PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the circumstances surrounding the death of a man at Elm Bank Approved Premises in the West Yorkshire Probation Area in July 2011

Report by the Prisons and Probation Ombudsman for England and Wales

February 2014

This is the report of an investigation into the death of a man, who died in his room at Elm Bank Approved Premises, West Yorkshire in July 2011. He was 66 years of age. The post mortem found that the cause of death was acute myocardial insufficiency and severe coronary atheroma. I extend my condolences to those affected by his death.

I am grateful to the staff at Elm Bank for their cooperation during the investigation. I apologise for the delay in issuing this report.

The man had been diagnosed with chronic obstructive pulmonary disease (COPD), arthritis, epilepsy and was a smoker. He had limited mobility due to breathlessness and pain from arthritis. He was able to move around with assistance and used a wheelchair and walking stick. He was released from HMP Hull on 23 February 2011 and was provided with accommodation at Elm Bank Approved Premises.

On afternoon at the beginning of July, a staff member was unable to rouse the man to warn him of a fire evacuation test. They sought help from another staff member and an ambulance was called, during which the operator instructed staff to start cardio pulmonary resuscitation (CPR) until the first responder arrived. Unfortunately, he was pronounced dead shortly after paramedics arrived.

As a result of the investigation, it is clear that staff would not have been able to foresee the man's death. The support and care provided during his short stay at Elm Bank was good and the emergency response and support for staff and residents were generally appropriate. However, it is disappointing that some staff lacked up to date first aid training and, while this has now been remedied, this was a concern raised in a previous investigation of a death at Elm Bank. I therefore repeat the recommendation. There is also a need to ensure that probation staff provide accurate information about those who they are referring to Approved Premises and I also make a recommendation about this issue.

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
Prison and Probation Ombudsman **February 2014**

CONTENTS

Summary

The investigation process

Elm Bank

Key events

Issues

Conclusion

Recommendation

SUMMARY

1. The man was released from HMP Hull on 23 February 2011 and was required to reside at Elm Bank Approved Premises in West Yorkshire. He had chronic obstructive pulmonary disease (COPD), arthritis, epilepsy and was a smoker. (COPD is a disease of the lungs. The airways become narrowed making it harder for air to get in and out of lungs.) He had limited mobility and used a wheelchair and walking stick. Before his release, appropriate agencies were contacted to help find him suitable accommodation in the community. As his licence conditions excluded him from entering certain parts of Yorkshire and he had restricted mobility, it proved difficult in finding suitable accommodation.

2. The referral form completed by the man's probation officer, prior to his arrival at Elm Bank, did not state that he had a disability so the staff were unaware of this. Nevertheless, he was fully inducted by his key worker and he was provided with a disabled room on the ground floor.

3. Staff assisted the man to register at the local doctor's surgery a few days after his arrival to ensure that the prescriptions for his medications could be continued and to provide continuity of care in regard to his health conditions. They also supported him in obtaining an electric scooter and walking stick to encourage his independence.

4. In July the man ate his lunch in the dining area at Elm Bank. Once he had finished, he asked the relief residential officer (RO) for some paracetemol, as he had a headache. The relief RO issued two paracetemol and he then went to his room for a rest, at approximately 12.20pm. Around 40 minutes later, another resident went to his room to give him a cigarette. He was unable to get a reply and could not find him in the residential areas so presumed he had gone to sleep.

5. A fire evacuation test was planned for that afternoon. The assistant RO went to the man's room at approximately 2.55pm to tell him but, when he knocked on his door, he did not get a response. He went into the room but was still unable to rouse him. The assistant RO then alerted the relief RO who checked him, but could find no signs of life. By then, it was around 3.00pm.

6. An ambulance was called and while they waited for it to arrive, the ambulance operator gave the relief RO instructions to start cardio pulmonary resuscitation (CPR). A first responder arrived some minutes later and took control of the situation. He was assisted by two paramedics shortly afterwards. They attached a defibrillator (a machine that monitors the heart's output and provides an electric shock if necessary) and injected stimulants to try and start the man's heart. However, this was unsuccessful and he was pronounced dead approximately 20 minutes later. The subsequent post mortem established that his death was due to acute myocardial insufficiency and severe coronary atheroma.

7. The investigation has found that staff at Elm Bank Approved Premises supported the man well and responded to his needs. When he was found lifeless in his room, they acted promptly to seek medical attention, but the staff on duty had no up to date first aid training. Staff and residents were managed sensitively and were offered support after the death was discovered. Two recommendations are made regarding first aid training and provision of information about disability.

THE INVESTIGATION PROCESS

8. Two of the Ombudsman's investigators made a preliminary visit to Elm Bank on 18 July 2011, where they met several of the staff, including the manager of the premises. They also met a resident who had known him well and he agreed to speak further as part of the investigation process.

9. Notices about the investigation and its terms of reference were displayed around the premises, inviting staff and residents to contact the investigator should they wish to do so. No other residents came forward. The investigators subsequently formally interviewed two members of staff and the resident. The following week, one investigator interviewed another member of staff over the telephone. The transcripts and notes of the interviews are annexed to the report.

10. The Acting HM Coroner for West Yorkshire Western District was informed of the nature and scope of the investigation. A copy of the post mortem was requested once it became available. A copy of this report will be sent to him to assist his enquiries into the man's death.

11. One of the Ombudsman's family liaison officers wrote to the man's friend listed as his next of kin, shortly after his death. She explained the investigation process and offered him the opportunity to raise any issues for consideration. His friend raised no issues at the outset of the investigation. However, he will also have the opportunity to receive and comment on the draft report and it is to be hoped that the findings of the investigation answer any questions or concerns.

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

ELM BANK

13. Approved Premises (formerly known as probation and bail hostels) are approved by the Secretary of State to accommodate sentenced offenders and those directed to live there by the courts as a condition of bail. Their purpose is to provide an enhanced level of residential supervision in the community, as well as a supportive and structured environment. They operate on each day of the year with 24-hour staff cover.

14. Elm Bank Approved Premises is a 22-bed residence for men, providing one disabled room, three double rooms and eighteen single rooms. It is one of four Approved Premises operated by the West Yorkshire Probation Area. It is managed by a Senior Probation Officer who has overall responsibility for the running it. There is also a deputy manager who is responsible for the day-to-day management of residents and for making decisions about enforcement of rules. The 'frontline' team is made up of four residential officers and one assistant residential officer. The services of relief staff are also drawn upon to cover staff sickness, training and annual leave.

15. Each resident is allocated a key worker soon after his arrival, and this member of staff acts as their primary point of contact for sorting out practical issues. Regular key work sessions give residents the opportunity to discuss their difficulties in depth. Although these sessions are not governed by a set agenda, issues such as benefits, health and move-on accommodation are routinely discussed.

16. Elm Bank has close links with local health services, and all residents are registered with a general practitioner (GP) located about half a mile away. West Yorkshire Probation Area pays the surgery to deliver an enhanced service, which ensures that residents get same day appointments when required.

17. Residents are required to pay rent and abide by the rules and regulations of the Approved Premises, including observing a strict overnight curfew between 11.00pm and 6.00am. When residents are subject to statutory supervision, pertinent information is shared regularly with field probation officers who act as case managers.

18. Elm Bank has a closed-circuit television (CCTV) system to maintain the security of the premises and help ensure the safety of residents and staff. The CCTV system has 12 cameras displaying events on three screens simultaneously. The screens and recording equipment are located in the office. The system is manually operated by staff, meaning certain areas can be seen in more detail. Communal areas such as the lounge are generally displayed on the large image screen, whilst the rest is displayed on the less detailed screens. Staff are expected to look at the screens regularly, but no one is required to watch them continuously. In practice, the system is used more often at night, when only two members of staff are on duty (one of whom is asleep and only there in case of emergencies). The system is also used when staff carry out searches of residents' rooms.

Release on Licence

19. 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;
    - only undertaking approved work;
    - not traveling outside the United Kingdom;
    - 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.

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

20. The man's death was the second death at Elm Bank since the Ombudsman started investigating deaths in custody in April 2004. The previous death, in 2007, was also due to natural causes. In the report into that death, we recommended that: "West Yorkshire Probation Area should consider training all Approved Premises staff, including relief workers, in first aid and emergency resuscitation". This issue is again discussed in the issues section of the report.

KEY EVENTS

21. The man was convicted of serious offences in September 2005. He was sentenced to nine years' imprisonment and taken into custody. He had been orphaned as a child and did not know his family medical history. He suffered from arthritis in his hands and knees, angina, epilepsy and had chronic obstructive pulmonary disease (COPD), a term used for people with chronic bronchitis and/or emphysema. He was a smoker and, because of pain due to arthritis and shortness of breath due to COPD, he had limited mobility and was a wheelchair user. He also reported a history of depression and anxiety. He presented with memory problems and confusion, however after many mental health tests the conclusion was that he was not suffering from dementia or any mental disorder.

22. In 2008, the man attended a cardiac clinic for chest pain. He was examined and it was noted that the chest examination found nothing abnormal. He also had a cough, which medical staff thought was due to him smoking. He had a computerised tomography (CT) scan (a detailed x-ray) and bronchoscopy (examination of the inside of the airways using a thin flexible tube with a light source and camera at the end) as he had lost weight and was producing some blood when he coughed. The results of the tests were normal.

23. In July 2010, the man felt what he described as a burning sensation in his stomach. He told staff that he did not want to attend outside hospital as the handcuffs caused too much pain to his wrists. It was noted in his medical record that he was having bowel problems and blood tests had shown unexplained anaemia. He had a right sided tender mass in his lower abdomen and it was suspected he might have cancer.

24. Staff explained the importance of further tests and with encouragement and support he went to hospital for diagnostic tests. The results showed that he was likely to have a stomach ulcer, however to confirm this he needed to have an endoscopy (an internal examination of the body, using a thin, long, flexible tube that has a light source and a video camera at the end) and a colonoscopy (endoscopic examination of the large intestine). He declined to have any further tests and signed a medical disclaimer to this effect. He continued to be short of breath and had developed a lump on his left shoulder that was very painful. He refused to attend any follow up appointments or diagnostic tests, despite staff encouragement.

25. Six months before the man's release from prison, his probation officer completed an Approved Premises referral form to obtain accommodation for him once he was released. The first choice on the form was Elm Bank Approved Premises in West Yorkshire.

26. The probation officer recorded on the form that the man did not have a disability and did not consider himself disabled. She noted that he had mobility issues, but that he was able "to play pool and could climb three flights of stairs" to see her on the wing. It was said that he would move to Box Tree Cottage, a residential accommodation for ex-offenders, in Bradford, after six weeks if a space became available. It does not show that he used a wheelchair or the fact that he became short of breath when walking distances.

27. On 23 February 2011, the man was released from HMP Hull and required to reside at Elm Bank. When he arrived at Elm Bank, staff noticed that he had mobility issues when they saw him being helped out of a taxi. A key worker was appointed and she inducted him fully. She explained the rules of the Approved Premises. She also reiterated the licence conditions that he was required to adhere to, such as his curfew and local areas of exclusion. She told him that he was to pay rent and he could register with the local general practitioner (GP). A disabled room on the ground floor was offered to him so that he could move around in his wheelchair and there was an emergency alarm that was linked to the main office if he needed help. He was said to have been very happy with this.

28. The man told his key worker of his medical conditions for which he had been prescribed aspirin, paracetemol, preventative and reliever inhalers, glyceryl trinitrate (GTN) spray and anti-depressants. This was recorded in his induction file and his medications were stored in a secure cabinet in the office. There is a medication book kept in the office, where residents' medications are listed, along with the quantity of medication, the dosage and frequency. When residents take their medication, they do so in front of staff. The book is then signed by the member of staff who issued the medication and countersigned by a witness member of staff. The quantity of medication taken and the time and date is also recorded.

29. The man said that he had struggled to find Elm Bank and had felt suicidal, wanting to throw himself under a passing car. He said that once he had arrived he felt much better and assured staff that he would tell them if he had any further issues. Due to this comment, staff put in place monitoring under the suicide and self-harm prevention procedures and opened a "self harm one" (SH1) form. This process is used to offer support to residents who may be at risk of self-harm and staff are able to document significant events or conversations, as well as any regular observations. Observations can be every fifteen minutes to an hour dependant on the risk. Staff changing shifts can refer to the form to ensure they are aware of all relevant information relating to that person.

30. The duty manager recommended that the man be checked hourly through the night. The SH1 form shows that he was checked every hour and appropriate comments were made. The following morning there was much improvement in his mood and he told staff that he felt fine. The monitoring was stopped and the form was then closed.

31. On 25 February, the man had a three-way meeting with his key worker and probation officer. He said that he felt tired and had not yet registered with the local GP. His key worker said that she would help him to do this. They discussed his wish to move to Box Tree in the next two months and agreed a referral would be made. His licence conditions were discussed again, giving him the opportunity to ask any questions and he was advised that staff were there to offer support if he needed it. He registered with the local GP a few days later.

32. On 2 March, the man had another meeting with his key worker and probation officer. He said that he was fine. He had attended a doctor's appointment that day and his medications had been re-prescribed. He asked for some help in arranging another doctor's appointment to discuss his COPD and prospective tests and his key worker agreed to assist him. An assessment for Box Tree was

completed, however he was deemed unsuitable for a placement there as there was no ground floor disabled accommodation. She said that she would research further options.

33. As the referral for an electric scooter was still being considered, the man was having difficulty in getting about outside of Elm Bank. He offered other residents money to push him around; however this caused difficulties between some residents. Staff spoke to him regarding this on 4 March, but he replied that he was unable to get around unless someone pushed him. He said that he needed an electric wheelchair in order to get out of the Approved Premises from time to time. Staff regularly checked progress on the application.

34. The man attended a doctor's appointment on 7 March. When he returned he told staff that his doctor had said that he was not to walk unaided and if his lungs were not better by his next appointment they would consider admitting him to hospital. He told staff that he was considering buying a walking stick to help him move around.

35. The man's key worker made an entry in CRAMS (a computer system) that it had been noticed that he was forgetting to take his medications. He was reminded that it was important for him to take his medications for his health conditions and he was given a poster to put on his wall in his room as a visual reminder.

36. The man went to see staff member in a distressed state on 17 March. He said that another resident had promised to take him out into town, but had left without him. The staff member discussed his feelings and he recognised that he was frustrated about his lack of independence and mobility. It was agreed to find out whether the application for the electric wheelchair could be hastened because of the adverse affect of being housebound on his mental state.

37. A multi agency public protection arrangements (MAPPA) meeting was also held that day, in which the man's health needs were discussed as well as the ongoing search for appropriate accommodation. (Multi-Agency Public Protection Arrangements (MAPPA) support the assessment and management of the most serious sexual and violent offenders. 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.)

38. The key worker made an entry in CRAMS on 29 March that she had contacted Kirklees Council about the wheelchair referral for the man. She was told that he was to be assessed at the local town hall and an appropriate time would be given. The assessment would take around half an hour and, once it was complete, he would be able to hire a scooter from Cleckheaton Housing.

39. On 3 April, staff became concerned about the man's breathing and his complexion. He was coughing constantly, so they called an ambulance. He was taken to the local accident and emergency department for further assessment and treatment. He was discharged a few hours later. He had been diagnosed with a chest infection and prescribed antibiotics.

40. The man passed his electric scooter assessment on 6 April and was immediately able to hire a scooter. He was said to have been happier and was enjoying his new found independence.

41. The accommodation at Elm Bank was a temporary measure while the man found more long term accommodation. Generally, residents stay for up to 90 days. As he had been at Elm Bank for some weeks, he was given notice to leave on 2 May. It was noted on CRAMS that his housing options needed to be discussed.

42. On 6 May, the man had a meeting with his key worker and a member of staff from Stonham Housing (a provider of supported housing). They discussed a support plan to identify his needs in regard to his health, mobility and the type of accommodation he would require. He was told how Stonham Housing worked and how it would benefit him.

43. An entry in CRAMS on 11 May by the key worker showed that the man had been feeling unwell and had made a doctor's appointment. She attended with him and noted that the doctor had been surprised that he was in a wheelchair. The doctor had said that it had not been necessary for him to have had an ambulance pick him up when attending the surgery as he should be trying to walk as much as possible. He discussed his chest, cough and lack of sleep. The doctor explained that his symptoms were due to his breathing condition and there was no apparent reason why he was still suffering from this. A plan was made to adjust his medications in order to resolve the problems and he was put on a nebuliser (a devise to convert liquid into droplets for inhalation) to help his breathing.

44. On 3 June, the man had a chest x-ray. It was recorded in CRAMS that he would make an appointment to see the doctor for the results. He also had an appointment to have the lump on his shoulder examined and get a letter from the doctor to enable him to apply for a metal walking stick. This would give him support to get around inside the approved premises.

45. Records show that by 14 June the man had a metal walking stick, arranged by his doctor. He had declined a walking frame. The key worker discussed the motorised scooter with him and he acknowledged that it was best used outdoors only as it would restrict him indoors and he needed to walk as much as possible. She noted that the housing application was "live" and he would hopefully be offered some suitable accommodation soon.

46. The man received a letter from hospital on 17 June about an appointment for an ultrasound scan of his shoulder. Appropriate transport was arranged for him to attend the appointment and a further one was arranged for a few weeks later.

47. The following day, 18 June, the man was told that accommodation had been found, but it was not big enough to accommodate an electric wheelchair. As he relied on the wheelchair, alternative accommodation was sought. The search was extended to other organisations and boroughs. He told staff that he had not been out much that week as he had not felt up to it, due to his chest condition.

48. The key worker noted on 22 June that the man was working closely with the doctor in relation to his health needs. This included assessments to find the most suitable medication to control his asthma and examination of his heart. He

continued to smoke, but said that he was trying to cut down. He agreed to make an appointment with the smoking cessation nurse.

49. The man attended a doctor's appointment on 28 June. An officer from Stonham Housing accompanied him and gave his key worker an overview of the appointment when they returned to Elm Bank. The officer said that the man had told the doctor that he was having trouble eating due to problems with his throat and he had been referred to the hospital about this. He had not previously mentioned this to staff, but they suggested that he be offered softer food, such as soup or scrambled egg.

50. On 5 July, the man attended his hospital appointment regarding the lump on his shoulder. He said that it had gone well and the results of the ultrasound scan would be sent to his doctor. It was noted that he was being provided with a softer diet to ensure that he was eating and his breathing had improved since his medications had been changed. He was said to look better in himself and he said that he felt better.

51. The following day, the man attended a further hospital appointment about his difficulty swallowing. He had an endoscopy of his throat. Doctors diagnosed thrush and prescribed medication to relieve this. He was also told that he had a hernia, which would be monitored by his doctor.

Events leading up to the incident

52. In July a Relief Residential Officer (RO) and an Assistant RO were on duty at Elm Bank. During an interview with the investigator, the RO said that as a relief residential officer, he provides cover to Approved Premises within the West Yorkshire Probation district. Within his role, he is responsible for running the establishment during his shift, including meeting the needs and requirements of the residents and enforcing the rules. He also had an assistant.

53. A resident who had befriended the man was interviewed by the investigator. He said that he had become a good friend of the man during his time at Elm Bank and had seen him that morning. He had told him that he had not had much sleep as he was not feeling too well. He said that he had felt pains in his chest for a few days. The resident had asked if they were any worse than normal, to which he replied they were not. He said he was going to go back to bed to see if he could get some more sleep. The resident saw him again while he they were eating lunch in the dining area. He said he was laughing and joking and seemed in good spirits. He asked if he would bring a cigarette to his room after lunch. He agreed.

54. After he had finished eating, the man asked the RO for some paracetemol, for a headache. The RO told the investigator that he gave him two, which he took in front of him. He did not have any concerns for his health at this time and he did not seem different to any other occasion when he had spoken with him or given him medication. He then said that he was going to his room for a rest. It was approximately 12.20pm at this time and it was not unusual for him to rest during the day, after lunch.

55. At approximately 1.00pm, the resident went down to the man's room to give him a cigarette. He knocked on his door and, as there was no reply, he went to look for

him in the other residential areas. As he could not find him, he presumed he had gone to sleep. He decided not to disturb him and went back to his own room.

56. A fire evacuation test was planned for that afternoon. The Assistant RO was responsible for telling the residents that the alarm was going to be activated for a practice test. He went to the man's room at approximately 2.55pm to tell him he would need to leave the building during the test. He knocked on his door, but he did not get a response. He then decided to go into his room to wake him.

57. The Assistant RO was still unable to rouse the man. He therefore ran to the centre office, directly opposite his room, to ask for the RO's help. The RO entered the room and saw him lying in his bed, on his side, facing the door. He was warm to touch, his eyes were partially open and his tongue was slightly blue and protruding through his teeth. He checked to see if he was breathing or had a pulse, but could detect neither. He then ran back to the office to call for an ambulance as there are no telephones in that area and staff do not carry mobile telephones. By then, it was approximately 3.00pm.

58. The RO gave the ambulance operator his mobile telephone number so that he could go back to the room. The ambulance instructor rang him back immediately and gave him instructions to start cardio pulmonary resuscitation (CPR). He told the investigator that he laid the man on his back, opened his airways and then started heart massage. He estimated that:

> "It was only I would say a minute, minute and a half, before the first response crew/ambulance crew arrived. They were very quick, very quick indeed."

59. The first responder paramedic was the first of the crew to arrive and as soon as they entered the room, the RO stopped what he was doing and handed over to them. Shortly afterwards, two ambulance paramedics arrived and assisted the first responder. The three paramedics attached a defibrillator (a machine that monitors the heart's output and provides an electric shock if necessary) to the man and injected stimulants to try and start his heart. However, this was unsuccessful and he was pronounced dead approximately twenty minutes later.

60. The RO then gathered the residents together in the lounge area to explain what had happened. He said he answered their questions as best as he could and offered them support. As residents who had been out of Elm Bank returned, he took them into the office, spoke to them personally and again offered support. He told the investigator that all the residents said they felt all right, but they were shocked at what had happened.

61. Staff subsequently offered residents further support and counselling. The area manager was impressed by the way staff had handled the incident. He wrote to the Assistant RO and RO to thank them for their actions on the day and also offered them support. The manager of Elm Bank told the investigator that the feedback he had received was positive and staff had felt valued and supported.

62. The funeral was held on 21 July. The manager of Elm Bank attended, along with five of the residents.

63. The post mortem found that the man's cause of death was acute myocardial insufficiency (heart failure) and severe coronary artery atheroma (build up of fatty

deposits in arteries, causing blockages and narrowing of the arteries). The post mortem report concluded that

> "Although it is not entirely possible to exclude an epileptic fit leading to death, there was no history of any recent fits, no suggestion of incontinence of urine or faeces, and the deceased was not found in a posture which would suggest a fit."

ISSUES

Medical care

64. The man suffered from chronic obstructive pulmonary disease (COPD), arthritis and epilepsy, for which he took various medications. He was often forgetful with taking his medication and staff had to remind him to take them to ensure that his symptoms were managed appropriately. To help him, staff made him a poster that he was able to put up in his room as a visual reminder.

65. The key worker helped the man to register with the local general practitioner (GP) in a timely manner. This ensured that he received continuity of care and he was able to be regularly reviewed in regard to his ongoing health conditions. He was said to have been happy with the level of care he was receiving and had made such comments to staff and residents. The resident that was interviewed as part of the investigation said that:

> "He said the staff here had helped him to start getting the healthcare that he needed."

66. The man's mobility was impaired and he was reliant on a wheelchair when getting around outside or long distances. The wheelchair that he was given by HMP Hull on release was not appropriate. Therefore staff actively assisted him in obtaining a new one by contacting relevant agencies and helping him complete the referral forms.

67. The man did not tell staff directly that he was having difficulty in swallowing. It was brought to the attention of staff after an accompanied doctor's appointment where he had mentioned it to the doctor. Once staff were aware of this, they made provisions for him to have a softer diet, to make it easier for him to swallow.

First aid training

68. The Relief Residential Officer told the investigator that he did not have any current first aid training. During previous employment some 30 years previously he had been fully trained in first aid but he had not received any refresher training. It is a legal requirement for any workplace to have an appointed first aider and an appropriate level of first aid trained staff, providing an adequate level of cover and sufficient equipment. First aid trained staff should undertake refresher training every year to refresh their skills and to keep them up to date with changing polices and practices.

69. The Elm Bank Manager told the investigator that some staff were trained in first aid and others were scheduled to attend a full three day first aid course. He also said that they were trying to get all relief staff trained in first aid as well. At the time of writing this report, all permanent members of staff have been trained in first aid. During January to March 2012, first aid refresher courses will be offered to relief staff that do not have up to date training. This will be the second round of refresher courses and some relief staff have already attended. We are pleased to note that this remedial action has now been taken. However, ensuring sufficient numbers of staff appropriately trained in first aid is a fundamental safety issue and legal requirement and it is disappointing to note that this had not happened when the man died, in spite of acceptance of a previous recommendation on this issue.

It is also of concern that a lack of adequate first aid training amongst staff featured in our investigation of a previous death at Elm Bank. We therefore feel it necessary to repeat the previous recommendation:

The manager of Elm Bank should ensure that staff duty rosters are drawn up to include at least one member of staff, per shift, who has up to date training in first aid.

Support for staff and residents following the man's death

70. The RO gathered the residents in the lounge area of Elm Bank to tell them that the man had died. He answered their questions and offered them support. He also told residents who were out, as they arrived back later in the day and again offered support. A few days later, staff spoke to residents again and repeated the offer of support.

71. The area manager wrote to staff to commend and thank them for their handling of the emergency and to offer support. When asked by the investigator if he had felt supported following the incident, The RO confirmed that he had and gave details of the approaches by various managers.

72. The manager of Elm Bank was not on duty the day the man died, however he told the investigator that when he made contact with the duty manager for an update:

> "Things seemed as if they were being extremely well managed which I was really pleased about. It made me quite proud of the fact that the staff who were here had done a good job actually."

Approved Premises referrals

73. When prisoners are due to be released into the community, their probation officer makes a referral to Approved Premises within the area where they wish to reside upon release. The referral form contains detailed information about that person, such as their level of risk, licence conditions, health and disabilities, if appropriate. This ensures that the staff are aware of any particular needs and are sure that the individual would be suitable for the accommodation provided. This is also to ensure that they have good support upon release and have the best opportunity for reintegrating into the community.

74. At the time of the man's referral, not all relevant information was recorded on the form. It was noted that he did not have a disability and did not consider himself disabled. It was acknowledged that he had mobility issues, but it was not recorded that he used a wheelchair or became short of breath when walking distances. There was no input from healthcare staff who would have been able to give a comprehensive account of his needs from his medical history. Thus, the information was insufficient. It did not present an accurate representation of him and his needs and might have posed a problem if the disabled room at Elm Bank had already been occupied.

75. When the man arrived at Elm Bank, staff noticed that him being helped out of a taxi. This was the first time they realised that he had a significant mobility issue. Fortunately, the disabled room on the ground floor was vacant and he was provided appropriate accommodation. He received a full induction from his key

worker and his needs were met appropriately.

76. There is a significant difference between using a wheelchair in a prison environment in comparison to doing so in the community. Within a prison, there is closer support from staff and it is a smaller environment to move around. Once released into the community and residing at an Approved Premises, residents are responsible for themselves and their healthcare and, curfew and licence permitting, are able to explore a wide area.

77. The man was fortunate that the absence of relevant information did not appear to have had an adverse effect on his level of care. However, to ensure that further referrals are completed appropriately, we make the following recommendation:

The West Yorkshire Probation Trust should ensure that probation staff include full and accurate information in referral documents to Approved Premises, before prisoners with a disability leave prison, to ensure that any individual needs are met.

CONCLUSION

78. The man was released from HMP Hull to Elm Bank Approved Premises. Prior to his release, insufficient information was included in the referral form completed by his probation officer and no medical information was obtained from the healthcare staff at HMP Hull. Consequently, staff at Elm Bank were unaware that he had such significant mobility issues and this could have posed a problem if the ground floor room designated for disabled residents had not been vacant. In light of this, there is one recommendation regarding the need for probation staff to provide accurate prisoner information when making an Approved Premises referral.

79. In spite of the fact that the staff were unprepared, the level of support and care provided to the man during his relatively short stay at Elm Bank was good. Staff engaged with him and encouraged him to be independent. Appropriate accommodation was provided and his care needs were met. Registration with the local GP and referrals to external agencies, such as those for supported accommodation and an electric wheelchair, were timely.

80. Although the man had a number of existing medical conditions, his death was unexpected and unforeseen. When he was found in his room, the emergency response was appropriate, albeit that the staff on duty had no up to date first aid training.

81. Staff sensitively handled the news of the man's death and both staff and residents were offered support. Aside from the inadequacy of the referral, we are satisfied that staff supervised and managed him appropriately.

RECOMMENDATIONS

1. The manager of Elm Bank should ensure that staff duty rosters are drawn up to include at least one member of staff, per shift, who has up to date training in first aid.

2. The West Yorkshire Probation Trust should ensure that probation staff include full and accurate information in referral documents to Approved Premises, before prisoners with a disability leave prison, to ensure that any individual needs are met.

West Yorkshire Probation Trust (WYPT) have considered the draft report into the man's death. WYPT is happy to accept the recommendations and is installing defibrillators in all its Approved Premises.