

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Jon Hanson a resident at Felmores Approved Premises on 24 January 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*



© Crown copyright 2015

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3 or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: psi@nationalarchives.gsi.gov.uk.

Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

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 Jon Hanson died at Felmores Approved Premises, Basildon on 24 January 2016, of haemorrhage and fluid on the lungs caused by heart failure. He was 40 years old. I offer my condolences to Mr Hanson's family and friends.

Mr Hanson had lived at Felmores for only 12 days, after his release on licence from HMP Highpoint. He died very suddenly and I am satisfied that staff at the approved premises could not have predicted or prevented Mr Hanson's death. However, there was a delay in informing his family of his death, because staff had not recorded his next of kin details.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

June 2016

Contents

| | |
|---------------------------------|---|
| Summary | 1 |
| The Investigation Process | 2 |
| Background Information | 3 |
| Key Events | 4 |

Summary

Events

1. On 12 January 2016, Mr Jon Hanson was released on licence from HMP Highpoint and was required to live at Felmores Approved Premises.
2. Mr Hanson suffered from epilepsy and depression, for which he took medication. When he arrived at Felmores, a key worker assessed his risk and decided he could keep supplies of his medication to administer himself.
3. Shortly before midnight on Saturday 23 January, Mr Hanson spoke to other residents for a few minutes before he went into his room for the night.
4. At approximately 1.30pm on Sunday 24 January, a member of staff checking rooms could not get a reply from Mr Hanson. He went into his room and found Mr Hanson unresponsive, lying between the bed and the wall. He ran downstairs to get help from another member of staff and they went back to Mr Hanson's room. Mr Hanson did not appear to be breathing and they called an ambulance. They decided not to attempt resuscitation, as it was apparent from signs of rigor mortis that Mr Hanson had been dead some time. A paramedic arrived and confirmed Mr Hanson's death.
5. A post-mortem examination found that Mr Hanson had died from sudden heart failure causing fluid to accumulate on his lungs, which then bled. There is nothing in the records to indicate that he had ever suffered from symptoms of respiratory or heart problems.

Findings

6. Mr Hanson died suddenly and unexpectedly and we are satisfied that staff at the approved premises could not have predicted or prevented his death. The emergency response after staff found Mr Hanson unresponsive was appropriate. Sadly, it was apparent that Mr Hanson had been dead for some time and staff made an appropriate decision not to attempt to resuscitate him.
7. The approved premises did not have up to date contact details for Mr Hanson's next of kin, which delayed informing his mother of his death.

Recommendation

- The Manager of Felmores Approved Premises should ensure that staff record next of kin details in each resident's file when they arrive and that this information is readily accessible.

The Investigation Process

8. The investigator issued notices to staff and residents at Felmores Approved Premises informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
9. The investigator visited Felmores on 29 January 2016. He obtained copies of relevant extracts from Mr Hanson's records.
10. On 18 February, the investigator interviewed one member of staff at Felmores. On 25 February, he interviewed another member of staff by telephone.
11. We informed HM Coroner for Essex and Thurrock of the investigation, who gave us a copy of the post-mortem and toxicology reports. We have sent the coroner a copy of this report.
12. One of the Ombudsman's family liaison officers contacted Mr Hanson's mother, to explain the investigation. His mother had no specific concerns for the investigation to consider.
13. Mr Hanson's family received a copy of the initial report. They pointed out some factual inaccuracies and/or omissions. This report has been amended accordingly.
14. 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

Felmores Approved Premises

15. 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 healthcare and expected to register with a GP.
16. Felmores Approved Premises in Basildon, Essex, is managed by the National Probation Service. It has twenty-four single rooms and one shared room. Breakfast and evening meals are provided and there is a communal area for eating and socialising. Each resident has a key worker to oversee their progress and well-being and that they adhere to their individual licence conditions and the premises' rules. Staff are on duty at Felmores 24 hours a day.

Previous deaths at Felmores

17. Mr Hanson was the first person to die at Felmores since 2011. There were no similarities with the circumstances of the other death.

Key Events

18. On 12 January 2016, Mr Hanson was released on licence from HMP Highpoint and was required to live at Felmores Approved Premises, Basildon. Shortly before his release, a pre-release clinic at Highpoint had noted his medication as mirtazapine (30mg) for depression, pregabalin (100mg) and epilim (300 tablets) for epilepsy, and omeprazole (20mg), to reduce stomach acid. There was no record that Mr Hanson had ever had any heart or respiratory problems.
19. When he arrived at Felmores on 12 January, Mr Hanson's key worker went through his licence conditions and the rules of the premises with him. She noted his medication and completed a risk assessment to assess whether Mr Hanson could keep his medication. She concluded that Mr Hanson was low risk and able to keep his medication to administer himself.
20. Mr Hanson had a single room on the first floor, which he could lock at night. He was registered with the same community GP, as before his sentence. Mr Hanson did not mention any health problems to staff at Felmores.

Events of Sunday 24 January

21. On the night of Saturday 23 January, Mr Hanson had gone to his room shortly before midnight. (CCTV shows he closed his door at 11.59pm.) He had spoken to other residents in the first floor corridor for a few minutes before.
22. At 8.00am on 24 January, two sessional probation workers took over from night staff. As it was a Sunday, they were the only two members of staff on duty. At approximately 12.00pm, Probation Worker A went to the dining room to supervise the residents' lunch and Probation Worker B remained in the reception area. Mr Hanson did not come down for his lunch.
23. After lunch, at 1.00pm, Probation Worker B decided to do the daily room checks and took a set of keys with him. He did not take a radio with him although these were available to allow staff doing checks to contact other staff on duty.
24. Probation Worker B checked the rooms on the ground floor first, so he did not arrive at Mr Hanson's room until approximately 1.30pm. He knocked on the door twice, but did not get an answer so he unlocked the door. When he went in, he found Mr Hanson face down between the bed and the wall. He called him again, but Mr Hanson did not respond. He ran downstairs to get his colleague.
25. When they got back to Mr Hanson's room, Probation Worker B noted that Mr Hanson did not appear to be breathing. He could not check for a pulse in his wrist because Mr Hanson was in an awkward position, but he could not find a pulse in his neck. Probation Worker A telephoned for an emergency ambulance and the ambulance service operator advised that they should place Mr Hanson on his back to start cardiopulmonary resuscitation. Probation Worker B lifted the bed onto one side to get better access. They were then able to see that Mr Hanson was clearly dead with signs of rigor mortis.

26. Probation Worker A informed the ambulance service that they still needed a paramedic. A paramedic arrived at 1.46pm and, at 1.50pm, recorded Mr Hanson's death.

Contact with Mr Hanson's family

27. Both probation workers were unable to find any contact details for Mr Hanson's next of kin in his records. The police made enquiries, obtained an address for Mr Hanson's mother, and informed her of his death, late on 25 January. A probation manager telephoned Mr Hanson's mother on 26 January to offer his condolences and ongoing support. On 29 January, Mr Hanson's partner visited the Felmores to collect his belongings.
28. Mr Hanson's funeral was on 24 February and a probation manager attended with two Felmores residents. The Probation Service contributed to the cost, in line with national policy.

Support for residents and staff

29. On 24 January, an out of hours manager telephoned and offered immediate advice and support to both the probation workers. On 25 January, two managers spoke to both members of staff and offered additional support.
30. On 24 January, Probation Worker B told the other residents who were present that Mr Hanson had died. Notices were posted to inform all staff and residents of Mr Hanson's death, and offering support. On 26 January, there was a meeting open to all residents for additional support.

Post-mortem report

31. A post-mortem examination found that Mr Hanson died of a haemorrhagic pulmonary oedema with underlying acute left ventricular failure (haemorrhage and fluid on the lungs caused by heart failure). The post-mortem report noted that pregabalin (epileptic medication) was present above the therapeutic level but this did not cause death.

Findings

Emergency Response

32. Probation Worker B started room checks at 1.00pm, the first time rooms had been checked that day. The staff had checked the electronic curfew system earlier to establish that all residents were in the building at the time. There is no set time for room checks to take place and the approved premises manual indicates that building tours, including checks of resident's rooms, should be at random times rather than on a fixed schedule.
33. Residents of approved premises are entitled to have their privacy respected and we consider that, particularly on a Sunday, there is no overriding need for room checks early in the morning, unless an individual resident has been identified as vulnerable. As it appears that Mr Hanson had died some time during the night, in this case, an earlier check would not have made a difference to the outcome.
34. Although Probation Worker B had not taken a radio when he was checking the rooms, there was no real delay in calling an ambulance. Sadly, when the staff assessed Mr Hanson further, it was apparent that he had died some time earlier. We are satisfied that the staff made an appropriate decision not to try to resuscitate him. Mr Hanson's death was sudden and unexpected and there was nothing staff at the approved premises could have done to prevent it.

Family contact

35. The approved premises manual states that staff must ask all residents when they arrive, to name two people who are willing and able to act as their next of kin. Staff should record their names (with addresses and phone numbers) in the resident's file.
36. Both probation workers tried to find Mr Hanson's next of kin details by checking his paper file and electronic case record, but could not find them. This meant that Mr Hanson's mother was not informed of his death until late the next day. We make the following recommendation:

The Manager of Felmores Approved Premises should ensure that staff record next of kin details in each resident's file when they arrive and that this information is readily accessible.

Medication in possession

37. Toxicology tests after Mr Hanson's death showed potentially toxic levels of pregabalin in his body, which would suggest that Mr Hanson had taken more than his prescribed dose. The toxicologist noted that on overdose of pregabalin was not likely to cause death. We are satisfied that staff at Felmores carried out an appropriate risk assessment to allow Mr Hanson to hold his medication in his possession rather than collecting it daily from staff. There were no indications that he was at risk of overdose or not able to manage his own medication.

**Prisons &
Probation**

Ombudsman
Independent Investigations