Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Stephan Yeomans a resident at Southview Approved Premises on 21 December 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 Stephan Yeomans died on 21 December 2015, of chronic obstructive pulmonary disease (COPD) and heart disease, while a resident at Southview Approved Premises, York. He was 68 years old. I offer my condolences to Mr Yeomans' family and friends.

Mr Yeomans had been in poor health for some time. I am satisfied that staff at Southview Approved Premises appropriately supported Mr Yeomans and that there was nothing they could have done to have prevented his death.

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 **June 2016**

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Summary

Events

1. On 21 August 2015, Mr Stephen Yeomans was released from prison on a life licence and moved to Southview Approved Premises in York. Mr Yeomans had chronic obstructive pulmonary disease, asthma and osteoarthritis, which limited his mobility. Staff at Southview helped him to register with a local GP and he managed his own medication. He saw the GP eight times in four months for chest infections and breathing difficulties.

2. Staff at Southview called paramedics four times in November when Mr Yeomans had breathing difficulties. The first three times he would not go to hospital but on 30 November, he agreed and was admitted for treatment. The hospital discharged him on 15 December and he went back to Southview.

3. At about 9.20pm on 20 December, Mr Yeomans was slumped on the floor of his room after an evening out drinking. Staff helped him into bed and decided they should check him during the night. There were five recorded checks.

4. At 7.00am the next morning, a member of staff carried out a routine check to ensure that all residents were present and was satisfied that both Mr Yeomans and his roommate had responded when she knocked on the door of their shared room. At approximately 10.40am, Mr Yeomans' roommate noticed that he was unresponsive and alerted staff who could find no signs of life. The manager called an ambulance and at 10.57am, paramedics recorded that Mr Yeomans had died.

Findings

5. We are satisfied that staff at Southview supported Mr Yeomans well and encouraged him to seek medical attention when he needed it. During the night of 20/21 December, staff checked Mr Yeomans several times and recorded the checks in the logbook but not in a computerised record as the local policy expects. However, we are satisfied that the checks were made. The manager of the approved premises later identified that, as staff had decided to check Mr Yeomans' welfare during the night, it would have been better to have checked him again in person at the routine 7.00am check. She has revised procedures to reflect this. We do not consider that staff at Southview Approved Premises could have done anything to prevent Mr Yeomans' death and we do not make any recommendations.

The Investigation Process

6. The investigator issued notices to staff and residents at Southview Approved Premises informing them of the investigation and asking anyone with relevant information to contact him. Three residents responded.

7. The investigator visited Southview on 8 January 2016 and obtained copies of relevant extracts from Mr Yeomans' records.

8. The investigator interviewed three members of staff at Southview on 8 January and two members of staff by telephone on 20 January and 1 February.

9. We informed HM Coroner for York of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

10. Mr Yeomans' family received a copy of the initial report. They did not make any comments.

11. The initial report was shared with the Probation Service. The Probation Service pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

Southview Approved Premises

12. 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.

13. The National Probation Service manages Southview Approved Premises in York. Southview can accommodate up to 22 residents in five twin and 12 single rooms. The staff team consists of two psychologists, one Senior Probation Officer, six Probation Service Officers, five night support workers plus ancillary staff. Staff are on duty at Southview 24 hours a day.

HM Inspectorate of Probation

14. The most recent inspection of Adult Offending Work in York and North Yorkshire was in February 2014. Inspectors reported, in relation to Southview, that constructive interventions had been delivered to all residents.

Previous deaths at Southview Approved Premises

15. There have been no deaths at Southview since 2001.

Key Events

16. On 13 May 2005, Mr Stephen Yeomans was sentenced to life imprisonment for arson and violent offences with a minimum time to serve of three years and 11 months. Mr Yeomans had poor health, including chronic obstructive pulmonary disease (COPD – the name for a collection of lung diseases including chronic bronchitis and emphysema), asthma and osteoarthritis, which affected his mobility. In June 2012, Mr Yeomans was released on life licence (with a restriction on alcohol) to Southview Approved Premises. In October 2012, he was recalled to Hull for breaching his licence by drinking alcohol.

17. On 21 August 2015, Mr Yeomans was again released on licence to Southview. His licence required him to be of good behaviour but did not specify any restriction on alcohol. Staff at Southview helped him to register with a local GP. Mr Yeomans kept and managed his own medication at Southview.

18. From August to November, Mr Yeomans saw his GP eight times for breathing problems or chest infections. Staff arranged for the GP to see him at the approved premises for two of these appointments.

19. On 9 October, staff at Southview informed the hospital that Mr Yeomans was living at Southview and had health problems that might need future treatment at the hospital at some stage. This was a safeguarding action as Mr Yeomans had committed his offences at the hospital.

20. On 17, 19 and 24 November, staff at Southview called paramedics when Mr Yeomans had breathing problems. Each time he refused to go to hospital but accepted oxygen therapy.

21. On 30 November, staff called paramedics again when Mr Yeomans had chest pains. This time he agreed to go to hospital and was admitted for treatment. He responded well and the hospital discharged him back to Southview on 15 December.

22. At 9.20pm on 20 December, another resident told a night support worker that Mr Yeomans was slumped on the floor of his bedroom after being out drinking that evening. The night support worker helped him into bed and the evening staff decided that they should check his welfare throughout the night. Staff checked Mr Yeomans at 10.10pm, 11.05pm, 1.30am, 2.30am and 4.50am. Each time they recorded in the logbook that they had no concerns about him.

23. At 7.00am on 21 December, a relief probation service officer checked that all residents were present by knocking on their room doors and asking if they were awake. Mr Yeomans shared a room. She told us that she heard two voices in response and believed one of them was Mr Yeomans', so she did not check further. Mr Yeomans' roommate did not want to be interviewed for the investigation, so we have been unable to ask him whether Mr Yeomans responded at the time.

24. At approximately 10.40am, Mr Yeomans' roommate, who had got up earlier, went back to their room and found Mr Yeomans unresponsive in his bed. He alerted the relief probation service officer, who asked him to go to the office and inform a

senior probation officer. She went into the room and checked Mr Yeomans for signs of life. She could not feel a pulse, he was not breathing and he felt cool. Shortly afterwards the senior probation officer joined her. She was also unable to find a pulse and noted that he felt cold. They both considered that Mr Yeomans' had died and did not try to resuscitate him. At 10.48am, the senior probation officer called the emergency services. At 10.53am, paramedics arrived and at 10.57am, after checking Mr Yeomans, recorded that he had died.

Contact with Mr Yeomans' family

25. Mr Yeomans had not given any next of kin details. The police were able to secure details for his sister-in-law. The police contacted her on 21 December. She said that she was prepared to be the point of contact but neither she nor his family wanted to be involved. On 24 December, the senior probation officer phoned Mr Yeomans' sister-in-law, offered condolences and discussed funeral arrangements.

26. Mr Yeomans' funeral was on 22 January 2016. The National Probation Service contributed to the cost in line with national policy.

Support for residents and staff

27. After Mr Yeomans' death, at a meeting on 21 December, managers gave staff and residents the opportunity to discuss their feelings and offered support.

Post-mortem report

28. A post-mortem examination found that Mr Yeomans had died from chronic obstructive pulmonary disease and coronary artery atheroma (hardening of the arteries that supply the heart).

Findings

Clinical care

29. Mr Yeomans had chronic obstructive pulmonary disease and asthma before he arrived at Southview Approved Premises. Staff at Southview helped him register with a local GP when he arrived and either collected his medication for him or arranged for it to be delivered to Southview. Mr Yeomans looked after his own medication and was responsible for taking it as required.

30. As with anyone else in the community, Mr Yeomans was responsible for managing his own health and attending medical appointments. Nevertheless, staff at Southview helped Mr Yeomans manage his conditions and encouraged him to attend health appointments. When he was particularly unwell, they arranged for a GP to visit him at Southview or called paramedics. We consider that staff at Southview appropriately helped Mr Yeomans access community health services when necessary.

Monitoring checks and emergency response

31. On the evening of 20 December, staff were concerned about Mr Yeomans after he had been drinking and decided to check him throughout the night. Staff recorded five checks during the night in the logbook. Although the local policy expects such checks to be recorded on a computerised record, we are satisfied they were done, as recorded.

32. The local policy for routine curfew checks requires residents to respond verbally and the relief probation service officer believed that Mr Yeomans had responded at 7.00am. After Mr Yeomans' death, the manager of Southview recognised that this might not adequately account for a resident in a shared room who is also subject to welfare checks, and has changed the process. There is no evidence that Mr Yeomans did not respond at the 7.00am check, but we are satisfied that the manager has taken appropriate action.

33. When Mr Yeomans' roommate alerted staff that Mr Yeomans was unresponsive they checked for signs of life and noted his body was cold. They were satisfied that he was dead and that it would be futile to attempt resuscitation. While we would normally expect staff to try to resuscitate someone who is unresponsive, we accept the judgement of the staff that resuscitation would not have been possible.

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