

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of a man, a resident at Bowling Green Approved Premises, on 19 December 2014

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

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*



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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.

The man drowned in the bath at Bowling Green Approved Premises on 19 December 2014. He was 77 years old. I offer my condolences to the man's family and friends.

On the day he died, the man had seen a GP for a vitamin injection. He did not report any significant symptoms and the GP had no concerns about him. The man suffered from diabetes and the post-mortem examination found that he had advanced heart disease. It is likely that one of these problems caused him to lose consciousness in the bath and drown. Although it is probable that the man's death was through natural causes, he had been regarded as at risk of suicide and self-harm at the time. Staff were expected to monitor him frequently, but a required check on the afternoon of the day he died did not take place. However, as the man had been dead for some time when staff found him, it is unlikely that the scheduled check would have changed the outcome. As in another recent case at Bowling Green and in other approved premises, I am concerned that the approved premises did not pay reasonable funeral expenses, as national policy requires.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

November 2015

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Summary

Events

1. On 13 October 2014, the man was released on licence from HMP Risley to Bowling Green Approved Premises, Carlisle. The man was 76 and had a number of health problems including diabetes, heart disease and an enlarged prostate. While he was at Bowling Green, the man saw a GP at a local practice several times about his health conditions.
2. On 16 December, a probation manager told the man that for public protection reasons, he would not be able to return to live with his wife at their current address. He was upset at this news and apparently told another resident that he was going to harm himself. The man denied that he had said this but the manager began Probation Service suicide and self-harm prevention procedures, known as ACT. Staff were required to observe him hourly. The next day, the man said he was upset but did not intend to harm himself and observations were reduced to six times a day.
3. On 19 December, the man had an appointment with his GP for a vitamin injection. The GP had no particular concerns about the man's health at the time and the man did not report any new significant problems. When he got back to Bowling Green, the man went to have a bath at 1.40pm. An ACT check, scheduled for 3.15pm, did not take place. Shortly after 4.00pm, a security officer opened the bathroom, after a resident reported water coming under the door. He found the man unresponsive in the bath. Staff lifted the man from the bath, but did not attempt cardiopulmonary resuscitation, as it was clear he had been dead for some time. Paramedics confirmed his death when they arrived about ten minutes later.

Findings

4. A post-mortem examination found that the man had advanced heart disease. The pathologist considered he might have lost consciousness in the bath because of his heart condition or because he had not eaten enough. The man was diabetic and had a history of suffering low blood sugar when taking a hot bath due to his diabetes, which could also have caused him to become unconscious.
5. Although the man had been identified as at risk of suicide as self-harm, there is little to indicate that his death was self-inflicted. The circumstances suggest that the man died shortly after getting into the bath. While it appears that a check at 3.15pm would not have changed the outcome for the man, we are concerned that staff did not make that check.
6. Bowling Green did not offer a sufficient amount towards funeral costs, as national policy requires.

Recommendations

- The manager of Bowling Green Approved Premises should ensure that staff carry out and record observations in line with ACT plans.
- The Director of the National Probation Service should ensure that all approved premises managers follow national policy about payment of funeral expenses after the death of a resident and offer to pay a contribution towards reasonable funeral expenses of up to £3,000.

The Investigation Process

7. The investigator issued notices to staff and residents at Bowling Green informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
8. The investigator obtained relevant extracts from the man's prison medical records and records from the approved premises. He interviewed six members of staff at Bowling Approved Premises on 21 January 2015.
9. We informed HM Coroner for North and West Cumbria of the investigation. Our investigation was suspended for three months until we received the post-mortem and toxicology reports from the coroner. We regret the consequent delay in issuing this report. We have sent the coroner a copy of the report.
10. One of the Ombudsman's family liaison officers contacted the man's wife to explain the investigation. His wife asked the investigation to consider the following questions:
 - What concerns had the man raised in a written complaint about his probation officer in December 2014?
 - Would the approved premises pay funeral costs?
 - How and when was the man found on 19 December?
 - Was she contacted as quickly as expected when the man died?
11. The man's family received a copy of the initial report. They raised a number of issues that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.
12. The initial report was also shared with the Approved Premises and Probation Trust. They pointed out some factual inaccuracies and this report has been amended accordingly. The action plan has been annexed to this report.

Background Information

Bowling Green Approved Premises

13. Approved premises (formerly known as probation and bail hostels) provide an enhanced level of residential supervision in the community. The National Probation Service, North West Area, manages Bowling Green Approved Premises in Carlisle. Residents must be aged over 18. Most residents are required to stay as a condition of a court order or prison licence.
14. Bowling Green accommodates up to 24 men. Residents are required to sign in and out of the building and follow agreed curfews. During induction, staff tell residents about the premises rules and allocate them a key worker who is their primary contact and who holds one-to-one sessions about the issues in the offender's sentence plan. Residents are responsible for their own health and are required to register at a local doctors' surgery. As part of the conditions of residence, staff hold all prescribed medicines and issue them as prescribed.

Assessment, care in the community and teamwork (ACT)

15. ACT is the care planning system the Probation Service uses to support prisoners at risk of suicide or self-harm. Once a resident has been identified as at risk, the purpose of the ACT process is to try to determine the level of risk, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Part of the ACT process involves assessing immediate needs and drawing up a list of actions to identify the resident's most urgent issues and how they will be met. ACT is equivalent to the Assessment, Care in Custody and Teamwork (ACCT) process used by the Prison Service. Regular multi-disciplinary reviews should be held. Guidance on ACT procedures is set out in chapter 23 of the Approved Premises Manual and states that approved premises must have a coherent strategy that achieves the same aims as that contained in Prison Service guidance (Prison Service Instruction 64/2011).

Previous deaths at Bowling Green

16. The man was the second resident of Bowling Green to die since the start of 2012 and there has been one death since. We have previously identified the need to pay an appropriate contribution towards funeral expenses.

Key Events

17. On 19 December 2011, the man was sentenced to five years and four months for sexual offences. On 13 October 2014, he was released on licence from HMP Risley to Bowling Green Approved Premises in Carlisle. His sentence and licence expiry date was 13 October 2017.
18. The man had diabetes, heart disease and an enlarged prostate. In prison, doctors had prescribed gliclazide, metformin (both used to treat diabetes), simvastatin (to reduce cholesterol), tamsulosin (used to treat prostate disorders) and aspirin (to reduce the risk of a heart attack). When he arrived at Bowling Green, staff recorded he took his medication as prescribed.
19. The man registered with St Paul's Medical Practice in Carlisle and visited for the first time on 16 October for a new patient consultation. He saw a GP at St Paul's again on 17 October and on 21 October, when a routine blood test to monitor his diabetes showed his vitamin B12 levels were low, due to poor diet. The GP booked two further appointments in December for vitamin B12 injections. On 29 October, the man had an appointment at Cumberland Infirmary for a urinary system problem. An ultrasound test showed he had an aortic aneurism (an enlargement of a main artery, which can cause back pain). A doctor referred him to a consultant for further investigation. On 5 December, he visited his GP again for a vitamin B12 injection.
20. On 16 December, the man's offender manager told him in a telephone call that his release address to the home he shared with his wife was unsuitable and regarded as a risk as it was near a holiday camp. He was expected to leave Bowling Green on 28 January 2015. The man's offender supervisor, who was with the man at the time, said that he had tried to reassure the man about this and asked him to think about other options. The offender supervisor said that they did not talk more about it that day because he thought that the man needed some time to come to terms with the news.
21. The man was very disappointed with the decision and another resident told the offender supervisor that the man had said he was going to harm himself. The man denied saying this but, later that day, the manager of Bowling Green, opened a Probation Service suicide and self-harm prevention plan (ACT) for the man to monitor him as a precaution.
22. The man told the manager that he was angry and upset that he would not be able to move back and support his wife, who also had health problems. The manager decided that staff should check the man every hour. The manager told the investigator that the man had been upset because he believed that he should have been informed of the decision that he could not go back to his home a lot earlier.
23. On 17 December, the manager, (the man's key worker) and a probation service officer, saw the man for an ACT case review. The manager recorded that the man was still very emotional but said he did not intend to harm himself. The manager asked the key worker to help the man find alternative accommodation and recorded that the key worker and the man had a good relationship.

24. The manager noted that staff should check the man at 7.30am, 8.30am, 12.00pm, 3.15pm, 7.30pm and 11.00pm and that they should search the man's room. The ACT log shows that the key worker checked his room at 1.30pm that day and found nothing to indicate that the man intended to harm himself. The man told staff that one of the reasons the probation decision had upset him was that he would be away from his wife. Staff arranged for the man's wife to visit him at Bowling Green on 22 December. The key worker also helped the man to write a complaint letter to the National Probation Service and to the Prisons and Probation Ombudsman (about the way the risk assessment on his release address had been handled. This letter had not been sent before he died. A complaint to this office at that stage would not have been eligible as the Probation Service would need to respond first.)
25. On 17 and 18 December, staff checked the man and supported him in line with the ACT plan. On 18 December, the man spoke to his wife on the telephone. She said that he did not sound well at the time.

19 December 2014

26. At 7.00am on 19 December, a supervisor at Bowling Green checked the man and the key worker saw him at 8.30am and 12.30pm. Neither had any significant concerns. At 12.30pm, the key worker recorded that the man appeared to be fine and was on his way to an appointment with his GP. This was the last entry in the ACT document.
27. Just after 12.30pm, the man left Bowling Green to attend an appointment with a doctor at St Paul's Medical Practice. The doctor gave him a vitamin B12 injection. The man arrived back at Bowling Green at around 1.20pm. He told a security officer, that he had back pain and was going to have a bath.
28. At 1.40pm, CCTV footage shows that the man went to the bathroom. The bath is in a separate room within the bathroom, which also contains communal washing and toilet facilities. No one carried out the expected ACT check at 3.15pm. CCTV footage shows that two residents went into the bathroom area at 3.16pm and 3.57pm respectively. Neither said they noticed anything unusual. At 4.03pm, a third resident went in and found water running underneath the bathroom door. He told another security officer.
29. At 4.05pm, the security officer unlocked the door and found the man unresponsive in the bath. The hot tap was running and water was coming over the side. He checked the man and found he had no pulse and his jaw was stiff. The security officer thought he was dead and asked a resident to stand by the door to prevent others from entering the room. He left the bathroom and told a supervisor, that he thought the man might have killed himself. At 4.07pm, the supervisor called an ambulance.
30. At 4.08pm, the supervisor went into the bathroom and the manager and the security officer arrived shortly afterwards. They lifted the man from the bath and put him on his back on the floor. The man's lips were blue, they were unable to open his mouth and rigor mortis was present. They did not attempt resuscitation, but did give him heart massage.

31. At 4.16pm, paramedics arrived and confirmed that the man had died. The police report stated that they found nothing suspicious at the scene or in the man's room. Paramedics noted that there was no sign of struggle or obvious injury.

Liaison with the man's family

32. The manager gave the police contact details for the man's wife, his next of kin, shortly after his death and they broke the news to her later that evening, at approximately 8.30pm. On 22 December, the manager telephoned the man's wife to offer his condolences and support. He arranged for the man's wife to visit Bowling Green and collect his property. The funeral took place on 13 January 2015. Bowling Green offered a contribution of £500 to the costs.

Support for staff and residents

33. Managers at Bowling Green offered support to the staff involved in the emergency and the manager organised a meeting of the residents that evening and told them that the man had died. He offered individual support to any resident who needed it.

Post-Mortem

34. A post-mortem examination found that the cause of death was drowning. Toxicology tests found no drugs or alcohol in the man's blood when he died. The pathologist also provided a supplementary letter, which explained there was evidence of a 'natural event', which could have caused the man to become unconscious and drown. The pathologist noted that the toxicology results showed ketones in his urine, which can be a sign of fasting and that the man was an elderly man with advanced heart disease. Fasting or heart disease can both lead to a temporary loss of consciousness, which could have caused him to drown in the bath.

Findings

Clinical Care

35. After moving to Bowling Green, staff helped the man register with the local GP practice. The man attended a number of GP appointments, including one on the day he died, and a hospital appointment. It is each resident's responsibility to manage their own healthcare, as in the community, but we are satisfied that staff at Bowling Green encouraged the man to get medical attention and supported him to attend appointments when he needed to.
36. On the day he died, the man saw his GP, for a vitamin injection. The doctor told us that the man's health appeared to be normal that day and he did not complain of any significant symptoms. He had no side effects or abnormal reactions from the injection (which was one of a series of vitamin B12 injections he had received).
37. The man was not under the influence of drugs or alcohol but tests showed increased ketones in his urine, which is a common finding when someone has not eaten for some time. The pathologist said this might have led to transient unconsciousness and drowning. The man had complained of lack of appetite and not eating well. He was diabetic and his wife said that he often had 'hypos' in the bath when he lived at home, which gave him headaches. At home, he opened the windows in the bathroom to relieve this but there was no window in the bathroom at Bowling Green so he could not do this. Hypoglycaemia (hypo) is triggered when blood sugar levels fall – which can be caused by too much insulin or too little food. We are satisfied from the man's medicines charts that he received his diabetic medication appropriately. He kept some in his possession and it is not possible to tell whether he had taken too much, which might also have caused low blood sugar, on the day he died.
38. The pathologist also noted that the man's advanced heart coronary disease (which was apparent at the post-mortem examination) could have caused him to become unconscious and drown.

ACT checks on 19 December

39. It seems most likely that the man died as a result of becoming unconscious through illness. However, we are concerned that on the day that he died, an expected check did not take place. Checks should have taken place at 7.30 am, 8.30am, 12.00pm, 3.15pm, 7.30pm and 11.00pm. All other checks were recorded as scheduled, but on 19 December, no one checked the man at 3.15pm. At this time, the man had been in the bathroom since 1.40pm, and was not found until after 4.00pm.
40. Paramedics recorded the man had advanced rigor mortis, which indicated that he had been dead for some time when he was found. It is therefore unlikely a check at 3.15pm would have changed the outcome. However, it is concerning that no one checked the man's welfare when he had been in the bath some time. Even if he had not been subject to ACT monitoring, he was an elderly man with a number of health problems. The manager told us that it was likely that staff were

sensitive to the man's privacy while he was having a bath and therefore did not carry out the scheduled check. If a resident is assessed as at risk of suicide or self-harm it is important that such checks take place and someone should have obtained a verbal response from the man to check that he was okay, without imposing substantially on his privacy. We make the following recommendation:

The manager of Bowling Green Approved Premises should ensure that staff carry out and record observations in line with ACT plans.

Liaison with the man's family

41. The manager at Bowling Green offered to contribute one third towards the man's funeral expenses which amounted to just £500. The Approved Premises Manual says, "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 the invoice". The manager told the investigator that he thought one third was a 'reasonable' amount and wanted further guidance from the National Probation Service before committing any further funds.

42. We consider the contribution made by Bowling Green was not sufficient and did not comply with the national policy, which requires payment of 'reasonable funeral costs' not an arbitrary proportion towards the costs. The investigator spoke to the Head of Probation for the North West region, who referred the issue to the deputy director for the National Probation Service, but the matter is still not resolved. It appears that many approved premises managers misunderstand the national policy. We are concerned that this is an issue that we find increasingly in investigations into deaths at approved premises. We make the following recommendation:

The Director of the National Probation Service should ensure that all approved premises managers follow national policy about payment of funeral expenses after the death of a resident and offer to pay a contribution towards reasonable funeral expenses of up to £3,000.

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