Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Jamie Andrews, on 4 December 2022, following his release from HMP Bristol

A report by the Prisons and Probation Ombudsman

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OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO

WHAT WE VALUE

Summary

1. 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.

2. If my office is to best assist HM Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

3. Since 6 September 2021, the PPO has investigated post-release deaths that occur within 14 days of a prisoner's release.

4. Mr Jamie Andrews died from heart disease caused by a narrowing of the coronary arteries on 4 December 2022, following his release from HMP Bristol three days earlier. He was 49 years old. He also had combined heroin, cocaine, methadone, nordiazepam and pregabalin toxicity which contributed to but did not cause his death. We offer our condolences to his family and friends.

5. On 21 November 2022, Mr Andrews was sentenced to three weeks in prison for theft and was sent to HMP Bristol. That same day he was remanded to Bristol for further offences. Mr Andrews was withdrawing from alcohol and drugs. He had a community methadone prescription and was homeless. His sentence ended on 1 December.

6. Mr Andrews' community offender manager completed a duty to refer (DTR) to Reading Borough Council. (The Homelessness Reduction Act 2017 requires prisons and probation services to refer anyone who is homeless or at risk of becoming homeless within 56 days to a local housing authority.)

7. A healthcare administrator arranged an appointment for Mr Andrews post-release at a community drug and alcohol team in Reading.

8. On 1 December, Mr Andrews was released on licence from HMP Bristol. Prison staff did not realise that when he was sentenced Mr Andrews was also remanded to prison and therefore, he was released from Bristol in error. He did not attend the planned appointment with his community offender manager in Reading, but he did go to his appointment with the community drug and alcohol team.

9. At 00.25am on 4 December, ambulance paramedics in Reading found Mr Andrews slumped over a parked car holding onto a bicycle. Mr Andrews was not breathing. The paramedics started cardiopulmonary resuscitation (CPR). At 1.00am, the paramedics confirmed that Mr Andrews had died.

The Investigation Process

10. On 4 December, the PPO was notified of Mr Andrews' death.

11. The PPO investigator obtained copies of relevant extracts from Mr Andrew's prison and probation records.

12. We informed HM Coroner for Berkshire of the investigation. She gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

13. The Ombudsman's family liaison officer wrote to Mr Andrews' daughter to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Andrews' daughter was concerned that Mr Andrews was released in error and that if he had not been released, he may not have died. She wanted to know the arrangements made for his release.

14. We shared the initial report with the Prison Service and the Probation Service. There were no factual inaccuracies.

15. We shared the initial report with Mr Andrews' daughter. She did not respond.

Background Information

HMP Bristol

16. HMP Bristol serves the local courts and holds around 600 men. Healthcare services are provided by Inspire Better Health, a partnership of eight health providers led by Bristol Community Health. Avon and Wiltshire Partnership provides mental health and substance misuse services.

Probation Service

17. The Probation Service work with all individuals subject to custodial and community sentences. During a person's imprisonment, they oversee their sentence plan to assist in rehabilitation, as well as prepare reports to advise the Parole Board and have links with local partnerships to whom, where appropriate, they refer people for resettlement services. Post-release, the probation service supervise people throughout their licence period and post-sentence supervision.

HM Inspectorate of Prisons

18. HMIP carried out an inspection of Bristol in May and June 2019. Following the inspection, HM Chief Inspector of Prisons invoked the Urgent Notification process informing the Secretary of State for Justice that there were numerous significant concerns about the treatment and conditions of prisoners.

19. Inspectors found that in relation to sentence progression; offender supervisor contact was reasonably frequent. Some prisoners remained at the establishment for too long and were unable to progress or address their offending needs. Public protection arrangements were not sufficiently robust. Not all prisoners had their resettlement needs addressed on arrival. Despite strenuous efforts to address accommodation needs, far too many prisoners were released homeless or to temporary accommodation.

20. HMIP carried out a scrutiny visit to Bristol in September 2020, reporting on conditions and treatment of prisoners during the COVID-19 pandemic. Inspectors reported that Bristol was a much-improved prison. The percentage of prisoners released without settled accommodation had reduced since their last inspection (when it was 47%) but, at 25% during the pandemic, was still far too high.

HM Inspectorate of Probation

21. The most recent inspection of Thames Valley Community Rehabilitation Company (now part of the National Probation Service) was in January 2020. Inspectors rated the service as good. Inspectors were impressed with the work of the 'Through the Gate Team', which, following national changes to the specification of this work, was providing comprehensive support to those being released from prison. Inspectors said that there remained work to do, to ensure that sentence plans were delivered in all cases and allow individuals to benefit from the interventions available.

Key Events

22. On 21 November 2022, Mr Jamie Andrews was sentenced to three weeks in prison for theft and was sent to HMP Bristol. That same day Mr Andrews was also remanded to Bristol for further offences.

23. An Offender Assessment System (OASys) risk and needs report completed in July 2022, said that Mr Andrews, who had 50 previous convictions, committed crime to fund his alcohol and drug addictions. The report said that Mr Andrews was homeless because he was evicted from his supported accommodation with Launchpad (a homelessness prevention charity). Mr Andrews had not worked for fifteen years and depended on state benefits. He was assessed as a very high risk of reoffending and was managed by the Integrated Offender Management Unit. (IOM- a multi-agency response to the crime and reoffending threats faced by local communities. The most persistent and problematic offenders are identified and managed jointly by partner agencies working together.)

24. A probation officer was already allocated as Mr Andrews' community offender manager (COM).

25. At his initial health screen, Mr Andrews told a nurse that he was withdrawing from alcohol and drugs, had a community methadone prescription and was homeless. Mr Andrews told the nurse that he drank more than ten units of alcohol at least four times a week. The nurse recorded a Clinical Institute Withdrawal Assessment for Alcohol (CIWA-Ar) score of 5, which indicated minimum to mild alcohol withdrawal and a Clinical Opiate Withdrawal Scale (COWS) score of 11 which indicated mild opiate withdrawal. Mr Andrews told the nurse that he had schizophrenia. The nurse referred Mr Andrews to the Substance Misuse Psychosocial Team.

26. A GP at Bristol prescribed chlordiazepoxide and thiamine (for alcohol withdrawal) and methadone.

27. On 23 November, a support worker in the Substance Misuse Psychosocial Team saw Mr Andrews for an initial assessment. Mr Andrews told her that he injected heroin and shared needles and had previously accidentally overdosed. Mr Andrews told her that he used £100 of crack cocaine daily which he injected and smoked and snowballed (injecting in a combination) heroin and crack. He said that he also used cannabis and illicit diazepam tablets daily. Mr Andrews said that he drank ten to twelve cans of strong cider daily and regularly blacked out. Mr Andrews told her that he would like naloxone (used to counter the effects of opioid misuse) which she added to Mr Andrews' personal property for his release.

28. Later that day, a mental health nurse carried out a mental health review. She saw no evidence in Mr Andrew's medical records that he had a diagnosis of schizophrenia. She did not plan to reinstate Mr Andrews' previous medication for poor mental health without a full mental health assessment being undertaken. She referred Mr Andrews to the mental health team.

29. On 23 November, Mr Andrews was allocated a prison offender manager (POM). The POM had no recollection of any contact with Mr Andrews.

30. On 24 November, a probation officer who works in the WRAP Centre (a prison departure lounge which offers support and advice at the prison gate) met Mr Andrews who told her that he would be released homeless as he had lost his supported housing and was homeless before he went to prison. Mr Andrews told her that he was 'on the run' from the police because he thought that he was wanted for something more serious. She told Mr Andrews that she would meet him at the prison gate and take him to the WRAP centre, so that he knew what to do on his release and to start a benefits claim.

31. That same day the COM completed a duty to refer (DTR). (The Homelessness Reduction Act 2017 requires prisons and probation services to refer anyone who is homeless or at risk of becoming homeless within 56 days to a local housing authority.) She also emailed a Launchpad worker to chase up a referral for housing support, which had been made on 9 September. She also asked if Mr Andrews could be considered for a room at Willow House in Reading (a Salvation Army night shelter).

32. On 26 November, a Healthcare Assistant (HCA) reviewed Mr Andrews (prisoners are assessed daily for a minimum of five days from arrival for signs of withdrawal) and recorded a COWS score of 7 which indicated mild opiate withdrawal. Mr Andrews asked the HCA for an increase in methadone from 30mls to 80mls. She tasked the Substance Misuse Psychosocial Team to review Mr Andrews.

33. On 29 November, a nurse reviewed Mr Andrews and noted that he had a COWS score of 7. A GP at Bristol said that she would increase Mr Andrews' methadone dose to 35mls and asked for his COWS score to be checked in a few days.

34. On 30 November, a healthcare administrator arranged an appointment for Mr Andrews at 11.00am on 2 December, at CGL (community drug and alcohol team) Reading, where Mr Andrews would receive his methadone.

35. On 1 December, a senior probation officer noted that the Access Panel (a local housing panel managed by Reading Borough Council, which includes representatives from the Salvation Army, Launchpad and the homelessness charity St Mungo's) had put Mr Andrews on the waiting list for Willow House or Shepton House (both Salvation Army hostels) but that at the last minute, a bed had not been made available as planned. Mr Andrews would be released homeless. She noted that the COM had contacted Reading Borough Council to ask about emergency accommodation but had not yet had a response. She noted concerns about Mr Andrews' risk of further offending if he was released homeless.

36. The senior probation officer noted that she had asked that the COM complete an emergency Approved Premises (AP- formerly known as probation and bail hostels) referral to cover the period until they could find him accommodation elsewhere, which the COM did that same day.

37. The COM said that there was no capacity at the local APs, and she was advised to seek housing support through local hostels.

38. On 1 December, a GP at Bristol prescribed Mr Andrews fourteen days of thiamine. Mr Andrews received a dose of 35mls of methadone. He did not receive naloxone.

39. That day, Mr Andrews was released on licence from HMP Bristol. His licence conditions required him to report at 12.00pm to the COM at the Reading Probation Office. A Custodial Manager explained the terms of his licence and Mr Andrews was given a travel warrant to Reading and his discharge grant of £85.

40. The probation officer met Mr Andrews at the prison gate, as she had promised, and took him to the WRAP centre, where she provided him with clothing and a bus pass to the train station.

41. Mr Andrews did not attend the appointment with the COM.

42. Shortly after Mr Andrews had been released, the police working as part of the IOM realised that Mr Andrews had been wrongly released as he had been remanded in prison for further offences on 21 November. The police said that they would obtain an arrest warrant (there is no evidence this had happened before Mr Andrews died).

43. Later that day, a prison manager advised the COM that Mr Andrews had been released in error.

44. Mr Andrews went to his appointment with CGL. A CGL worker told the COM that Mr Andrews came for his CGL appointment, and he said that he needed to go to the Probation Office and the Job Centre and would return after 1.00pm to collect his methadone prescription.

45. Mr Andrews did not go back to CGL to collect his prescription and to complete his CGL registration. And a CGL deputy services manager and quality lead said that he was not seen again by CGL staff.

Circumstances of Mr Andrews' death

46. At 12.25am on 4 December, paramedics were called to a street in Reading after a member of the public found Mr Andrews holding onto a bicycle, slumped over a parked car. Mr Andrews was not breathing. The paramedics started cardiopulmonary resuscitation (CPR). Paramedics, police officers and members of the public continued CPR for 35 minutes. At 1.00am, the paramedics said that Mr Andrews had died.

Post-mortem report

47. A post-mortem examination established that Mr Andrews died from ischaemic heart disease caused by severe atheroma of the left anterior coronary artery (narrowing of the coronary arteries caused by a build-up of plaque). He also had combined heroin, cocaine, methadone, nordiazepam and pregabalin toxicity which contributed to but did not cause his death.

Support for staff

48. After Mr Andrews died a senior probation officer offered the COM support and directed her to the workplace support service.

Contact with Mr Andrews' family

49. On 4 December, police officers told Mr Andrews' brother that he had died.

Findings

Substance misuse services

50. Mr Andrews had a history of drug and alcohol addiction and committed crime to fund his habit. Healthcare staff at Bristol treated Mr Andrews for drug and alcohol withdrawal and referred him to a community substance misuse service.

51. Despite a support worker in the Substance Misuse Psychosocial Team telling Mr Andrews that he would be released from Bristol with naloxone and giving him training in its use, this did not happen. Given the circumstances of his death, it is unlikely that possession of naloxone would have made any difference to the outcome for Mr Andrews. We do not know why, given that the support worker said that it would be in his property, Mr Andrews left the prison without naloxone. The Governor and Head of Healthcare will want to consider this finding and conduct their own investigations to establish what happened and whether there is any learning.

Release in error

52. The Acting Head of Offender Management Services at Bristol said that sentence calculations are carried out by the case administration team within the Offender Management Unit (OMU) and checked by a peer. Before release the calculations are rechecked by a senior case administrator or a manager. He said that Mr Andrews' calculations were checked two days before his release using the warrants of detention that were available to them. He said that the paperwork for the court hearing which remanded Mr Andrews in custody was originally, but incorrectly, sent to HMP Bullingdon as the local prison for the court area. HMP Bullingdon forwarded the paperwork to Bristol after the release calculations had been performed and it was not seen by OMU staff before Mr Andrews was released.

53. If Mr Andrews had not been released in error, it is likely that he would not have been able to access, at that point, the range of illicit substances found in his system after he died. However, he would in all likelihood have been released at some point from HMP Bristol and given his cause of death was heart disease, on the balance of probabilities this error is unlikely to have had a significant impact on the eventual outcome. The Governor and Head of the Offender Management Services at Bristol will want to consider whether any changes to existing processes would have prevented Mr Andrews being released in error.

Issues to highlight outside our remit

54. Homelessness on release from prison is a significant and complex challenge. This was particularly the case for Mr Andrews.

55. Mr Andrews was appropriately referred to Reading Borough Council under the conditions of the Homelessness Reduction Act and despite attempts to house him in Salvation Army hostels, St Mungo's hostels and approved premises he was released from Bristol homeless. We do not know where Mr Andrews lived in the three nights after his release and before his death.

56. While we are satisfied that prison and probation staff referred Mr Andrews to appropriate agencies, Mr Andrews was released homeless. The provision of suitable accommodation for people leaving prison, particularly for those with complex vulnerabilities, risks and needs, is an issue that extends beyond the remit of HMP Bristol or local probation services, and the Department for Levelling Up, Housing and Communities and the local authority may want to be aware of the issues raised in this case.

Inquest

57. The inquest into Mr Andrews' death concluded on 4 September 2024. The jury found that Mr Andrews died due to mixed drug related and natural causes. They found that his erroneous early release contributed to the circumstances of his death.

Adrian Usher
Prisons and Probation Ombudsman **September 2023**

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