

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Ms Jennifer Smith-Dennis a resident at Bedford Approved Premises for Women on 8 August 2016

**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.

Ms Jennifer Smith-Dennis died on 8 August 2016 of pneumonia in hospital. She was 65 years old. I offer my condolences to Ms Smith-Dennis' family and friends.

The investigation found that staff at Bedford Approved Premises for women could not have prevented Ms Smith-Dennis' death. I am satisfied that staff monitored her closely when it was clear she was unwell and that they offered Ms Smith-Dennis the opportunity to go to hospital, which she declined. I am also satisfied that staff called an ambulance at an appropriate time.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

February 2017

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Summary

Events

1. Ms Jennifer Smith-Dennis had been living at Bedford Approved Premises for Women since 23 April 2015, after being released from HMP Send. Ms Smith-Dennis had chronic obstructive pulmonary disease (COPD – the name for a collection of lung diseases including chronic bronchitis and emphysema), asthma, osteoporosis (a medical condition that causes bones to become brittle and fragile) and heart problems. She took a range of medication for her conditions and was registered with the local community GP practice.
2. Throughout her time at the premises, Ms Smith-Dennis visited the community doctor. A nurse also visited the premises once every two weeks, and saw Ms Smith-Dennis to discuss her medical issues. However, records show that Ms Smith-Dennis was sometimes reluctant to report when she was feeling unwell, although staff encouraged her to do so. She also had a panic alarm on her, in case of emergencies, which she used once in February 2016.
3. On 7 August 2016, Ms Smith-Dennis returned to the premises with her son, and appeared to be unwell. She said was feeling, and appeared to be, better that evening and staff monitored her.
4. At 7.00am on 8 August, staff checked on Ms Smith-Dennis in her room, as is usual on a weekday. She was responsive, but had difficulty breathing and appeared very weak. Staff phoned an ambulance and paramedics arrived. After taking observations, they took Ms Smith-Dennis to hospital. Her health deteriorated over the day, and she died that evening. Two of her sons were with her when she died.

Findings

5. The investigation found that Ms Smith-Dennis' death could not have been prevented by staff at the approved premises. Staff encouraged her to take her medications and go to the doctors, although she was sometimes reluctant to do so. We were satisfied that Ms Smith-Dennis received a good level of care from the visiting nurse.
6. When staff saw Ms Smith-Dennis on the morning of 8 August, they assessed the situation promptly and called an ambulance appropriately, although Ms Smith-Dennis did not report being unwell and wanted to continue with her planned activities. We are pleased that they did so.

The Investigation Process

7. The investigator issued notices to staff and residents at Bedford Approved Premises for Women, informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
8. The investigator visited Bedford Approved Premises for Women on 15 August 2016. She obtained copies of relevant extracts from Ms Smith-Dennis' probation and medical records.
9. The investigator interviewed five members of staff of Bedford Approved Premises for Women over the telephone on 21, 22 and 29 September, and 5 October.
10. We informed HM Coroner for Bedfordshire District of the investigation who gave us the cause of death. We have sent the coroner a copy of this report.
11. One of the Ombudsman's family liaison officers contacted one of Ms Smith-Dennis' sons, to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He said that he wanted to know how the staff at the approved premises monitored Ms Smith-Dennis' weight loss and diet. He also wanted more clarification on what happened from 7 August and how his mother was found unwell on 8 August.
12. Ms Smith-Dennis' family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.
13. The initial report was shared with the National Offender Management Service, and with the National Probation Service. Neither found any factual inaccuracies.

Background Information

Bedford Approved Premises for Women

14. Bedford Approved Premises for Women provides accommodation for 17 women. It aims to manage the residents risk in the community and support them to move to independent living. A nurse visits the premises one day every two weeks, and the women register with the local doctor's surgery. The local pharmacy delivers medications to the premises. Medicines are mostly located in the office and provided to residents by staff as needed. A minimum of two staff are in the premises 24hours a day and a chef cooks meals daily.

Previous deaths at Bedford Approved Premises for Women

15. There have been no other deaths at the approved premises since the Prisons and Probation Ombudsman began investigating fatal incident in 2004.

Key Events

16. Ms Jennifer Smith-Dennis was released from HMP Send, after serving part of a ten year prison sentence for perverting the course of justice, to Bedford Approved Premises for Women on 23 April 2015. The next day, she saw the visiting nurse, who noted that Ms Smith-Dennis had chronic obstructive pulmonary disease (COPD – the name for a collection of lung diseases including chronic bronchitis and emphysema), asthma, osteoporosis (a medical condition that causes bones to become brittle and fragile) and heart problems. She took prednisolone, carbocisteine, tiotropium and sarbutamol for her COPD; accrete and alendronic acid for osteoporosis; clopidogrel and simvastatin for heart issues; topiramate for migraines; zapain and codeine as painkillers; omeprazole to reduce stomach acid; and flutiform for asthma. The nurse informed Ms Smith-Dennis that there was help available to stop smoking, which she declined. Ms Smith-Dennis registered with the local community GP practice.
17. Ms Smith-Dennis had treatment for cataracts, and was prescribed carbomer eye drops as well as her other medications. The local pharmacy delivered medications to the premises and Ms Smith-Dennis collected her medications, as needed, from the office, where staff kept them in a cupboard. Ms Smith-Dennis kept her inhalers for COPD and asthma with her.
18. As a result of Ms Smith-Dennis' COPD and frailty, staff at the premises gave her a panic alarm to alert staff if she needed help. She used this once on 18 February 2016, when she felt faint and unwell. Staff attended to her and thought she may collapse so they called an ambulance. Paramedics attended and after checking her, suggested she speak with her doctor. The doctor referred her for blood tests, which showed no abnormalities.
19. Following this incident, Ms Smith-Dennis gave the nurse permission to speak to her doctor. The nurse wrote letters to the doctor asking for advice on how to support Ms Smith-Dennis. The doctor responded on 9 May, informing her that, although a chest x-ray had been ordered, Ms Smith-Dennis had not gone to hospital to have one.
20. Ms Smith-Dennis' key worker at the premises saw her frequently. She stated that Ms Smith-Dennis told her she had been for the chest x-ray, even though she had not. When she asked Ms Smith-Dennis how she was, she frequently said she was ok even when she looked and seemed unwell. Residents told staff they thought Ms Smith-Dennis seemed unwell on 4 August, and staff also recorded that she did not seem well. They encouraged her to book a doctor's appointment, which Ms Smith-Dennis arranged for 8.30am on Monday 8 August.

Events from 7 August

21. On 7 August, Ms Smith-Dennis spent the day with her son, and returned to the approved premises at around 4.00pm. A member of staff accompanied Ms Smith-Dennis to her room. Ms Smith-Dennis found it hard to breathe and seemed unwell, but she declined the suggestion that she go to hospital.
22. Two members of staff, were on shift that evening. They decided to monitor Ms Smith-Dennis and call an ambulance if she became more unwell. Later that

evening, Ms Smith-Dennis reported feeling better and she came downstairs to make a cup of tea.

23. Both staff both finished work by 11.00pm and told the night staff about their concerns for Ms Smith-Dennis. They checked on Ms Smith-Dennis twice: once at 11.15pm (when all residents are seen to ensure they are well) and again at around 0.50am. At both times, Ms Smith-Dennis seemed well and appeared to be breathing without difficulty. They woke her the second time, and agreed not to check her again so that she could get an undisturbed night's sleep.
24. At 7.00am on 8 August, both staff checked Ms Smith-Dennis as part of the approved premises' weekday checks on their residents' wellbeing. Ms Smith-Dennis was awake, but she appeared to have been incontinent of urine, although she was not aware of this. She tried to sit up in bed to get ready for her day but could not. She appeared to be weak and had laboured breathing so the staff decided to call an ambulance. Paramedics arrived at 7.20am, and took her observations. While paramedics took Ms Smith-Dennis' observations, she was on the phone to her son and they asked her to put the phone down while they finished the observations. Ms Smith-Dennis called her son again later and informed him that she was going to hospital. Paramedics left the approved premises at 7.58am, to take Ms Smith-Dennis to hospital.
25. The key worker telephoned the hospital during the day for updates on Ms Smith-Dennis' health. During the first call, at about 11.00am, hospital staff said that she was ok. However, at around 5.00pm, a nurse told her that Ms Smith-Dennis might die that day. Ms Smith-Dennis died later that evening.

Contact with Ms Smith-Dennis' family

26. Two of Ms Smith-Dennis' sons were at the hospital with her on 8 August. They were in contact with the main point of contact, the Operational Manager, from that afternoon. She offered ongoing support. Ms Smith-Dennis' funeral was held on 5 September and the approved premises contributed towards the costs, in line with national policy. The approved premises also planned to build a memorial in the garden to Ms Smith-Dennis.

Support for residents and staff

27. After Ms Smith-Dennis' death, the Operational Manager ensured that staff knew how to access the care team if they felt they needed extra support. Staff within the approved premises also supported each other informally.
28. Staff at the approved premises told residents about Ms Smith-Dennis' death the next morning, and offered support.

Cause of death

29. The cause of death was given as lobar pneumonia. Toxicology tests were ordered by the Coroner, and there were no concerning results.

Findings

Clinical care

30. We were satisfied that Ms Smith-Dennis received good care from the visiting nurse and are impressed with this original idea that the approved premises set up. When the visiting nurse was not available, staff at the approved premises were aware of her various health conditions and encouraged her to seek medical help, although Ms Smith-Dennis was often reluctant.
31. There were two occasions on which staff at the approved premises contacted paramedics when Ms Smith-Dennis was unwell. These were both appropriate contacts. Staff at the premises monitored Ms Smith-Dennis according to her needs.

Emergency response

32. When staff checked on Ms Smith-Dennis at 7.00am on 8 August, her health had deteriorated from the day before. Staff realised that she was very unwell and called an ambulance. Throughout, she was talking but found it difficult to mobilise. Ms Smith-Dennis did not present as an emergency the day before, and declined to go to hospital. We are pleased that the next morning, staff called an ambulance promptly and treated Ms Smith-Dennis as an emergency.

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