

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr David Howitt a resident at Quay House Approved Premises on 7 July 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 Howitt died on 7 July 2019 of lung cancer at Quay House Approved Premises. He was 59 years old. I offer my condolences to Mr Howitt's family and friends.

The emergency response by staff was appropriate, but I am concerned that a member of staff's first aid training was out of date.

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**

**May 2020**

## **Contents**

Summary .....	1
The Investigation Process .....	2
Background Information .....	3
Key Events .....	4
Findings.....	7

# Summary

## Events

1. On 18 November 2018, Mr Howitt was released from prison, and lived at Quay House Approved Premises (AP).
2. In April 2019, Mr Howitt was diagnosed with lung cancer and was treated with radiotherapy and chemotherapy. He was told that the cancer could not be cured, but was not given a prognosis.
3. On 7 July, Mr Howitt's health deteriorated significantly and staff requested an ambulance at 7.38pm and 8.36pm. Shortly after the second request, Mr Howitt was found unresponsive in his room and staff started cardiopulmonary resuscitation (CPR).
4. At 8.44pm, paramedics declared that Mr Howitt had died.

## Findings

5. The emergency response by Quay House AP staff was appropriate. They correctly followed the ambulance service's instructions.
6. A contracted member of staff's first aid training was out of date.

## Recommendations

- **The Approved Premises Manager should satisfy themselves that all staff have current first aid training to meet safety requirements.**

## The Investigation Process

7. The investigator issued notices to staff and prisoners at Quay House AP informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
8. The investigator visited Quay House AP on 19 November 2019. She obtained copies of relevant extracts from Mr Howitt's AP records.
9. The investigator interviewed three members of staff at Quay House AP on 19 November 2019.
10. We informed HM Coroner for Wales - Swansea District of the investigation. He gave us a copy of the Coroner's certificate. We have sent the coroner a copy of this report.
11. One of the Ombudsman's family liaison officers contacted Mr Howitt's next of kin to explain the investigation and to ask if he had any matters he wanted the investigator to consider. He did not have any matters he wanted to be considered but asked for a copy of this report.
12. Mr Howitt's next of kin received a copy of the draft report. He did not make any comments.
13. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

# Background Information

## Quay House Approved Premises

14. 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.
15. Quay House AP in Swansea, South Wales, is managed by the National Probation Service. It has 26 single 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 Quay House AP 24 hours a day.

## Previous deaths Quay House

16. In the two years before Mr Howitt died, there were no other deaths at Quay House AP.

## Key Events

17. On 13 April 2012, Mr Howitt was sentenced to 10 years in prison for sexual offences.
18. On 18 November 2018, Mr Howitt was released on licence from HMP Rye Hill and went to Quay House AP. Mr Howitt had several licence conditions, including that he lived at Quay House AP and did not commit another offence. He had to be at Quay House AP between 8.00pm and 8.00am every day.
19. At Quay House AP, Mr Howitt lived in a single room on the first floor with shared bathroom facilities. Mr Howitt told staff his pre-existing medical conditions, including asthma, epilepsy and depression. He registered with a community GP, who prescribed his medication.

## Diagnosis and Treatment

20. In April 2019, Mr Howitt was diagnosed with lung cancer. He was told that it could not be cured but that with treatment, it may be managed. He was not given a prognosis.
21. From May, Mr Howitt had radiotherapy and chemotherapy. He attended hospital for oncology appointments and a hospice for pain management. AP staff went with Mr Howitt to appointments for support.
22. The AP stored Mr Howitt's controlled medication and he took it under the supervision of staff. Staff also gave Mr Howitt a panic alarm so that he could alert staff if he felt unwell, and they checked him at least every two hours.
23. When Mr Howitt's health deteriorated, he was moved to a room on the first floor with a private bathroom. At first, he wanted to stay there, but as his health deteriorated, he agreed to move to the disabled room on the ground floor.
24. Swansea Social Services agreed that Mr Howitt should be moved to a specialist care home in the Swansea area. The move was delayed as it could not be agreed which local authority would provide the necessary care package. (Mr Howitt was a resident of Pembrokeshire before going to prison, but living in Swansea when he was diagnosed with cancer.) He died before the move was arranged.

## Sunday 7 July

25. In the morning on 7 July, Mr Howitt's health deteriorated significantly and he stopped eating. A residential support worker contacted NHS Direct for medical advice, and was advised to contact the on-call GP.
26. The on-call GP recommended that AP staff contact Mr Howitt's GP the following day (Monday) to review his medication, discuss his end of life arrangements and whether he wished to be resuscitated. The on-call GP prescribed Mr Howitt laxatives and anti-sickness tablets, and recommended high energy drinks.
27. The residential support worker contacted a hospice to explain the GP's advice. He made an appointment for Mr Howitt on 9 July and checked Mr Howitt hourly.

28. Mr Howitt's condition deteriorated throughout the afternoon. A residential support worker telephoned the AP manager, and the on-call manager, who both advised her to get medical advice.
29. The residential support worker contacted NHS Direct for medical advice. She explained that Mr Howitt was seriously ill. She gave them Mr Howitt's temperature, which she said was 36 degrees Celsius, which is just below normal. She noted that the nurse said Mr Howitt should be seen by a doctor. She contacted the on-call GP who advised her to call an ambulance for Mr Howitt.
30. At 7.38pm, she called an ambulance for Mr Howitt, as advised by the GP, and Mr Howitt was told that he was going to hospital.
31. She telephoned the AP manager to let her know that an ambulance had been called. The AP manager arranged for an off-duty residential support worker to meet her at the AP so that they could accompany Mr Howitt to hospital. (They arrived at the AP shortly after Mr Howitt died.)
32. While waiting for the ambulance to arrive, Mr Howitt lost control of his bowels. A night worker cleaned and dressed Mr Howitt and tried to make him comfortable. He left Mr Howitt's room, and told the residential support worker that Mr Howitt's pulse appeared to have weakened and that he was concerned.
33. At 8.36pm, the residential support worker called the ambulance service again to see when the ambulance would arrive. She passed the telephone to the night worker for him to describe Mr Howitt's condition, and went to Mr Howitt's room to check him. She told us that there were approximately four minutes between the night worker leaving Mr Howitt's room, and her going to check him.
34. She told us that when she got to his room, Mr Howitt did not appear to be breathing, his eyes were glassy and he was very cold. She pressed her panic alarm to alert staff of an emergency, and tried to lift Mr Howitt to the floor to start cardiopulmonary resuscitation (CPR). The night worker arrived, and was still on the telephone to the ambulance service. Following their advice, the night worker moved Mr Howitt to the floor and began chest compressions while she got a defibrillator. She put the defibrillator on Mr Howitt and followed the instructions. She told us that it said to continue chest compressions, but that no shock was advised.
35. At 8.42pm, paramedics arrived. The night worker said that they told him to continue doing chest compressions while they checked him, but he was then told to stop.
36. At 8.44pm, paramedics declared that Mr Howitt had died.

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

37. Following Mr Howitt's diagnosis, staff encouraged Mr Howitt to contact his next of kin, but he did not. He also did not provide Quay House AP with his next of kin's contact details.
38. On 7 July at 10.50pm, Porth police contacted Mr Howitt's next of kin to inform him of Mr Howitt's death.
39. On 8 July, the AP manager contacted the Coroner's office and gave them the AP's details in case any family members came forward.
40. On 9 July, National Probation Service staff told the AP manager, that the police had informed Mr Howitt's next of kin that Mr Howitt had died, and gave her his address. She wrote a letter of condolence to Mr Howitt's next of kin.
41. Mr Howitt's funeral was arranged by the local authority and took place on 6 August 2019. The National Probation Service offered to contribute to the cost, in line with national policy, but the local authority paid for the funeral with Mr Howitt's own funds.

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

42. After Mr Howitt's death, the AP manager held a debrief and offered her support to the staff involved in the emergency response. A further debrief was held with staff on 30 July. Staff were given access to a counsellor and provided with structured supervision and support.
43. On the evening that Mr Howitt died, Quay House AP staff informed other residents that he had died. Residents were told to speak to staff if they needed support. Mr Howitt's death was discussed with residents in key work sessions. Staff also reviewed all residents assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Howitt's death.

### **Coroner's certificate**

44. The Coroner's certificate showed that Mr Howitt died of lung cancer. It concluded that he had chronic obstructive pulmonary disease which contributed to, but did not cause his death.

# Findings

## Emergency response

45. Approved Premises (AP) staff at Quay House responded appropriately when they found Mr Howitt unresponsive in his room. They tried to resuscitate Mr Howitt, following instructions from ambulance service staff over the telephone. AP staff used the defibrillator, as advised by the ambulance service. When paramedics arrived, a member of staff continued resuscitation efforts until paramedics told him to stop. We consider the emergency response appropriate following Mr Howitt's collapse.

## First aid training

46. First Aid Training is valid for three years from the date of the certificate. The night worker completed his training in October 2015, so it was out of date.
47. The AP Area Manager informed us that it is the responsibility of OCS Group (UK) Ltd, the contractor who provides night staff to the AP, to ensure that their staff are appropriately first aid trained. It remains the AP Manager's responsibility to ensure all staff are appropriately qualified to work in the AP. She told us that she is working with OCS to ensure that this does not happen again.
48. It is concerning that a member of staff did not have current first aid training. It is unlikely to have changed the outcome for Mr Howitt, but it may be critical for residents in different circumstances. I make the following recommendation:

**The Approved Premises Manager should satisfy themselves that all staff have current first aid training to meet safety requirements.**

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