

**Investigation into the circumstances surrounding the  
death of a man, a resident at Merseybank Approved  
Premises, who died at hospital in December 2011**

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

**February 2013**

This is a report into the circumstances surrounding the death of a man who was a resident at Merseybank Approved Premises, Liverpool. He died of a heart attack in hospital in December 2011. He was 50 years old when he died. I offer my sincere condolences to his family and friends.

The investigation was carried out by a senior investigator. I am grateful to the staff at Merseybank Approved Premises for their co-operation with the investigation.

The man was released from HMP Liverpool on licence, to reside at Merseybank on 7 July 2011. During his time there he suffered from physical and mental ill health. He was admitted to hospital on 3 December after being found in his room suffering from shortage of breath.

He was treated at hospital but during the last three days of his life he pulled out his ventilation tubes and refused medication. He died several days later after suffering a heart attack. He had not given any next of kin contact details to the Approved Premises staff and was estranged from his family. I understand this was his choice.

Overall, staff at Merseybank provided a great deal of support to the man with his social and health problems. He was settled and apparently happy there. It is, however, sad that staff shortages prevented any visits to him in his last days in hospital.

Staff at Merseybank were unable to inform the man's family about his death as they did not have any contact details. However, the bereavement team at the hospital traced his sister and a brother. Unfortunately they were not offered any financial assistance towards the funeral and this has resulted in one recommendation in this report.

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 residents involved in my investigation.

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

**February 2013**

## **CONTENTS**

Summary

The investigation process

Merseybank Approved Premises

Key events

Issues

Conclusion

Recommendation

## SUMMARY

1. The man was released on licence to Merseybank Approved Premises on 7 July 2011. Staff said that he was settled at the hostel and that he had told them that "it was the happiest time he had in his life". However, he suffered from bad health and spent numerous periods in hospital during his time living at the Approved Premises. Staff seemed to cope with his ill health well.
2. On 3 December, night staff checked on the man and found him having breathing difficulties. An ambulance was called and he was taken to hospital and admitted. After a few days in hospital his health deteriorated and he later died after suffering a heart attack.
3. The man chose not to give staff at the Approved Premises any details of his next of kin, saying he was estranged from his family. He also did not inform hospital staff of any next of kin. Staff from the Approved Premises were unable to visit him whilst he was in hospital because of staff shortages.
4. We are satisfied that staff at Merseybank did everything possible to assist the man with his social and health problems during his residence at Merseybank. It is, however, unfortunate that staff were not able to visit such an isolated resident as he in his last days in hospital. We have made one recommendation in this report and this relates to Merseyside Probation Trust contributing financially to the funeral.

## THE INVESTIGATION PROCESS

5. The man died at hospital in December 2011. A senior investigator was appointed to investigate the circumstances of his death. She subsequently visited Merseybank Approved Premises on 19 December 2011 and interviewed the manager and the man's keyworker. She was shown round the Approved Premises and visited the room where he had lived. She was also provided with all his documentation.
6. Notices were issued to staff and residents informing them of the investigation and inviting anyone who had relevant information to contact the investigator. No residents or staff came forward in response to the notices. The investigator also contacted the man's Offender Manager by telephone.
7. At the opening visit, hostel staff were unable to provide any next of kin details for the man. Therefore, we were unable to make contact with his family. However, on 16 February 2012, the investigator contacted the hostel manager and was told that hospital staff had been able to trace some relatives. She passed the details onto one of our family liaison officers, who contacted the family to ask if they had any concerns that they would like to be raised in the investigation. The family have not raised any concerns but will be sent a copy of the draft report.
8. The family have had the opportunity to see and comment on the draft report. The man's sister maintains that she was concerned that the hostel staff did not contact her to tell her of her brothers' death and said that she believed they did have her address. She was also concerned that her brother's property was returned to her other brother and not to her.

## **MERSEYBANK APPROVED PREMISES.**

9. Approved Premises are approved by the Secretary of State under the provisions of section 13 of the Offender Management Act 2007. They provide a structured, supportive environment in the community for high risk offenders, many of whom have been released from prison to Approved Premises as part of a supervision plan, agreed with the offender's probation officer.
10. Merseybank is one of four Approved Premises in the Merseyside area and it has the following aims:
  - Protect the public
  - Prevent re-offending
  - Provide residents with an opportunity to address their problems in a safe, stable environment
  - Enable residents to face up to their offending behaviour
  - Complete the conditions of their order or licence
  - Facilitate their resettlement into the community
11. Merseybank has 24 beds, all for men. Residents are 18 years old or over and the majority are on statutory licences or orders. (A statutory licence is made when a prisoner leaves prison. It sets out the conditions of the licence, which the offender agrees to abide by. This is the type of licence the man was subject to while he was at Merseybank.)
12. The property has a closed circuit television system installed in the main areas of the building. The video images are recorded 24 hours a day, every day of the year. The recorded images are kept for a short while and if required give an accurate timed account of movement in and out of the premises, as well as internally.
13. When they arrive at Merseybank, every resident takes part in an induction process which ensures residents are required to read, agree and sign the Merseyside Probation Area 'Resident's Contract' and 'National Offender Management Service Core Approved Premises Rules'. By signing the document, residents confirm they understand the rules and agree to abide by them. Failure to comply with any of the listed rules means the resident can be returned to court for possible breach action and potentially recalled to prison. Every resident is allocated a key worker who is a member of staff with whom the resident meets to discuss their progress, well being and participation in the activities and group work.
14. All Approved Premises have strict rules regarding alcohol and illegal drugs. The possession of alcohol, solvents and controlled drugs is not allowed. This is reinforced by random but regular room searches. Prescribed medication must

be handed to staff for safe storage, following which compliance with medication is closely monitored. New residents are advised about the hostel doctor who will accept registration from residents. It is a hostel rule that new residents register with the doctor and they sign a consent and rules form to confirm that they agree.

### **Assessment, Care and Teamwork (ACT)**

15. Merseyside Probation Trust use the Assessment, Care and Teamwork (ACT) procedure, which is designed to help staff support residents who are at risk of self harm and suicide. ACT was introduced in 2006 and is similar but not identical to the Assessment, Care in Custody and Teamwork (ACCT) procedures used by the Prison Service. This adapted document and procedure has been implemented across the North West region but is not a national policy.
16. The prison ACCT procedures and Approved Premises ACT aim to provide such support as is necessary to ensure the safety of a prisoner or resident identified as being at risk of suicide and/or self harm. All members of staff should have clear responsibilities under the ACCT/ACT system but preventing suicide/self harm is wider than caring for those identified as 'at risk'.
17. By being supportive to all prisoners and residents, taking into account the very different needs of individuals, staff can reduce the levels of distress in their establishment. In turn this will reduce the number of prisoners/residents who may be at risk of self harm. Suicide prevention is the responsibility of all staff.

### **Previous deaths at Merseybank**

18. There has been one previous death at Merseybank Approved Premises in 2005. This was a self inflicted death and bears no similarities to the death of the man.

## KEY EVENTS

19. The man was born in July 1961 and was sentenced to 27 months imprisonment on 23 November 2010. He was released on licence from HMP Liverpool, to Merseybank hostel on 7 July 2011.
20. A keyworker was allocated to the man when he arrived at the hostel. He told the investigator that at first the man found it hard to manage the independence he had at the hostel compared to prison. He also said that the man suffered from poor physical and mental health. In particular, he had been diagnosed with chronic obstructive pulmonary disease (COPD) and was regularly seeing a community psychiatric nurse. (COPD is a disease of the lungs which causes shortness of breath.) He also had a history of mental health problems linked to his offending. He was diagnosed with schizophrenia in 1991 and was subject to a hospital order in 2007 due to his threatening behaviour. He was also sectioned under the Mental Health Act in 2006 and 2007. He said that the man had long history of amphetamine, crack cocaine and cannabis abuse.
21. In the early stages of the man's residency at the hostel, he told staff that he wanted to kill himself and that he had no reason to live. He was subsequently made subject to suicide and self harm procedures (ACT). This was well managed and was closed on 28 July. After this, he started to settle into the hostel regime with support from his keyworker.
22. While living at the hostel the man became ill on a number of occasions because of his COPD. He was admitted to hospital in Liverpool. He did not have visitors because both his parents were deceased and he chose not to have contact with his other family members.
23. On 3 December at 12.05am, the night staff member at the hostel checked the man's room. He found him struggling to breathe at his bedroom window. He subsequently telephoned an ambulance and reassured him until paramedics arrived at 12.35am. They examined him and decided that he needed to be admitted to hospital. He was subsequently taken to hospital.
24. The next day, staff contacted the hospital by telephone and were told that the man had been transferred to the respiratory unit. Although he was still breathless, he was responding to treatment. Staff contacted the hospital by telephone daily whilst he was there. When the investigator asked if anyone from the hostel had been to visit him she was told that staff were unable to visit because of staff shortages.
25. The man remained in hospital for a few days and during this time he did not ask staff to contact any of his family members. A few days later a nurse from the hospital telephoned the hostel to explain that he was in a "serious" state and they needed next of kin contact details. The nurse also explained that he had suffered a heart attack the night before. He had also refused medication for the past three days and pulled out his ventilation and oxygen tubes, saying that he "wanted to die". The hospital staff had tried to support him but he continued to pull out his ventilation tubes.

26. As the man had not given any next of kin details to the hostel staff they were unable to help the hospital apart from giving names and contact details of his professional contacts, such as his social worker and community psychiatric nurse. His Offender Manager said that she had often asked him if he wanted to be in touch with his family but he refused and said that he did not want contact with them. At 10.15pm, a nurse from the hospital telephoned the hostel to inform them that he had died of a heart attack at 9.30pm and no family contact had been established at that time. Staff and residents at Merseybank were notified of his death by the manager and all were offered support.
27. The Bereavement Team at the hospital made enquiries and eventually found two members of the man's family, a sister and a brother. The manager at the Approved Premises subsequently contacted them and he, another staff member, two residents and one ex resident attended the funeral. Staff at the Approved Premises handed over his property to his sister on 9 January. However, the family were not subsequently offered a financial contribution to the funeral in line with the Approved Premises Manual 2011.

## ISSUES

### Clinical Care

28. The man suffered from poor physical and mental health throughout his time at Merseybank. Although this was difficult for staff, they ensured that he liaised with his Community Psychiatric Nurse and Social worker and other professionals. They encouraged him to take his medication and assisted appropriately and promptly when he became ill on 3 December. We find no concerns and believe that he was well cared for at the Approved Premises.

### Ongoing support while in hospital

29. The man was in hospital for a few days before he died. He had no next of kin as he was estranged from them by his own choice. While he was in hospital he did not notify staff of any wish to inform his family of his illness. Unfortunately, due to staff shortages, no one from the hostel was able to visit him whilst he was in hospital. Although this is sad, there is nothing in the Approved Premises rules which states that there is a mandatory obligation for staff to visit residents when they are in hospital.

### Contribution to funeral costs

30. Chapter 23 subsection 39 of the Approved Premises Manual 2011 states:

“Trusts are required to offer to pay reasonable funeral costs of up to £3,000 with the money being paid direct to the funeral director upon receipt of an invoice. The amount paid should cover the cost of the funeral only and not ancillary items such as clothing for those attending, or go towards the cost of a wake, etc. (Note: in cases where the resident was at an independently-managed AP, the local Trust will be responsible for such costs.)”

In line with this instruction we make the following recommendation.

**Merseyside Probation Trust should ensure that a contribution is made towards the funeral costs when a resident of an Approved Premises dies.**

## **CONCLUSION**

31. The man was in poor physical and mental health when he went to Merseybank. When he first arrived he found the more open regime of the hostel difficult and was supported by the ACT procedure. He soon settled and with support from his professional health team and his keyworker and he told other residents that this had been the best time in his life.
32. He suffered from COPD and on a number of occasions he was admitted to hospital. On the 3 December, a staff member found him struggling for breath in his room during the night and appropriately called for an ambulance. He was admitted to hospital where his health deteriorated over the few days he was hospitalised and sadly died. While staff at Merseybank supported him well, staff shortages prevented any visits during his last days in hospital.

## RECOMMENDATION

1. Merseyside Probation Trust should ensure that a contribution is *offered* towards the funeral costs when a resident of an Approved Premises dies.

NOMS and Merseyside Probation Trust noted that the Approved Premises Manual 2011, states that there should be an 'offer' of a contribution towards funeral expenses. The wording of this recommendation has therefore been amended from 'made' to 'offered' and has been accepted.