

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Ronald Napier a resident of Ellison House Approved Premises on 22 December 2017

**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*



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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.

Mr Napier died of a heart attack on 22 December at Ellison House Approved Premises. He was 63 years old. We offer our condolences to Mr Napier's family and friends.

Mr Napier had been a resident at Ellison House for only a month before his death. We are satisfied that staff there could not have predicted or prevented his death and that they quickly began cardiopulmonary resuscitation after finding him unresponsive. We commend the resident who actively assisted with the resuscitation attempts.

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

**Elizabeth Moody**  
**Acting Prisons and Probation Ombudsman**

**June 2018**

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# Summary

## Events

1. Mr Ronald Napier was released from prison, on licence, on 22 November 2017. He arrived at Ellison House Approved Premises the same day. Staff inducted him and he settled well.
2. Mr Napier registered with a local GP and last attended on 18 December with symptoms of a pain in his leg.
3. Between 7.30am and 8.00am on 22 December, Mr Napier and another resident had a conversation in his room. At approximately 8.23am, the resident returned to Mr Napier's room and found him lying, unresponsive, on his bed. He quickly informed a member of staff. At 8.24am, the security officer called an ambulance, while the staff member and the resident immediately began cardiopulmonary resuscitation. Paramedics attended at 8.30am and continued the resuscitation attempts. At 9.33am, they confirmed that Mr Napier had died.
4. The police decided to inform Mr Napier's next of kin, his son, of his death and they tried to do so face to face. They found that Mr Napier's son had moved abroad and telephoned him the next day. The manager of Ellison House subsequently contacted him to offer condolences and support.
5. A post-mortem examination concluded that Mr Napier had died of a heart attack.

## Findings

6. Mr Napier died suddenly and unexpectedly. We are satisfied that after he was found, resuscitation attempts began immediately and staff requested an ambulance without delay.
7. Although there was a delay of around 24 hours in notifying Mr Napier's next of kin, this was beyond the control of Ellison House staff.

## The Investigation Process

8. The investigator issued notices to staff and residents at Ellison House Approved Premises informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
9. The investigator visited Ellison House on 12 January 2012. She obtained copies of relevant extracts from Mr Napier's personal records.
10. The investigator interviewed one member of staff by telephone on 22 January. She attended Ellison House on 25 January and interviewed two further members of staff and a resident.
11. We informed HM Coroner for Inner South London District of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
12. The investigator wrote to Mr Napier's son, his next of kin, to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He did not respond.
13. We shared the initial report with HM Prison and Probation Service and they found no factual inaccuracies.

# Background Information

## Ellison House Approved Premises

14. Approved premises, previously known as probation and bail hostels, accommodate offenders released from prison on licence and those directed 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.
15. The National Probation Service manages Ellison House Approved Premises. It has 30 bedrooms. Each resident has a key worker to oversee their progress and wellbeing and to help them adhere to licence conditions and the Approved Premises' rules. Staff are on duty 24 hours a day to monitor residents' behaviour and report to their offender manager. They conduct wellbeing checks of residents at 8.30am, 3.00pm, 7.00pm and 11.30pm each day.

## Previous deaths at Ellison House

16. We have investigated two previous deaths at Ellison House. The second death was also caused by heart disease, but there were no other similarities to the circumstances of Mr Napier's death.

## Key Events

17. On 27 March 2003, Mr Ronald Napier was convicted of murder and sentenced to life imprisonment. On 22 November 2017, he was released from HMP Leyhill, on licence, to live at Ellison House Approved Premises, Camberwell. Staff and residents had known him for several months as he had stayed there during periods of temporary release from prison. Mr Napier had no known health concerns when he arrived.
18. Mr Napier's key worker completed his induction and assisted him with actions such as registering with a GP at Manor Place Surgery and dealing with financial matters. The contact details of his next of kin were noted in his records.
19. Mr Napier adhered to Ellison House's rules and fully complied with the conditions of his licence. Random drug and alcohol test results were negative. He was popular and had a good rapport with staff and other residents. Mr Napier rarely went out and spent a lot of time in his room, so staff would conduct additional checks to ensure that he was alright.
20. Mr Napier had repeatedly complained of a pain in his leg. He went to see his GP on 18 December and told staff he had been advised to rest.
21. Mr Napier became friends with resident A. On the evening of 21 December, they both watched television in resident A's room until around 10.00/10.30pm. During the curfew checks between 11.00 and 11.30pm, a staff member saw Mr Napier in bed in his room. When asked if he was okay, Mr Napier said 'yes'.
22. At around 7.30am on 22 December, resident A went into Mr Napier's room and they had a conversation. Resident A left the room, but returned a short time later. (He believed this was shortly before 8.00am, but CCTV footage and the weight of evidence from other witnesses indicate that this was at approximately 8.23am.) He saw Mr Napier lying on his bed, unresponsive. He tried to rouse him by tapping on his collarbone, but there was no response. Resident A then ran downstairs to the reception area and told the staff member what had happened.
23. The staff member had started the morning wellbeing checks at around 8.15pm, but he had not yet gone to Mr Napier's room. CCTV records shows he went upstairs with resident A at 8.24am and saw Mr Napier lying across his bed, with his arms spread out and his legs on the floor. The staff member, who was a trained first aider, shouted and shook Mr Napier, but there was no response. He immediately radioed the security officer to request an ambulance. The staff member and resident A began cardiopulmonary resuscitation (CPR) straightaway. Resident A gave breaths while the staff member carried out chest compressions.
24. The security officer called an ambulance immediately, at 8.24am (confirmed by ambulance records). The ambulance service call handler instructed him to take the defibrillator to the room and the staff member attached it to Mr Napier.
25. The first ambulance arrived at 8.30am and paramedics were with Mr Napier by 8.33am, followed by two further crews a few minutes later. The paramedics asked the staff member and resident A to continue resuscitation while they

administered medication. The defibrillator then gave four shocks. The paramedics were unable to revive Mr Napier and confirmed his death at 9.33am.

### **Contact with Mr Napier's family**

26. The police officers who attended the incident regarded it as their role to notify Mr Napier's next of kin of his death and that they should do so in person. The manager of Ellison House gave the officers the contact details for Mr Napier's son and asked to be informed promptly after they had contacted him so that she could speak to him personally. She told them about suggestions from residents that he had moved to Spain. The manager also gave the police the telephone number for Mr Napier's daughter-in-law, who lived in London, emphasising that they should inform Mr Napier's son quickly as residents were likely to call her.
27. When the police arrived at the address recorded for Mr Napier's son, they found it occupied by tenants. They notified him by telephone the day after Mr Napier's death. By that time, a resident had already told his daughter-in-law and this caused some tension within the family.
28. The manager spoke to Mr Napier's son on the day the police broke the news to him. She offered her condolences and explained the procedures to be followed. In the following weeks, she gave continuing support and he visited Ellison House to collect Mr Napier's property. In line with national instructions, the Probation Service contributed to the costs of Mr Napier's funeral, which was held on 5 January 2018.

### **Support for residents and staff**

29. After Mr Napier's death, the manager spoke to staff individually to offer support and gave them the contact details for the employee assistance programme. A senior manager also attended to support staff. Trauma support specialists held a debrief and support session for all staff on 15 January. Staff told the investigator they felt well supported.
30. The manager and Ellison House staff informed the other residents individually and posted notices about Mr Napier's death. They offered immediate support and arranged for additional support from the Samaritans.

### **Post-mortem report**

31. The post-mortem examination confirmed the cause of Mr Napier's death as 1a acute myocardial infarction, 1b coronary artery atherosclerosis. (A heart attack caused by 'hardening' or 'furring up' of the arteries - a condition that reduces the blood supply to the heart.)

# Findings

## Management of Mr Napier

32. Approved premises staff fully inducted Mr Napier. They also helped him with personal matters, such as registering with a GP and booking an appointment when he reported leg pain a few days before his death.
33. Mr Napier died unexpectedly and we consider that staff could not have predicted or prevented his death.

## Emergency response

34. Mr Napier was found unresponsive less than an hour after he was last seen alive. Staff telephoned to request an ambulance within a minute of finding him and it arrived six minutes later. The staff member and resident A began CPR and, on the instructions of the ambulance dispatcher, they used the defibrillator.
35. We are satisfied that there was no delay in calling an ambulance and that the staff member, assisted by resident A, began the resuscitation attempts immediately.

## Family liaison

36. The Approved Premises Manual sets out the expected procedures and standards for notifying a resident's family of their death. It says that a representative of the approved premises should contact the resident's family immediately, in most cases face-to-face. The exception is where a GP has certified the death, in which case the police notify them of the death.
37. The police officers who attended Ellison House during the emergency asserted that it was the responsibility of the police service to break the news of Mr Napier's death. The manager gave them as much information as possible and stressed the urgency. Unfortunately, through no fault of Ellison House staff, the police were initially unable to contact Mr Napier's son and they did not tell him about his father's death until the following day. In the meantime, a resident had telephoned Mr Napier's daughter-in-law, so she learned of Mr Napier's death before his son.
38. Ms Roye understandably acted on the instructions of the police officer. We are satisfied that she did her best to pre-empt any delay in notifying Mr Napier's son and that it would not have been possible for the Probation Service to do this face-to-face, given that he was living abroad.

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