Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael Quinn a resident at Nelson House Approved Premises on 25 January 2019

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 I oversee can improve their work in the future.

Mr Michael Quinn died in hospital on 25 January 2019 following a cardiac arrest at Nelson House Approved Premises. Mr Quinn was 49 years old. I offer my condolences to Quinn's family and friends.

Mr Quinn was only at Nelson House for three days after being released from prison on licence. He did not show signs of being unwell before he died and I am satisfied that staff at Nelson House could not have foreseen or prevented his death.

I am also satisfied that staff at Nelson House responded promptly and professionally when Mr Quinn collapsed.

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

Sue McAllister CB
Prisons and Probation Ombudsman **August 2019**

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Summary

Events

1. On 22 January 2019, Mr Michael Quinn was admitted to Nelson House Approved Premises, Middlesbrough, after being released from prison on licence. During his induction, Mr Quinn disclosed that he had arthritis and epilepsy but did not mention any other health concerns.

2. Mr Quinn had prescribed medication locked in the reception medication cabinet. Staff noted that Mr Quinn was going to register with a GP. Two days later, they recorded that he was going to see his GP to collect more medication.

3. On the morning of 25 January, Mr Quinn went out to have a cigarette in the smoking area of the grounds of Nelson House. At approximately 7.15am, another resident discovered him unresponsive and informed reception staff. Staff immediately called for an emergency ambulance and provided life support to Mr Quinn while they waited.

4. The ambulance crew took Mr Quinn to hospital. He did not recover and was pronounced dead at 9.05am.

Findings

Mr Quinn's clinical care

5. We are satisfied that staff at Nelson House could not have reasonably foreseen that Mr Quinn had a serious underlying health condition. They did all they reasonably could to ensure he was registered with his own GP.

Emergency response

6. We consider that the emergency response was appropriate once staff became aware that Mr Quinn had collapsed.

Contact with Mr Quinn's next of kin

7. We are satisfied that Nelson House conducted its contact with Mr Quinn's next of kin appropriately.

Recommendations

- We make no recommendations.

The Investigation Process

8. The investigator issued notices to staff and residents at Nelson House Approved Premises informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

9. The investigator visited Nelson House on 7 February 2019. He obtained copies of relevant extracts from Mr Quinn's probation records. The investigator also interviewed three members of staff and one resident during his visit.

10. We informed HM Coroner for Teesside of the investigation. She gave us the results of the post-mortem examination, and we have sent the coroner a copy of this report.

11. One of the Ombudsman's family liaison officers wrote to Mr Quinn's girlfriend, to explain the investigation and to ask whether she had any matters she wanted the investigation to consider. She did not respond to our letter.

12. The initial report was shared with the National Probation Service (NPS). NPS did not find any factual inaccuracies.

Background Information

Nelson House Approved Premises

13. Approved Premises (or APs, 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 are expected to register with a GP.

14. Nelson House, in Middlesbrough, is managed by the National Probation Service. It can accommodate up to 23 residents. Nelson House is staffed by Probation Service employees who are on duty 24 hours a day. Sodexo provide security staff and cleaners. Staff on reception keep each resident's medication locked away and administer it as required. Nelson House staff are not clinically trained other than to distribute medication.

15. Residents are subject to AP rules on top of any licence conditions they have been given. They are not permitted to leave the building between 11.00pm and 6.00am. They are also not permitted to smoke while in the building. Nelson House has an external smoking area with a separate covered shed.

Previous deaths at Nelson House

16. Mr Quinn's death was the second death at Nelson House, the previous one occurring in 2012. There were no similarities between this death and that of Mr Nelson.

Key Events

17. On 22 January 2019, Mr Michael Quinn was release on life licence from HMP Northumberland. Mr Quinn's licence conditions required him to live at Nelson House Approved Premises (AP), Middlesbrough. He had a condition to comply with his supervising officer to address his offending behaviour in relation to alcohol and drug abuse, as well as anger management. Mr Quinn was subject to a daily curfew requiring him to be at Nelson House between 8.00pm and 7.00am.

18. A staff member conducted Mr Quinn's induction on his arrival at Nelson House. She explained the AP rules, including that he had to be in the AP after 8.00pm and a ban on smoking inside the building. Mr Quinn provided the contact details for his next of kin. He disclosed that he had arthritis and epilepsy but did not mention any other health conditions. The medication he had brought with him was booked in and locked in the reception medication cabinet.

19. The following day, a staff member noted that Mr Quinn was going to register with a GP practice located near his girlfriend's house because he hoped to move there when he left Nelson House. She also recorded that he only had three days of his medication left. Nelson House agreed to extend Mr Quinn's curfew to 10.00pm, due to the distance and transport difficulties between there and his girlfriend's house.

20. On the morning of 24 January, a staff member recorded that Mr Quinn said that he was going to see his GP to collect medication. That evening, an agency support worker recorded that Mr Quinn had been out for a smoke but that the 11.00pm checks were all in order.

21. A sessional support worker was also on duty that night. In interview, he explained that his was an interim role with the National Probation Service pending security clearance. He recorded that Mr Quinn had been in another resident's room that evening. He said that he had to speak to Mr Quinn that night because he was restless, knocking on other resident's doors, and making a lot of noise. He said that Mr Quinn told him he was nervous because he was going to see his girlfriend the next morning for the first time since his release.

22. In Interview, the agency support worker said that he spoke to Mr Quinn the following morning. He was laughing and joking because he was excited about seeing his girlfriend for the first time since being released. He said that Mr Quinn's curfew ended at 7.00am, so he went out for a cigarette while he waited. He said that Mr Quinn was accompanied by two other residents when he went out.

23. The sessional support worker said that Mr Quinn had come to the office that morning, at some time before 7.00am, to collect his medication and to collect extra medication for that day. He said that Mr Quinn was excited about going to see his girlfriend and that they had a playful conversation about it. He said that Mr Quinn went out for a cigarette, while he waited for his curfew to expire so he could leave the premises.

24. A resident said in interview that Mr Quinn came to his room at about 3.00am during the night to ask for a cigarette. He gave him a couple of cigarettes so that

he could go back to sleep. The resident said that he came down to reception at approximately 6.00am the following morning and had a cup of tea with Mr Quinn and another resident. He said they then went out to the smoking area for a cigarette. The resident said that Mr Quinn went upstairs and returned with his bag and walking stick. He said that Mr Quinn then went outside again.

25. The resident said that after 10-20 minutes, he went out for another cigarette and sat with another resident. He said that he turned around and, in the pre-dawn darkness, saw what looked like a shadow on a chair near the covered smoking area. He said that he walked over and realised it was Mr Quinn. He tapped Mr Quinn's face and called his name but did not get a response. He said that Mr Quinn's face was freezing cold, so he ran into the office and told the staff on reception that he thought Mr Quinn was dead. He said that he immediately ran back outside and, with the help of the other resident, laid Mr Quinn flat on the floor. He said that he then ran back into reception and asked staff to come out and help. The sessional support worker grabbed the emergency bag and followed him out.

26. The sessional support worker said that at approximately 7.20am, a resident ran in and was very flustered. He said that the resident asked him to come out quickly but was not making a lot of sense. The sessional support worker said that he asked the agency support worker for the emergency bag and went straight out. He said that he could not get any response from Mr Quinn but that it was hard to tell whether he was breathing or not because he was wearing so many layers of clothes. He said that he could just feel a pulse, so he checked his airways and then started cardiopulmonary resuscitation (CPR). He said that, at one point, Mr Quinn vomited so he had to stop giving him breaths. He asked a resident to inform the agency support worker that an ambulance was definitely required and to bring the defibrillator. He said that, shortly afterwards, the agency support worker appeared with the defibrillator. The sessional support worker said that the ambulance arrived before he had been able to attach the defibrillator.

27. The agency support worker said that he recalled a resident rushing into reception saying, "He's collapsed." He said that he thought this was one of the other residents who had looked "off his face" (that is, under the influence of drugs or alcohol) earlier. He said that the sessional support worker went outside to respond to the incident while he phoned for an ambulance. He said that he informed the ambulance operator that CPR was underway and that the defibrillator was in situ. He said that, after a short time, the sessional support worker called him to come out and assist with chest compressions because he was getting tired. He went to help.

28. The ambulance crew continued to provide life support to Mr Quinn for several minutes. The sessional support worker said that at one point they accepted his offer to help with CPR. The ambulance crew took Mr Quinn to James Cook University Hospital, Middlesbrough.

29. The sessional support worker telephoned the manager of Nelson House AP to inform her of the incident. At 8.50am, the manager arrived at Nelson House.

She recorded that, at 9.05am, the hospital telephoned to say that Mr Quinn had died.

30. CCTV footage was unable to show the smoking area clearly due to the dim light at that time. It shows that, at 7.16am, a resident left the building. The sessional support worker followed later, at 7.17am. Footage shows that the ambulance arrived at 7.29am.

Post-mortem report

31. The post-mortem concluded that Mr Quinn died from cardiac arrest and cardiac dysrhythmia (an abnormal heartbeat). It noted that this was caused by coronary occlusion (obstructed blood flow in the arteries) which was in turn caused by coronary artery atherosclerosis (a build-up of plaque in the arteries).

32. Toxicology testing was not performed. The coroner stated that there was a clear physical cause for the cardiac arrest so it was not necessary to test for drugs.

Contact with Quinn's next of kin

33. Mr Quinn's next of kin was his girlfriend. Shortly after Mr Quinn collapsed, the agency support worker telephoned to inform her that Mr Quinn had been taken to James Cook University Hospital. The sessional support worker said that shortly afterwards, the hospital called him to say that Mr Quinn had died. The hospital asked for the contact details of his next of kin and these were provided.

34. The AP manager said that the police told her that the hospital had informed Mr Quinn's girlfriend of his death. She said that a letter was sent to Mr Quinn's girlfriend the same day. On 28 January, Mr Quinn's girlfriend spoke to the AP manager on the telephone and left contact details for Mr Quinn's sister. The AP manager recorded that she called Mr Quinn's sister on a number of occasions but there was no answer. She continued to liaise with Mr Quinn's girlfriend.

35. Mr Quinn's funeral was held on 6 March. The Probation Service contributed to the costs in line with national guidance.

Support for prisoners and staff

36. After Mr Quinn's death, the AP manager offered support to the sessional support worker. She told him that he did not have to work his next shift but he declined this offer. The AP manager also gave him details for counselling services in case he required them.

37. The agency support worker said that he did not have direct access to support because he did not work for the National Probation Service. He spoke to his manager who said he was available to offer support, if needed. He was also offered time off but preferred to come to work.

38. The following day, the AP manager held a residents' meeting to inform them of Mr Quinn's death and to offer support.

Findings

Mr Quinn's clinical care

39. We consider that Nelson House managed Mr Quinn's health concerns appropriately. Although Mr Quinn appears to have had an underlying medical condition, staff at APs are not clinically trained and can only assist residents to seek their own medical advice. The AP had documented that he had been seeing a GP and collecting medication when his own supply was running low. There was no indication that Mr Quinn was unwell during his brief time at Nelson House.

Emergency response

40. We are satisfied that AP staff conducted the emergency response appropriately. As soon as they became aware that Mr Quinn had collapsed, they responded promptly and called an ambulance immediately. The sessional support worker performed life support commendably, and was asked by the ambulance crew to assist them once they arrived.

Mr Quinn's next of kin contact

41. The Approved Premises Manual recognises that it can sometimes be difficult to establish the next of kin for a resident although it does require APs to keep a record of next of kin. It also requires APs to appoint a responsible member of staff to act as the family liaison officer in the event of a resident's death, and to remain the main point of contact. The Manual also states that the next of kin should be the person who staff contact in the event of a resident's death, unless this is being done by the police.

42. We are satisfied that staff at Nelson House conducted their next of kin contact appropriately. At his induction, Mr Quinn informed staff of the contact details for his nominated next of kin - his girlfriend - and staff recorded this on his record. When Mr Quinn was taken to hospital, staff immediately telephoned his girlfriend to inform her. Following his death, staff immediately provided these contact details to the hospital who then informed his girlfriend. The AP manager then assumed the role of main point of contact. We recognise that the AP manager was unable to make contact with Mr Quinn's sister after her details were provided by Mr Quinn's girlfriend but we accept that she did all she reasonably could to do so.

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