought the doctors were useless.

48. Later that evening at around 11.15pm, the man was experiencing breathing problems and chest pain. Staff telephoned for an ambulance and three ambulance crews arrived. After an electrocardiogram (test to measure the electrical activity of the heart) and nebulisers (device to inhale medication as a mist) had been given, they took him to hospital. Police and appropriate Probation Trust staff were informed of the admission as required in his Trigger Plan. On 24 August, hospital staff reported that he was popping in and out of the ward to smoke cigarettes. He remained in hospital until the following day, 25 August, when he was discharged.

49. Just after 10.00am the following morning, 26 August, the man said he felt unwell and appeared so to staff. He was offered the opportunity to call an ambulance. He refused, stating that he had lost all faith in the hospital as it was dirty and had messed up his medication. He went back to his room and used his nebuliser and again refused medical attention. However, a short time later, he had rallied sufficiently to leave Felmores with another resident, returning later in the day. At around 3.15pm, he complained of severe pain in his chest and an ambulance service was called. The key worker expressed his concerns to the ambulance crew that he was taking double the dose of omeprazole (a medicine to reduce the amount of acid produced in the stomach). They noted this concern and took him to the A&E Department at hospital and he was again admitted. He remained in hospital until he was discharged during the evening of 1 September and an ambulance took him back to the Approved Premises. He had been given a discharge letter.

50. The Approved Premises officer on duty the following morning, 2 September, at around 9.20am saw the man and thought he looked unwell. He contacted the local GP practice to advise them and sent the discharge letter to the surgery. They in turn said that a doctor should be able to attend at about lunchtime. Following this, the GP practice booked an ambulance to take the man to hospital at 6.00pm that evening. The officer visited him regularly until he went off duty at 3.45pm. He said that, at times, he seemed to be all right and, at other times, appeared unwell with breathing difficulties.

51. At about 5.30pm the same day, one of the other residents reported to the key worker that the man was laying semi-conscious on the floor of his room. He

went to his room and found him slumped, partly on his bed and moaning that he was in unbearable pain. He contacted the GP surgery to tell them about the man's condition and a few minutes later the ambulance service telephoned to ask whether his condition had deteriorated. He confirmed that he thought he required medical attention. After that conversation, a paramedic arrived at the Approved Premises at about 5.50pm, followed at 6.25pm by an emergency ambulance, which at 6.30pm took him to the Medical Assessment Unit at hospital.

52. Following the man's removal to hospital, the key worker activated the Trigger Plan, notifying the relevant people that the man was now in hospital. Following the notifications, regular checks on his progress were made with the hospital by staff at Felmores and his offender manager, who also visited him there. His nephew visited him in hospital and collected clean clothing and other personal property from the Approved Premises. He also updated them on his uncle's progress over the telephone and during the visits.

53. Over the following three weeks, the man underwent medical tests and scans. By 20 September, the hospital wanted to discharge him as soon as possible. However, the prognosis was that his death was likely to occur within three months. In view of his condition, it was likely that this would be to hospice or a nursing home, although he did not fully meet the criteria for that move. The hospital agreed to allow him to remain until funding for a suitable move had been resolved. After that decision a complex case manager explored with the man's offender manager the most suitable environment for this transfer. However, before arrangements could be made, he died in hospital a few days later. Felmores was informed and staff from Essex Probation Trust notified his family.

54. On the day of the man's death, his nephew visited Felmores and told staff that his uncle had died at around 2.10pm. He told them during that visit that his uncle had deteriorated daily and had been taking prescribed morphine during the last two weeks for pain associated with multiple cancers in his stomach. His lungs were also constantly drained of fluid.

55. Staff at Felmores arranged for the man's nephew to return the following day to collect his uncle's remaining property, except his car, which was collected some time later. The funeral was arranged by his family. There is no evidence of an offer to contribute towards the costs of the funeral. His Offender Manager returned to work on 3 October, following a period of annual leave. He telephoned the man's nephew to give his condolences and offer any help that he could.

56. At interview, staff said they were not offered formal support following the man's death but felt adequately supported by managers and colleagues. There is no evidence that residents were offered support. During interview, the manager of Felmores said that she was not aware of the formal policy or process for the care of staff or residents after such events.

ISSUES

Management of the man

57. The man was a high risk offender who was required to be managed under the MAPPA procedures. His offender manager actively managed his case, in collaboration with other agencies, prior to his release from prison. Once released, he was initially, jointly managed by two offender managers and seen on a weekly basis, which was subsequently reduced to monthly. The offender managers and Approved Premises staff liaised appropriately and when he was admitted to hospital, the required notifications were made. The remaining offender manager kept in touch with the hospital and visited him in the last few weeks of his life. We are satisfied that proper arrangements were made for his transition from prison to living in Approved Premises and that, during his residence at Felmores, staff managed him in accordance with his sentence plan and licence conditions.

The man's health

58. When the man was first received at the Approved Premises on 4 April 2011, he was a 73 year old man with a range of healthcare issues and a history of self-harm. He was appropriately allocated a ground level room for easier access and, as is normal during his induction procedure, was registered with the local GP's surgery. The registration document was faxed to the surgery and an appointment was made for him to see a doctor the following day.

59. The man attended that appointment during which he claims that the locum doctor made a point of requesting details of the offence for which he was imprisoned, something he later mentioned to staff at Felmores. The investigator was told by staff, including the Approved Premises Manager, that other residents had made similar complaints.

60. It is beyond the remit of this office to consider the policies and actions of community health providers. However, given the risks posed by, and to, many Approved Premises residents, it is appropriate that the Felmores Manager followed up the man's complaint by contacting the practice manager at the surgery. It is disappointing that she received no response. We would encourage the Probation Trust to continue to seek clarity about, and a resolution to, the matter.

61. The man expressed little regard for the doctors treating him. He often failed to adhere to their advice and suggested medication regimes. He was a lifelong smoker and continued to be so throughout his time at Felmores which appeared inconsistent with his medical conditions.

62. As with all Approved Premises, residents of Felmores manage their own health in consultation with their doctors and can, as the man did, maintain confidentiality about such matters. Approved Premises staff, who are not trained or equipped to deal with residents with complex health needs, were aware that he was unwell but were not made aware of any specific diagnoses

relating to him. When he was obviously unwell, staff did try to get him to make appointments with the doctor or attend hospital. On some occasions he did so and on others he did not. However, when he appeared to be very unwell staff rightly took matters out of his hands and called the local ambulance service to take him to hospital. This became more frequent in late August and early September 2011, until his final admission culminating in his death.

63. The placement at an Approved Premises is a first step after imprisonment to re-integration into the community. In a difficult case like the man's, there is a fine line between where that aim competes with the need for close and sometimes intrusive supervision. It is a credit to Felmores' staff that, although the specifics were largely unknown to them, his complex medical problems were addressed throughout with regard to his legitimate wishes for privacy and self determination, but sufficiently reactive to ensure that he received appropriate and prompt medical care when it became necessary.

Management of risk of self-harm

64. On arrival at the Approved Premises, because of his previous serious self-harm, before going to prison and whilst he was there, the man was assessed as being still at risk of harming himself. Approved Premises staff took the precaution of restricting access to his prescription medication by keeping it in secure conditions and supervising him when he took the medication. He was content with this precaution. Even so, he was witnessed taking double the dose of at least one medicine (omeprazole) and was challenged about this by the supervising staff member. In response to his assertion that the doctor had increased the dosage, the staff member checked by telephoning the surgery and confirming that this was untrue. He was also found in possession of prescription drugs (promethazine) which were removed from him. Staff also removed sharp objects from his immediate possession, again a precaution he was happy with.

65. Although those actions might appear to have limited worth, given that he had free access to most areas at the Approved Premises and alternative possibilities or tools for self-harm were readily available both inside and outside the residence, it is a fact that he did not attempt to harm himself. The management of his risk of self-harm by those measures and frequent interaction with him by Approved Premises staff appear to have been effective and minimised his risk. Subsequent concerns about self-harm were managed by putting in place a self-harm prevention plan.

Support for staff and residents

66. Approved Premises staff were content with the support of their managers and colleagues, which was given in an informal manner. However, the manager of the Approved Premises said she was unaware of the formal policy or structure for providing support for staff and residents. The Approved Premises Manual 2011, states, "Following a sudden death Trusts/IMCs should consider providing support to both staff and residents, including counselling services being made available to residents". One of the annexes in the manual lists a number of

organisations that can offer such support. Although staff said they believed they would have been given additional support if they wanted it, we consider that this should have been formally offered to both staff and residents. Accordingly, we make the following recommendation:

The manager of Felmores Approved Premises should ensure that following the deaths of residents or other serious or potentially traumatic events, staff and residents are formally offered support.

Family liaison

67. The Approved Premises Manual also specifies that "Trusts are required to offer to pay reasonable funeral costs of up to £3,000 …" There is no indication that Felmores offered to contribute towards the funeral costs. A recommendation is therefore made in this regard.

The manager of Felmores Approved Premises should ensure that, in the event of the death of a resident, the deceased's next of kin are offered a contribution towards the funeral expenses, in accordance with national guidance.

CONCLUSION

68. The man was an elderly man with serious health issues when he first arrived at Felmores Approved Premises in April 2011. He was a difficult man who had a history of serious self-harm and non compliance with medical advice.

69. Healthcare provision for residents of the Approved Premises is made in the same manner as is generally available in the wider community ie registering with a medical practice, attending appointments there and at local hospitals for more specialised treatment. The man complained about intrusive questioning by a locum doctor regarding his offence history and it became apparent that this was not an isolated instance. While beyond this office's remit, it is appropriate that the Approved Premises manager has sought to gain a better understanding with the surgery about this matter.

70. While at Felmores, the man underwent a series of medical tests at local hospitals. In accordance with medical confidentiality, the results of those tests were not made available to Approved Premises staff. However, they were aware that his health was deteriorating and did their best to ensure that, when necessary, he was advised to consult doctors. On several occasions, when his condition was clearly severe, they appropriately called the emergency services.

71. When the man was admitted to a local hospital for the final time, staff at Felmores and his offender manager kept in contact with him and the nursing staff. It was evident that his condition was terminal and attempts were made by the hospital to discharge him to a suitable establishment in which to end his life. Before that move was arranged he died, a little over three weeks after entering hospital. His family told staff soon after his death that he died of multiple cancers in his stomach. He accessed healthcare as a member of the community receiving the same service available to people with similar conditions in the local community.

72. The other aspects of the man's care and management, for which the Approved Premises staff were responsible, were handled appropriately. Although, following his death, better support ought to have been provided to staff and residents and a contribution towards funeral expenses should have been offered.

73. We conclude that given his age and health challenges, his death could not have been prevented.

RECOMMENDATIONS

1. The manager of Felmores Approved Premises should ensure that following the deaths of residents or other serious or potentially traumatic events, staff and residents are formally offered support.

2. The manager of Felmores Approved Premises should ensure that in the event of the death of a resident, the deceased's next of kin are offered a contribution towards the funeral expenses, in accordance with national guidance.

No formal response to the recommendations was received.