

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Peter Hewson a resident at Fleming House Approved Premises on 24 March 2019

A report by the Prisons and Probation Ombudsman

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 Peter Hewson died from alcoholic cardiomyopathy (heart failure caused by chronic alcohol misuse) on 24 March 2019 at Fleming House Approved Premises. Mr Hewson also had liver cirrhosis (scarring of the liver caused by long-term liver damage) which contributed to but did not cause his death. He was 65 years old. I offer my condolences to his family and friends.

I am satisfied that staff at Fleming House cared appropriately for Mr Hewson who had poor mobility and poor health. Staff appropriately completed welfare checks on Mr Hewson when he came back from a pub intoxicated the day before his death and tried to resuscitate him promptly when they found him unresponsive on the floor of his bathroom.

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

November 2019

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Summary

Events

1. On 11 December 1997, Mr Peter Hewson was sentenced to life in prison for rape and false imprisonment. On 6 February 2019, he was released on licence from HMP Whatton. His licence conditions required him to live at Fleming House Approved Premises (AP).
2. Mr Hewson had a number of pre-existing medical conditions and had very poor mobility. When he arrived at Fleming House, he was given a room on the ground floor with an en suite disability bathroom. A Probation Service officer completed Mr Hewson's induction and Mr Hewson agreed to comply with the AP's rules.
3. On 10 February, Mr Hewson failed a breath test for alcohol and received a written warning from AP staff. On 13 February, he failed another breath test.
4. Mr Hewson went to hospital with breathing problems three times in February and returned to Fleming House each time after tests and treatment.
5. On 14 March, Mr Hewson went to a local pub and returned to Fleming House at 11.04pm, heavily intoxicated. The following morning, staff called an ambulance because he was unwell and paramedics took him to hospital. Later that day, he discharged himself from hospital and told probation staff that he did not know what had happened to him but thought that someone had replaced his non-alcoholic drink with an alcoholic drink. While in hospital, Mr Hewson allegedly assaulted a woman, and the matter was referred to the police to investigate.
6. On 21 March, Mr Hewson told his probation officer that he had taken crack cocaine, and that he had booked a room at a nearby hotel and had booked an escort but that he had not had sex with her. The AP manager issued Mr Hewson with a final hostel warning and his probation officer told him that he would receive a formal licence warning.
7. On the evening of 23 March, Mr Hewson went to a pub with two residents and drank wine, beer and cider. At about 10.45pm, they returned to Fleming House.
8. A residential worker saw the two residents carrying Mr Hewson by his shoulders into Fleming House and went to Mr Hewson's room. He saw that they had been drinking. The residential worker checked Mr Hewson's welfare at 11.00pm, and again at 2.20am, the following morning.
9. At about 9.30am, a residential worker conducted a count of residents. She found Mr Hewson lying on the floor of the bathroom. She fetched a colleague who could not find a pulse and thought that Mr Hewson had died.
10. At 9.33am, the residential worker telephoned for an ambulance. The ambulance service operator told her colleague to start cardiopulmonary resuscitation (CPR).
11. At 9.41am, paramedics arrived at Fleming House and, at 9.43am, they confirmed that Mr Hewson had died.

Findings

12. We are satisfied that Mr Hewson received appropriate care at Fleming House. He had a ground floor room adapted to his many health needs. Staff appropriately tested Mr Hewson for drugs and alcohol and began a process to remove him from the premises when his standards of behaviour fell below that required by a resident.
13. We are satisfied that a residential worker checked on Mr Hewson's welfare after he came back from the pub. We are also satisfied that day staff promptly called an ambulance.
14. Although there appear to have been signs that Mr Hewson was dead when the AP staff found him, we cannot be certain as part of his body was still warm and the ambulance operator instructed AP staff to continue with resuscitation attempts. Although staff should be aware of when not to resuscitate a resident, on balance, we make no recommendation.

The Investigation Process

15. The investigator issued notices to staff and residents at Fleming House Approved Premises informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
16. The investigator obtained copies of relevant extracts from Mr Hewson's AP records.
17. The investigator interviewed six members of staff and three residents at Fleming House on 11 and 12 April.
18. We informed HM Coroner for Kent and Medway of the investigation. She gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
19. We shared the initial report with the National Probation Service. There were no factual inaccuracies.

Background Information

Fleming House Approved Premises

20. 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 are expected to register with a GP.
21. Fleming House Approved Premises in Maidstone, Kent, is managed by the National Probation Service. It has 23 single rooms and four shared rooms, including a ground floor room with disabled facilities. 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 wellbeing and see that they adhere to their individual licence conditions and the premises' rules. Staff are on duty at Fleming House 24 hours a day.

Previous deaths at Fleming House

22. Mr Hewson was the second resident to die at Fleming House since we began investigating deaths in approved premises in 2001. The previous death was in May 2017. There were no significant similarities between our findings in the two investigations.

Key Events

23. On 11 December 1997, Mr Peter Hewson was sentenced to life in prison for rape and false imprisonment. On 6 February 2019, he was released on licence from HMP Whatton. His licence conditions required him to live at Fleming House Approved Premises, behave well, not commit an offence, keep in contact with his probation officer and let her know of any developing intimate relationships with women. His curfew required him to be at Fleming House between 11.00pm and 6.00am every day.
24. Mr Hewson had a number of pre-existing medical conditions including rheumatoid arthritis, liver cancer, chronic obstructive pulmonary disease (COPD - inflamed airways and damaged air sacs in the lungs), excess weight and very poor mobility. Before he went to Fleming House he had a care and support assessment. When he arrived at Fleming House, he had a room on the ground floor with an en suite disabled bathroom. Mr Hewson registered with a community GP, who re-prescribed his medication.
25. On 6 February, a Probation Service officer completed Mr Hewson's induction. Mr Hewson signed the AP rules (which included that he was not allowed to bring alcohol onto the premises and could be subjected to an alcohol test). He agreed to keep and administer his own medication, except for gabapentin (for epilepsy, nerve pain, diabetes and shingles). The community GP provided a dosette box to help him manage his medication.
26. On 10 February and 13 February Mr Hewson failed breath tests for alcohol and received a written warning.
27. On 17 February, Mr Hewson went to the general office and told a sessional worker, that he had problems breathing. Paramedics went to Fleming House, gave him oxygen and took him to hospital. Hospital staff diagnosed pneumonia. They discharged him the following morning.
28. On 21 February, the probation service officer spoke to social services because Mr Hewson's care package had not been assessed. Social services staff told him that there was a delay because there were no male carers available. That same day, approved premises staff searched Mr Hewson's room but did not find drugs or alcohol.
29. On 22 February, a resident went to the general office and told a staff member that Mr Hewson was struggling to breathe. The staff member called an ambulance. Paramedics diagnosed extreme anxiety and said that Mr Hewson did not need to go to hospital but should see his community GP. On 23 February, staff gave Mr Hewson a panic alarm to use if he became ill and needed help.
30. On 24 February, Mr Hewson went to the general office, struggling to breathe. Paramedics took him to hospital. Later that day, hospital staff discharged him and he returned to Fleming House.
31. On 27 February, Mr Hewson had a random drug test which tested positive for opiates. A residential worker noted that he was prescribed dihydrocodeine (an opioid pain killer).

32. On 5 March, social services' carers went to Fleming House and assessed Mr Hewson's care needs. The carers agreed to help Mr Hewson shower and dress each morning.
33. At 11.04pm on 14 March, Mr Hewson returned to Fleming House, heavily intoxicated. Residents helped to move his mobility scooter into his room. A residential worker went to see Mr Hewson. He did not respond to her voice; his eyes were rolling back in his head and he appeared under the influence of a drug. Staff checked him every hour. Later in the night, she saw that Mr Hewson was unable to keep still, was unable to speak properly and was moaning loudly. At 4.12am on 15 March, staff called an ambulance. Paramedics took Mr Hewson to hospital.
34. Later that day, Mr Hewson telephoned Fleming House from the hospital. He told a residential worker, that he did not know what happened to him the previous evening. He said that the non-alcoholic lager he was drinking had been switched by someone. In the evening, Mr Hewson discharged himself from the hospital against medical advice.
35. On 19 March, a police officer emailed a probation officer, and said that on 15 March, while he was in hospital, Mr Hewson had allegedly assaulted a woman by grabbing her arm, pulling her and shouting. The police were still investigating what happened and had not yet spoken to the alleged victim who had not yet made a complaint.
36. On 21 March, a probation officer saw Mr Hewson who told her that he had taken crack cocaine and that he wanted help to stop. She said that Mr Hewson also told her that had had booked a room at a nearby hotel and had booked an escort but that he had not had sex with her.
37. On 22 March, a probation officer spoke to her manager about Mr Hewson and they agreed that he would receive a formal licence warning. She said that because of his behaviour, it was reaching the point where he could be recalled to prison.
38. The approved premises manager told the investigator that he issued a final warning to Mr Hewson and informed the probation officer. He said that the warning was not a licence warning which was dealt with by the National Probation Service. The warning given meant that a resident could be evicted from the approved premises but would not be recalled to prison.
39. The probation officer who had known Mr Hewson since 2012, said that she had concerns about the AP residents he was mixing with, particularly those who had been involved with drugs. She said that it became known in Fleming House that Mr Hewson had left prison with £27,000 in compensation for the historic abuse he had suffered in care homes during his childhood.
40. The approved premises manager said that Mr Hewson had given him £2,000 in cash which he had put in the safe because he was concerned that having that amount of money would attract unwarranted attention. He said that other residents helped Mr Hewson with everyday tasks such as collecting food.

Events of 23 and 24 March

41. At about 2.00pm on 23 March, a resident saw Mr Hewson in the community on his mobility scooter. He said that he had been shopping and was wearing new grey jogging bottoms and new trainers. He said that Mr Hewson was struggling to carry two large bags on his scooter so offered to help him back to Fleming House. When they arrived at Fleming House, he noticed that Mr Hewson was struggling with his breathing.
42. Mr Hewson asked him if he would go for a drink later. At about 8.10pm, they left the approved premises with another resident and took a taxi to a local pub. A resident said that Mr Hewson bought all their drinks. A resident said that Mr Hewson drank a bottle of wine alone and then bought another bottle which they shared.
43. At about 10.00pm, shortly before their curfew, they returned to Fleming House by taxi. As Mr Hewson did not have his mobility scooter, the two residents supported him and helped him back to his room, where Mr Hewson looked for his asthma pump. They found it, gave to him and then put him on the bed.
44. A residential worker saw two residents carrying Mr Hewson by his shoulders down the hallway from the entrance. He went to Mr Hewson's room and saw that he was lying on the bed and that the two other residents were sitting on the bed. He said that it was obvious that all three of them had been drinking. He asked both of them to go to the general office where he breathalysed them. They were both over the drink-drive limit. Because Mr Hewson was not very responsive, he did not breathalyse him.
45. At 11.00pm, the residential worker went back to Mr Hewson's room and saw that he was lying on top of the bed in a t-shirt and jogging bottoms. He said that he was breathing and asked him if he was okay but he just grunted. At 2.20am, the following morning, he went back to Mr Hewson's room to check on him. He asked him if he was okay and Mr Hewson raised his hand, which he interpreted to mean that he was okay.
46. Between 9.00am and 9.30am on 24 March, a residential worker completed a count of residents. She said that if a resident has not been seen by 9.30am, they do room checks. She said that there were between six and eight residents left to check. She went to Mr Hewson's room last, knocked on the door, shouted, did not get a response so opened the door, which was unlocked. She saw Mr Hewson lying on the floor in the en suite bathroom, naked from the waist down. His head was nearest the door, but she could not see his face because he was lying on his right-hand side. She thought that Mr Hewson had been sick and had fallen asleep on the floor as a result of drinking alcohol the previous night. She said that she took one step past the door to see if he was breathing and 'in her head' thought that he was breathing.
47. Due to Mr Hewson's state of undress, she went to fetch a male colleague. As she left the room, she passed two residents, who were standing outside Mr Hewson's room. She went to the general office (a short distance away) and told a sessional worker, what she had seen.

48. A resident went into the bathroom to see if Mr Hewson was all right. He and another resident tried to put him into the recovery position. A resident saw that his legs had light purple blotches and were cold to touch, his face was purple, his lips were purple and blue, and he saw that Mr Hewson had urinated on the floor. He thought that he was dead.
49. The sessional worker went to Mr Hewson's room. He saw him lying on the floor of his en suite bathroom with his head towards the door. He could not find a pulse, Mr Hewson was cold to touch, and he saw that there were patches of blood under the skin on his forearm. He thought that Mr Hewson was dead. He rolled Mr Hewson onto his back and saw that his face was a deep purple-red colour and that his lips were a deep purple blue. He pinched him hard but got no response.
50. The sessional worker radioed the residential worker to call an ambulance, but she did not respond. He therefore went to the office and told her to call an ambulance. She said that she replied to the radio message. At 9.33am, she telephoned the ambulance service.
51. The residential worker went back Mr Hewson's room, talking to the ambulance service operator by mobile phone. The operator told her that they had to start cardiopulmonary resuscitation (CPR). The sessional worker tilted Mr Hewson's head back but said that it was difficult to move. He said that he could feel some warmth on his body under his arm. He could not open Mr Hewson's mouth so started chest compressions. The operator counted the compressions over the telephone, and he counted with her and continued for about four minutes.
52. The residential worker went back to the general office to get the defibrillator. The sessional worker used the defibrillator on Mr Hewson. It advised no shockable rhythm on several occasions. A resident took over chest compressions and then Mr Marshall resumed chest compressions. The residential worker went back to the general office so that she could let the paramedics into the building.
53. At 9.41am, paramedics arrived at Fleming House. At 9.43am, they confirmed that Mr Hewson had died.

Contact with Mr Hewson's family

54. When Mr Hewson went to Fleming House, he said that his daughter who lived in Bournemouth was his next of kin. On 21 February, Mr Hewson told a member of staff that he wanted to go to Bournemouth to see his daughter and grandchildren but had not spoken to his daughter for many years.
55. After Mr Hewson died, Kent Police asked an officer from Dorset Police to visit Mr Hewson's daughter. The officer found that she did not live at the address they had for her. Kent Police made enquiries with four other police services but were unable to find Mr Hewson's next of kin.
56. The Approved Premises instruction on the death of a resident states that when a resident has no family, or his family has disowned them, the Coroner will inform the local authority, which has a statutory obligation to make funeral arrangements. This is what happened for Mr Hewson.

Support for residents and staff

57. After Mr Hewson's death, the approved premises manager debriefed the staff involved in the emergency response to ensure that they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
58. The approved premises manager had a meeting with the residents and told them that Mr Hewson had died and offered support.

Post-mortem report

59. A post-mortem examination established that Mr Hewson died of alcoholic cardiomyopathy (heart failure caused by chronic alcohol misuse). It concluded that he had liver cirrhosis which contributed to but did not cause his death.

Findings

Mr Hewson's care

60. Mr Hewson had complex health needs which were appropriately assessed before he went to Fleming House. We are satisfied that he received appropriate care at Fleming House: he had a ground floor room which was adapted to his many health needs and poor mobility, he promptly registered with the local GP practice and received his medication. He had an induction meeting with a probation officer and confirmed that he understood the approved premises rules. A probation officer spoke to social services' staff to chase up his care package and arranged for carers to help him with his daily needs.
61. When Mr Hewson was unwell, staff appropriately called an ambulance and he frequently went to hospital for tests and treatment for breathing problems.
62. Mr Hewson went to pubs, where he drank alcohol. He also took controlled drugs. This appears to have had a detrimental effect on his health and wellbeing. Approved premises staff appropriately tested Mr Hewson for drugs and alcohol and began a process to remove him from the premises when his standards of behaviour fell below that required by a resident.

Breach of licence and approved premises' rules

63. We have considered whether Mr Hewson should have been recalled to prison before his death given that he had failed breath tests, demonstrated poor behaviour, admitted using drugs and arranging to have sex with a woman, and was being investigated by the police for an alleged assault on a woman. However, we note that the police had not yet spoken to the victim of the alleged assault, she had not made a complaint and the police were still investigating the matter and had not charged Mr Hewson. Although Mr Hewson could have been recalled to prison at this stage, we are satisfied that this was a judgment call for the probation officer, and that her decision to issue Mr Hewson with a licence warning was not unreasonable in the circumstances. We are also satisfied that the AP manager took prompt action and issued Mr Hewson with a final AP warning.

Checking on Mr Hewson and emergency response

64. We are satisfied that the residential worker appropriately checked on Mr Hewson's welfare after he came back from the pub drunk on 23 March, and that the day staff promptly called an ambulance when they found Mr Hewson unresponsive the next morning.
65. We were concerned that resuscitation attempts were made when although the sessional worker, thought that Mr Hewson was dead. Resuscitating someone who is dead is inappropriate, distressing for staff and undignified for the deceased. The European Resuscitation Council Guidelines for Resuscitation 2010 state that resuscitation is inappropriate when there is clear evidence that it will be futile, such as the presence of rigor mortis. The sessional worker noted that Mr Hewson's face was purple and that his lips were blue and that he was cold to the touch. He also noted that it was difficult to tilt Mr Hewson's head back

or open his mouth, which would suggest possible rigor mortis. In these circumstances, however, we note that the ambulance operator strongly encouraged staff to attempt resuscitation and that an area under Mr Hewson's arm was warm. We cannot therefore conclude with certainty that Mr Hewson had died and while it is advisable that staff know the circumstances when not to resuscitate, we do not think it necessary to make a recommendation on this occasion.

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