Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Keith Piggott, a resident at The Grange Approved Premises, on 10 May 2015

A report by the Prisons and Probation Ombudsman
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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Keith Piggott died in hospital from a stroke on 10 May 2015, while a resident at The Grange Approved Premises in Portsmouth. He was 47 years old. I offer my condolences to Mr Piggott's family and friends.

Mr Piggott had lived at The Grange since December 2014. He suffered from diabetes and high blood pressure and collapsed on 8 May. The next day, he had a massive stroke in hospital. He died on 10 May. I am satisfied that staff at The Grange appropriately supported Mr Piggott and encouraged him to seek the medical attention he needed. They could not have done anything to prevent his death. However, the investigation identified a need for more effective family liaison.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **November 2015**

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Summary

Events

1. On 4 December 2014, Mr Keith Piggott was released on licence from a life sentence to live at The Grange Approved Premises, Portsmouth. He suffered from diabetes and high blood pressure and registered with a local GP who prescribed appropriate medication. Mr Piggott missed a number of follow up health appointments, although staff at The Grange encouraged him to attend. Mr Piggott met his supervising probation staff regularly. They discussed his health but he did not mention any specific concerns.

2. In the early hours of 8 May 2015, some other residents alerted staff about noises coming from Mr Piggott's room. A member of staff went into his room and found Mr Piggott collapsed on the floor. He was conscious and breathing but unable to move or speak. Staff called an emergency ambulance.

3. Mr Piggott was admitted to hospital in a critical condition. No one informed his family at the time. On 9 May he suffered a massive stroke and died on 10 May.

Findings

4. We are satisfied that staff at The Grange could not have done anything to prevent Mr Piggott's death and responded appropriately when he collapsed. However, staff were unsure of the procedures to follow afterwards and it took too long to inform his family of his admission to hospital. Staff were unaware of the requirement to meet reasonable funeral expenses and did not offer Mr Piggott's family help with this until prompted by the investigator.

Recommendations

- The manager of The Grange Approved Premises should ensure that when a resident becomes seriously ill, a member of staff informs his next of kin as soon as possible, unless the resident has indicated otherwise.

- The manager of The Grange Approved Premises should ensure there is effective and supportive liaison with families after a resident dies, including offering to pay an appropriate contribution towards funeral costs, in line with national policy.

The Investigation Process

5. The investigator issued notices to staff and residents at The Grange Approved Premises informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

6. The investigator visited The Grange on 20 May 2015 and obtained copies of Mr Piggott's records. He interviewed one resident and spoke to several members of staff.

7. We informed HM Coroner for Portsmouth and South East Hampshire of the investigation who gave use the cause of death. We have sent the coroner a copy of this report.

8. One of the Ombudsman's family liaison officers contacted Mr Piggott's sister to explain the investigation process. She asked why it had taken so long for anyone to notify her that her brother was in hospital.

9. Mr Piggott's sister received a copy of the initial report and indicated that she was satisfied with the findings.

10. The Approved Premises received a copy of the initial report. They pointed out a factual inaccuracy and this report as been amended accordingly. They also submitted an action plan detailing what they have done to address the issues we raised and this is annexed to the report

Background Information

The Grange Approved Premises

11. Approved premises (formerly known as probation and bail hostels) accommodate offenders released from prison on licence 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. Residents are responsible for their own health and are expected to register with a GP.

12. The Grange, in Portsmouth, is managed by the National Probation Service. It has 22 single rooms. Evening meals are provided and there is a communal area for dining and socialising and areas for group work. Each resident is allocated a key worker/offender supervisor to oversee their progress and well-being and that residents adhere to licence conditions and the premises' rules. Probation service employees are on duty at The Grange 24 hours a day.

Previous deaths at The Grange

13. There had been no previous deaths at The Grange.

Key Events

14. On 14 October 1986, Mr Keith Piggott was sentenced to life imprisonment for murder. He was released on licence in November 2006, but recalled to prison in September 2009. On 4 December 2014, he was released on licence again. His licence conditions required him to live at The Grange Approved Premises, Portsmouth.

15. Mr Piggott had diabetes and high blood pressure. On 16 December, he registered with Stakes Lodge medical surgery and a doctor prescribed medication. The doctor advised Mr Piggott he would need regular reviews by the diabetic nurse and regular blood tests.

16. The local pharmacy delivered Mr Piggott's medication to The Grange and staff arranged repeat prescriptions on his behalf. He kept his medication in his room.

17. On 29 January 2015, Mr Piggott told staff that his former partner would not allow him access to their son. He said this affected his sleep and he thought he might be depressed. An offender supervisor advised him to discuss this with the nurse at his next appointment or to make an appointment with the doctor, which staff could help him with.

18. On 4 March, Mr Piggott missed an appointment at the surgery when he got the time wrong. An offender supervisor arranged with the surgery for him to have a blood test the next day and a diabetic review on 30 March. The surgery receptionist told the offender supervisor that Mr Piggott often missed appointments. She encouraged him to attend and let staff know if he had problems getting to appointments.

19. Mr Piggott had regular meetings with his offender supervisor and his offender manager. Among other issues, they discussed his health and he did not mention any specific concerns.

20. On 7 May at 11.00pm, the night duty staff at The Grange began a night curfew check. (Residents are usually expected to be in the premises by 11.00pm.) Mr Piggott was in room at the time. One staff said she spoke to him about a jigsaw puzzle he was doing.

21. The night duty staff did a further check at midnight and one staff checked again just after 2.00am. Both times, Mr Piggott was in his room and appeared to be sleeping.

22. Shortly after 3.00am on 8 May, a resident heard noises outside his room. He went into the corridor and another resident said the noises were coming from Mr Piggott's room. Residents are not allowed to go into each other's rooms after 11.00pm.

23. At 3.14am, a resident went downstairs to the staff office and told one of the night staff that he was concerned about the noises coming from Mr Piggott's room. The night staff went up to Mr Piggott's room and tried to open the door, but it was blocked from inside. He managed to open the door a little and saw

that Mr Piggott was on his back on the floor; his feet were against the door, preventing it from opening.

24. The night staff forced the door open and found Mr Piggott conscious and breathing but unable to speak. The night staff asked the two residents to stay with Mr Piggott. He went to the office and, at 3.21am, rang for an ambulance and he and his colleague went back to Mr Piggott's room.

25. A resident had placed a pillow under Mr Piggott's head for support. He was still breathing but unable to move or answer any questions. One night staff said he felt cold and clammy. She stayed with him to reassure him until the ambulance and a first responder arrived at 3.30am. The ambulance took Mr Piggott to hospital.

26. At 4.00am, a night staff telephoned the on-call duty manager to inform her that Mr Piggott had gone to hospital.

27. At 8.00am on 8 May, the manager of The Grange asked an administration officer to contact the hospital for an update on Mr Piggott's condition. The administration officer spoke to several people, but could get no information. There is no record of further contact with the hospital that day.

28. On 9 May, an offender supervisor spoke to hospital staff, who said that Mr Piggott was critically ill and on a ventilator. She asked hospital staff to inform staff at The Grange of any change.

29. The duty manager then phoned Mr Piggott's sister, his next of kin, and informed her that he was in hospital. The duty manager did not record the time but told us she believed it was between 10.00 and 11.00am. That afternoon, a hospital doctor phoned The Grange and explained that Mr Piggott had suffered a massive stroke and was unlikely to survive more than 48 hours.

30. On the morning of 10 May, an offender supervisor spoke to a nurse at the hospital, who told her it was possible that Mr Piggott could live longer than initially anticipated and that the hospital would inform them of any change. There was no further contact with or from the hospital that day. On 11 May, Mr Piggott's sister telephoned the manager of The Grange to let him know that Mr Piggott had died on 10 May at 11.34am.

31. The manager of The Grange called Mr Piggott's sister later that afternoon and they discussed collecting his property. On 12 May, she and a friend went to The Grange and spoke to members of staff and residents. She agreed to let them know about the funeral arrangements.

32. On 22 May, after a conversation with the investigator, the manager at The Grange tried to phone Mr Piggott's sister to discuss the funeral arrangements and costs but was unable to get a reply. On 27 May, Mr Piggott's sister rang The Grange and told them the details of Mr Piggott's funeral, which was held on 2 June. The manager and two residents attended.

33. On 5 June, the manager of The Grange telephoned Mr Piggott's sister to discuss funeral costs. She explained that the family had to pay a deposit. Mr Piggott's sister later received a grant for part of the funeral costs. The

Probation Service undertook to pay the difference and the deposit back to Mr Piggott's family.

Support for residents and staff

34. When they had news, staff at The Grange kept residents informed of Mr Piggott's condition. On 9 May, after the evening meal, an offender supervisor told them he had suffered a stroke.

35. On 11 May, at about 4.00pm, the manager of The Grange called all the residents into the TV lounge and told them Mr Piggott had died. He offered his support and that of the other staff at The Grange. Additional support services, including counselling, were offered. A resident told the investigator that he thought it was well managed. Staff also told the investigator that they felt well supported by the manager.

Cause of death

36. The coroner did not require a post-mortem examination. He reported that Mr Piggott had died from middle cerebral artery infarction (a stroke), diabetes and hypertension (high blood pressure).

Findings

Clinical care

37. Mr Piggott had diabetes and high blood pressure. Shortly after his release on licence, he registered with a local GP and attended a number of GP appointments. Prescribed medication was delivered to The Grange where staff ensured Mr Piggott received it and re-ordered his prescriptions as necessary.

38. Mr Piggott was independent and, as with anyone else in the community, was responsible for managing his own health and attending medical appointments. Nevertheless, staff at The Grange supported Mr Piggott with managing his conditions and encouraged him to attend his appointments, especially when it became apparent that he had missed a number of them. We are satisfied that staff at The Grange could not have done anything to prevent Mr Piggott's death. They quickly ensured he received emergency treatment by calling an ambulance immediately they found he had collapsed.

Contact with Mr Piggott's family

39. Mr Piggott went to hospital by emergency ambulance on 8 May, at 3.55am. Despite his serious condition, no one from the approved premises informed his family that he had been admitted to hospital until mid-morning on 9 May.

40. On 11 May, after his sister informed them that Piggott had died, the manager of The Grange arranged for her to visit the premises the next day. Apart from when she telephoned on 27 May, he had no further contact with Mr Piggott's sister until 2 June, the day of Mr Piggott's funeral.

41. Mr Piggott's family initially paid a deposit for his funeral, and received a grant from the Department of Work and Pensions (DWP) for part of the costs. The Approved Premises Manual (2014) makes it clear that the probation service should offer to pay reasonable funeral expenses of up to £3,000, unless the deceased had a pre-paid funeral plan, or the family was eligible to apply for a grant (such as from the DWP) that covers the costs. The manager of The Grange was not aware of this until the investigator informed him and had therefore not discussed a possible contribution with Mr Piggott's sister.

42. After the investigator spoke to the manager of The Grange, the Probation Service agreed to pay the balance of the funeral costs and refund the deposit paid by Mr Piggott's family. Because of the initial delay, this took over two months.

43. We understand that dealing with the death of a resident was a new experience for the staff at The Grange. However, we have some concerns about the overall quality of liaison with Mr Piggott's family. There was a delay in informing Mr Piggott's sister when he went to hospital, no regular family contact after his death and a lack of knowledge about funeral costs, which caused Mr Piggott's family some hardship. We have noted that many approved premises managers misunderstand or are unaware of the national policy about funeral costs and we have recently made a national recommendation about this. We make the following recommendations:

The manager of The Grange Approved Premises should ensure that, when a resident becomes seriously ill, a member of staff informs his next of kin as soon as possible, unless the resident has indicated otherwise.

The manager of The Grange Approved Premises should ensure there is effective and supportive liaison with families after a resident dies, including offering to pay an appropriate contribution towards funeral costs, in line with national policy.

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