

**Investigation into the circumstances surrounding the
death of a man
at Southwood Approved Premises, Liverpool, in the
Merseyside Probation Area, on 17 July 2006**

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

January 2007

This is a report into the death of a man at Southwood Approved Premises in Liverpool on 17 July 2006. He was 48 years old. I offer my sincere condolences to all those touched by his passing.

The man had been living at Southwood from 13 April as a condition of his release from prison. He had been sentenced to two years custody by Liverpool Crown Court in July 2005.

The man died in his room at some point between 5.45pm, when he was last seen on the hostel's closed circuit television system, and 7.00pm, when he was discovered as part of a routine check by staff. A post mortem carried on behalf of the Liverpool Coroner identified the cause of death as heart failure linked to heart disease and high blood pressure.

This investigation has been undertaken by a member of my team. I would like to thank the Senior Probation Officer in charge of Southwood and her staff for their co-operation and active participation. Particular thanks go to the deputy manager for making the arrangements for my investigator's visit.

One of my Family Liaison Officers contacted the man's mother to inform her of my investigation and to offer her the opportunity to raise any concerns. I hope this report answers any questions she or any other family member may have about the circumstances surrounding his death.

I make two recommendations, one of which relates to the training of hostel staff in emergency resuscitation techniques.

Stephen Shaw CBE
Prisons and Probation Ombudsman

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Evidence considered:

The man's record of contact
OASys assessment
Southwood information booklet
Southwood logbook
Medical charts

CCTV footage was also made available for viewing

SUMMARY

The man who died became a resident at Southwood Approved Premises on 13 April 2006, having been released from a two year prison sentence imposed by Liverpool Crown Court the previous July. Upon his arrival at the hostel, he received a formal induction during which he disclosed that he suffered from high blood pressure and a number of other health problems.

Having previously been a resident at the hostel, he quickly settled into a routine. He kept all but one of his appointments with his supervising probation officer and complied fully with the hostel regime. He got on well with the staff team and was thought of warmly by his fellow residents.

Throughout his time at Southwood, the man took prescribed medication for his high blood pressure. His prescription was changed by his General Practitioner on 19 June and again on 11 July, following consultation with the man who later died. The man never disclosed to hostel staff why his medication was changed, although it is believed that he experienced unwanted side-effects, including headaches.

On 6 July, the man who died was admitted to hospital overnight after complaining of blurred vision, a numb left arm and a headache. The next morning, he returned to the hostel, claiming that he had been discharged. In fact, he had discharged himself, against medical advice.

At 7.00pm on 17 July, during the course of a routine curfew check, the man who is the subject of this report was found dead in his room. The staff who found him formed the opinion that he had been dead for some time and decided not to commence emergency resuscitation. An ambulance was called to the hostel and arrived around 7.15pm. The paramedics confirmed death shortly afterwards.

THE INVESTIGATION PROCESS

1. My investigator considered the man's probation records, including those held by Southwood Approved Premises. The investigation was formally opened on 25 July 2006, when my investigator met the Senior Probation Officer in charge of the hostel. He returned to the hostel on 25 September when he interviewed four members of staff. He also spoke to the man's supervising probation officer by telephone.
2. Prior to my investigator arriving at Southwood, notices were issued to staff and residents announcing the investigation and inviting anyone with information relevant to the man's death to make themselves known to the investigator. One resident came forward, but unfortunately he left the hostel shortly after the man's death and my investigator has been unable to trace his whereabouts.
3. Investigations into all deaths conducted by my office attempt to address the concerns of the next-of-kin or other family members. One of my Family Liaison Officers contacted the man's mother to find out whether she had any concerns. She wanted to know whether the man's hospital admission on 6 July 2006 had anything to do with his death 11 days later.
4. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of the investigation. On this occasion, the Coroner has decided not to hold an inquest into the circumstances surrounding the death.

SOUTHWOOD APPROVED PREMISES

5. Probation Approved Premises provide a supportive, structured environment in the community for high risk and difficult to manage offenders. Approved Premises operate on each day of the year with 24 hour staff cover. Southwood is a 29-bed hostel, located in the St Michael's area of Liverpool. It is managed by a Senior Probation Officer. There is a deputy manager and a team of ten staff members, responsible for the daily management of residents. Between midnight and 7.00am each day, one member of staff sleeps at the hostel to provide support to a colleague who stays awake throughout the night.
6. Southwood has an open admissions policy based on assessment of risk. Potential residents are refused only if significant, unmanageable, risk is identified to the community, to other residents or to staff, or if a proper assessment cannot be made due to lack of information. Where potential residents are charged with violent or dangerous offences, the facts of the case and information about the individual are considered carefully before a decision is taken.
7. Residents are required to pay rent and to ensure that the hostel can obtain payment, if necessary, directly from benefits. The hostel provides a programme of activities and groups in which all residents are expected to participate.
8. All the residents are registered with a local GP surgery which staff report is able to provide appointments for the next working day. Residents who are prescribed medication are not physically given their prescriptions; rather, the GP surgery faxes the prescriptions to a local pharmacist who delivers the medication directly to the hostel. Southwood retains all prescribed medication in a locked cabinet and dispenses it at the required intervals to ensure there is no misuse.
9. When residents are subject to statutory supervision, pertinent information is shared regularly with field probation officers who act as case managers, responsible for decisions about the management of offenders.
10. The hostel operates a system of regularly checking on residents. There are four 'formal' checks, carried out at 7am, 7pm, 9pm and 11pm respectively. These times coincide with the various curfew times to which residents can be subject, although all residents are checked at the set times whatever their own curfew. During checks, it is usual practice for staff to enter residents' bedrooms.

KEY FINDINGS

11. The man who died was sentenced to two years imprisonment at Liverpool Crown Court on 26 July 2005. He was released on licence from HMP Liverpool on 13 April 2006. One condition of his release was that he reside at Southwood Approved Premises. He arrived at the hostel on the day of his release, as directed.
12. He was inducted into the hostel on 13 April, by a Probation Residential Officer (PRO). As part of the induction process, the man was asked to provide some basic information about his health. He disclosed that he suffered from high blood pressure. On the Basic Information Sheet, which is filled in as part of the induction, there is a question relating to current medical treatment, against which 'N/A' (not applicable) has been written. On the Medical Matters checklist, which is also completed as part of the induction, the following sections have been ticked (indicating problem areas): overweight, smoking, drugs, alcohol and depression. A Risk Of Self-Injury and Suicide screening was completed by the Senior Probation Officer, and the man gave his consent for medical information to be shared between the hostel, the hostel GP and other agencies. He chose not to nominate a next of kin, and 'None' was entered into the relevant section on the Basic Information Sheet.
13. As the man had previously been a resident at Southwood, he quickly settled into hostel life. He complied fully with the hostel regime and enjoyed positive relationships with fellow residents and staff alike. As required by the terms of his release from prison, he reported regularly to his supervising probation officer, and also attended a group work programme designed to help him address the causes of his offending behaviour. Significantly, he appears to have avoided consuming alcohol, and the consensus amongst the probation staff interviewed as part of the investigation was that he was committed to making positive changes in his life.
14. In the early part of his residency, the man who later died took Ramipril medication as prescribed by his GP. This drug is part of a family of medicines called Angiotensin Converting Enzyme (ACE) inhibitors, which expand the blood vessels and thereby reduce blood pressure in people who are at risk of heart failure. He was also prescribed Co-Codamol, a strong painkiller which he was allowed to take up to four times a day. Between 14 June and 21 June, he also completed a course of Flucloxacillin antibiotics, which were prescribed to treat an infected insect bite.
15. On 19 June, the man had an appointment with his GP. His Ramipril medication was discontinued and replaced by Atenolol, a beta-blocker used to treat high blood pressure, angina and chest pain. I have been unable to ascertain exactly why the Ramipril was discontinued, although it would not be unreasonable to surmise that he was suffering from unwanted side-effects. (For the record, the staff at Southwood independently stated that the man rarely, if ever, discussed health issues with them and nobody that was interviewed could recall why his blood pressure medication was changed.)

16. At 10.00am on 6 July, a resident at Southwood, told staff that the man who is the subject of this report was experiencing blurred vision, a numb left arm and a headache. The staff immediately telephoned the GP surgery for advice, and an appointment was made for the man to see the doctor later in the morning. The GP instructed him to go to the Royal Liverpool Hospital immediately, and another resident drove him there in his car at 11.55am. The man was subsequently admitted as an in-patient for the purposes of observation.
17. He remained at the hospital overnight. At 9.30am on 7 July, he telephoned Southwood from the Royal Liverpool and informed one of the PROs that he would probably be discharged from the hospital later in the morning. At 10.30am, he returned to the hostel and told a different PRO that he had been diagnosed with a migraine and discharged. He then went to his scheduled probation appointment with his supervising officer at Wirral Probation Centre.
18. At 11.20am, the hostel received a call from a staff nurse at the Royal Liverpool Hospital. The nurse informed the hostel staff that the man had not in fact been discharged by medical staff and that he left the hospital of his own accord. Hostel staff telephoned the man's supervising officer at Wirral Probation Centre to tell her that the man needed to telephone the nurse at the hospital as soon as possible. The man's supervising officer told my investigator that the man used the phone in her office to make the call, although she was not privy to what was discussed. He did not disclose to her what he talked about with the nurse, and she had no reason to interrogate him. The man who later died returned to Southwood at 4.20pm and settled into his normal routine. It would appear that no member of staff approached the man to ask him why he discharged himself from the hospital, apparently against medical advice.
19. On 11 July, the man had a further appointment with his GP. The doctor discontinued his Atenolol medication and replaced it with Lisinopril, another ACE inhibitor taken to control high blood pressure. Again, my investigator has been unable to ascertain why the man's primary medication was changed.
20. Over the next few days, the man who later died kept to his normal routine. He admitted to one of the PROs on more than one occasion that he continued to struggle with a migraine, but she had no reason to question whether this was indicative of something more ominous.
21. According to Southwood's closed circuit television system, the man went to his bedroom at 5.45pm on 17 July after dinner. At 7.00pm, a PRO commenced the formal 'curfew check' on residents. He started at room 1 and worked his way systematically through the hostel. Shortly after 7.00pm, he arrived at the door to the man's room, room 15, knocked and entered. He observed that the man was lying on his back and noticed that his eyes were fixed open. He shouted out to the man, but received no response. He then approached the man and touched him on his shoulder, which he discovered felt cold. At this point, the PRO who found the man "panicked" and ran downstairs to alert his colleague to what he had found.

22. The PRO who found the man in his room found his colleague in the general office and told him that he believed the man was dead. The pair of them made their way to room 15, one of them collecting a set of walkie-talkies along the way. Upon entering room 15, the colleague of the PRO who first found the man observed that he was lying on his back but his posture looked “contorted” and unnatural. Having approached the bed, he also saw that the man who is the subject of this report had been incontinent of urine and that his skin was visibly “off white”. He called out to the man, but receiving no response he checked his neck in search of a pulse. He could not find one. Whilst checking for a pulse, he too noticed that the man’s skin was cold to the touch. Based on his observations and his previous experience of discovering a deceased resident at the hostel, the staff member concluded that the man was dead and had been so for a period of time.
23. Whilst the staff member was in the process of conducting basic checks for signs of life, the PRO who first discovered the man in his bedroom contacted the emergency services using the telephone in the general office. The emergency services operator asked him a series of questions about the man’s presentation and appearance, which he relayed to the other member of staff via the walkie-talkie radio. After the emergency services operator suggested that mouth-to-mouth resuscitation be commenced, the staff member at the man’s bedside expressed a view that he had been dead for some time. He therefore did not initiate mouth-to-mouth resuscitation or any other form of emergency life support. An ambulance was dispatched to Southwood.
24. Around 7.10pm, whilst awaiting the arrival of the ambulance, one of the two members of staff on duty contacted the deputy manager of Southwood, who by chance was the on-call manager for all the Merseyside Approved Premises. (The on-call system operates to provide out of hours management support to hostel staff working nights, evenings and weekends.) He told the deputy manager that the man had been found dead in his room during the 7.00pm curfew check. After confirming that the emergency services had been summoned, the deputy manager took the decision to return to the hostel (his regular shift had ended about two hours earlier, around 5.00pm) to support the staff and residents.
25. The ambulance arrived at Southwood around 7.15pm. The paramedics conducted basic checks of essential life signs, before connecting a defibrillator machine to the man. According to the PRO who found the man in his room, the defibrillator indicated that ‘no shock’ should be administered. Shortly afterwards, the paramedics confirmed that the man was dead.
26. The deputy manager arrived at the hostel at some point between 7.30pm and 7.45pm. He says that police officers and the paramedics were already there when he arrived. He spoke to the two members of staff who were on duty to see if they were alright, and also talked to the residents, many of whom were left understandably shocked by the man’s death.
27. The deputy manager left the hostel around 9.50pm. The PRO who found the man in his bedroom finished his shift slightly late, at 10.30pm instead of

10.00pm. The remaining member of staff continued to work as scheduled, sleeping at the hostel overnight and leaving at 9.15am the next morning after conducting a formal handover with the on-coming day staff. He says that he did not get much sleep as a result of the man's death.

28. Prior to starting his next shift at 5.00pm on 18 July, the PRO who found the man received a telephone call from one of the hostel managers to ask if he was alright. He was offered the opportunity not to work that evening, but declined. He was also made aware of Merseyside Probation Area's Employee Assistance Programme, and he reported that he felt "supported" by the management team.
29. After finishing his shift at 9.15am on 18 July, the other member of staff who was on duty when the man was found had a rest day on 19 July and was scheduled to commence another sleepover shift at 4.45pm on 20 July. At no point between his shifts was he contacted by the hostel management to see if he was okay and fit to work on 20 July.
30. As the man who died had not provided the hostel with any next of kin details, it was not possible for Southwood to contact a family member to inform them of his death. The Coroner therefore assumed responsibility for informing his next of kin, who learned of his death after returning from a holiday on 24 July.

ISSUES

Southwood's response to the man's hospital admission

31. On the basis of the evidence collected as part of the investigation, there is nothing to suggest that anything more could reasonably have been done by Southwood to prevent or delay the man's death. He had a long history of substance abuse and suffered from high blood pressure which made him extremely vulnerable to heart failure, even at the relatively young age of 48. The fact that he had apparently managed to abstain from alcohol since his release in April 2006 would have done little to repair the damage caused by more than 20 years of chronic alcohol misuse.
32. That said, I was surprised to find out that the staff at the hostel responded to his admission to hospital on 6 July in the way they did. Shortly after the man returned to Southwood on the morning of 7 July, claiming that he had been discharged by the Royal Liverpool Hospital, staff received a telephone call from the hospital. The nurse who called made it clear that he had not been medically discharged and that he needed to contact the hospital immediately. As the man had left the hostel to attend a scheduled probation appointment, a member of hostel staff quite properly contacted the man's supervising probation officer to pass on the message. During his probation appointment, the man who later died was allowed to use the office telephone to call the hospital. He did not disclose to his supervising officer what the call was about and so she had no information to feed back to the staff at Southwood.
33. When the man returned to the hostel later that afternoon, it would appear that none of the staff approached him to ask why he had discharged himself from hospital against medical advice. As a minimum, I would have expected a member of staff to impress upon him the desirability of co-operating with medical treatment.
34. Whilst acknowledging that residents do have a right to privacy and the right to choose whether they co-operate with medical treatment, I think it would have been in the hostel's interest to attempt to find out more about the man's hospital admission. It seems self-evident that chronic health problems that necessitate a hospital admission could affect a resident's ability to comply or participate in the hostel regime. If, as seems likely in this case, a resident is not being totally frank about their health problems, the hostel is fully entitled to use the medical consent form that the resident signed upon reception to find out more.
35. I am not a great fan of 'checklists', as they encourage a mentality whereby the task of collecting information becomes more important than what the information collected actually says. However, hospital admissions and other significant medical events in residents' lives need to be followed up in a structured way, and the information collected needs to be shared amongst hostel staff and field probation teams as a minimum.

A formal system of following up discharges from hospital and other significant medical events should be introduced. The information obtained should be shared between hostel staff and field probation teams.

Support for staff involved in dealing with fatal incidents

39. After discovering the man dead in his room and finishing his shift slightly late at 10.30pm, one member of staff went home. The next morning, a few hours before he was due to start his next shift, he received a call at home from one of the two managers at Southwood (he cannot remember whom) and was asked whether he was alright. He was also asked if he would prefer not to work that evening, an offer he appreciated but in the event turned down. Upon his return to work he was spoken to by the hostel manager who made him aware of the Employee Assistance Programme that is available for all Merseyside Probation Area staff. The member of staff concerned told my investigator that he felt supported.
40. The experience of the PRO who found the man in his bedroom contrasts with that of the other member of staff who was on duty at the time. After checking the man for signs of life and contacting the on-call manager, he remained on duty until midnight, and then did the sleepover. He says that he was not offered the chance to leave early and, perhaps unsurprisingly, when he commenced his sleepover he says he could hardly sleep. He got up, as usual, at 7.00am to resume his duties, handing over to the day staff around 9.00am. He finished his shift at the hostel at 9.15am, more than 14 hours after the man who died had been discovered in his room.
41. His next shift at Southwood was another sleepover, which commenced at 4.45pm on 20 July. In the intervening period, nobody from the hostel called to see if he was okay and fit to return to work. The member of staff told my investigator that he did not feel supported.
42. The Chief Officer of Merseyside Probation Area has acknowledged that one of the two members of staff on duty at the time the man was found was not contacted by the hostel management between his shift ending on the morning of 18 July and his next one starting on the afternoon of 20 July. However, he says that his ability to continue working on the evening of 17 July was informally assessed by the on-call manager who attended after the man had been found. He also says that the member of staff was informed of the local Employee Assistance Programme. I have been assured by Merseyside Probation Area that the staff member's concerns will be explored more fully in one-to-one supervision, and I therefore refrain from making any recommendation relating to the support offered to staff after fatal incidents.

Emergency life support training

43. Based on the independent accounts of the two members of staff who were on duty when the man was found, one of whom had previously dealt with the death of a resident at Southwood, it would seem as though the man who died was beyond the point where emergency life support would have had any beneficial

effect when he was discovered. The PRO who found him in his bedroom told my investigator that the man was totally unresponsive when he called out to him, whilst his colleague could find no pulse and believed that the way his body was “contorted” indicated that rigor mortis had started to set in.

44. Whilst accepting that it is unlikely that any sort of emergency life support would have saved the man’s life, my investigator has established that none of the staff who were on duty on the evening of 17 July were trained in the most up-to-date emergency life support and resuscitation techniques. This raises questions about what would have happened if the man had been able to be resuscitated. Guidance in the area recommends that individuals receive training updates every twelve months. One of the staff who was on duty had done emergency life support training some years ago, whilst the other told my investigator that he has twice applied for a place on a first aid / emergency life support course in the last year, but on each occasion he was informed that the course was oversubscribed.
45. At the time of man’s death, two other members of staff were fully trained as first aiders. A further three have been trained in basic first aid, which includes Cardio Pulmonary Resuscitation (CPR) techniques, since the man’s death.
46. Whilst it would be desirable for all probation staff to be trained in administering emergency life support, I believe that hostel staff should be given priority when allocating training places as Approved Premises have a ‘duty of care’ as defined in law.

Merseyside Probation Area should review its provision of emergency life support training to ensure priority is given to Approved Premises staff when allocating places on training.

RECOMMENDATIONS

To the manager of Southwood Approved Premises

1. A formal system of following up discharges from hospital and other significant medical events should be introduced. The information obtained should be shared between hostel staff and field probation teams.

To Merseyside Probation Area

2. Merseyside Probation Area should review its provision of emergency life support training to ensure priority is given to Approved Premises staff when allocating places on training.