Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Mark Tyrer, a prisoner at Bunbury House Approved Premises, on 25 May 2021

A report by the Prisons and Probation Ombudsman

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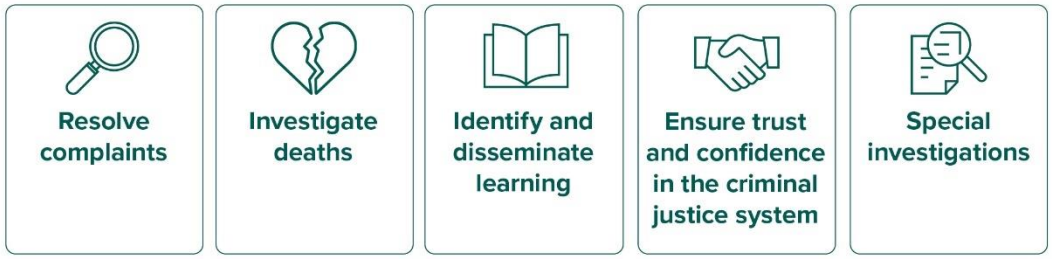
OUR VISION

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

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 Mark Tyrer died on 25 May 2021 of sepsis with an acute fatty liver at Bunbury House Approved Premises. He was 44 years old. I offer my condolences to Mr Tyrer's family and friends.

During the short time he was a resident at Bunbury House Approved Premises, Mr Tyrer fully complied with the premises' rules and engaged well with staff. He did not have pre-existing medical conditions and was not prescribed any medication.

I am satisfied that Mr Tyrer received a good standard of care at Bunbury House Approved Premises and that staff could not have foreseen his death.

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

Sue McAllister CB
Prisons and Probation Ombudsman **June 2022**

Contents

Summary

Events

1. On 21 May 2021, Mr Mark Tyrer was released on licence from HMP Lancaster Farms to live at Bunbury House Approved Premises (AP), Ellesmere Port. Mr Tyrer was serving a prison sentence of one year and seven months for assault.

2. Mr Tyrer had no health issues and was not prescribed any medication. On 23 May, Mr Tyrer went to hospital after he complained of feeling breathless with sore and numb legs. Hospital investigations showed that he had an underlying infection. He was discharged from hospital and returned to Bunbury House the same day.

3. At 9.00am on 24 May, AP staff found Mr Tyrer unresponsive in his room. They telephoned for an emergency ambulance and carried out cardiopulmonary resuscitation (CPR). The ambulance arrived within ten minutes but, at 9.18am, the paramedics confirmed that Mr Tyrer had died.

4. The post-mortem report gave Mr Tyrer's cause of death as sepsis with acute fatty liver.

Findings

5. Mr Tyrer did not have any pre-existing medical conditions when he arrived at Bunbury House, and he was not prescribed any medication.

6. Staff sent Mr Tyrer to hospital when he complained of feeling unwell. Mr Tyrer returned to Bunbury House the same day and did not complain of feeling unwell again.

7. We are satisfied that staff could not have foreseen or prevented Mr Tyrer's death on 25 May.

8. We make no recommendations.

The Investigation Process

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

10. The investigator obtained copies of relevant extracts from Mr Tyrer's records and interviewed one member of staff on 4 November 2021.

11. We informed HM Coroner for Cheshire of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

12. We wrote to Mr Tyrer's next of kin, his brother, to explain the investigation and to ask if he had any matters he wanted the investigation to consider. Mr Tyrer's father asked the following questions:

    - why did Mr Tyrer go to hospital;
    - when was Mr Tyrer last checked by staff at Bunbury House before his death;
    - is septicaemia the cause of death;
    - could Mr Tyrer have had septicaemia when he was at the hospital; and
    - how long does it take for pregabalin to leave the system.

    We have answered these questions in this report and in separate correspondence.

13. Mr Tyrer's family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.

14. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

Bunbury House Approved Premises

15. 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 health and are expected to register with a GP.

16. Bunbury House, in Ellesmere Port, is managed by The National Probation Service. It has 23 single rooms. All meals are provided and there is a communal area for dining and socialising, and areas for group work. Each resident is allocated a key worker or an offender supervisor to oversee their progress and well-being, and to ensure that residents adhere to licence conditions and the premises' rules. Probation Service employees are on duty at Bunbury House 24 hours a day.

HM Inspectorate of Probation

17. HM Inspectorate of Probation's annual report for the northwest published in February 2019, said that senior leaders had a clear vision and strategy for high quality services, but not enough staff to deliver them. Inspectors found that, overall, the division was delivering a good standard of service, despite being under strain.

Previous deaths at Bunbury House Approved Premises

18. Mr Tyrer was the second resident to have died at Bunbury House since February 2018. The previous death was a drug related death. There are no similarities with the investigation into Mr Tyrer's death and the previous death.

Key Events

19. On 1 October 2020, Mr Mark Tyrer was convicted of assault and sentenced to one year and seven months in prison. Mr Tyrer had a history of drug abuse and had been in prison before.

Bunbury House Approved Premises

20. On 21 May 2021, Mr Tyrer was released on licence from HMP Lancaster Farms. Before his release, a prison nurse saw Mr Tyrer. She took his observations and recorded that his temperature, pulse and oxygen saturation level were all normal. Mr Tyrer did not express any concerns about his health. He did not have any pre-existing medical conditions and he was not prescribed any medication.

21. Mr Tyrer's licence conditions required him to live at Bunbury House Approved Premises (AP), Ellesmere Port. He had a curfew requiring him to be at Bunbury House between 8.00pm and 7.00am every day and had to report to AP staff at 12.00pm each day. Mr Tyrer was also required to engage with substance misuse services to provide him with ongoing support to prevent a relapse into drug use, and to attend a support group to address his anger and violent offending behaviour.

22. Mr Tyrer arrived at Bunbury House at 7.06pm. He received an induction from a residential support worker. He was told about, and issued with copies of, the AP rules, the facilities, regime, fire, health and safety procedures, the alcohol and substance misuse policy and the support available from AP staff. Mr Tyrer signed to say that he understood, and that he had received copies of the rules and policies. Mr Tyrer was also told about his specific licence conditions, restrictions and curfew times and the medication policy. The support worker noted that Mr Tyrer intended to register with a GP practice and he was not prescribed any medication.

23. AP rules say that new residents must have additional checks in the night for the first 48 hours. These are conducted at 2.00am and 5.00am and residents are made aware that these will be taking place. AP staff completed the additional checks and did not record any concerns. Mr Tyrer complied with the conditions of his licence on 22 and 23 May.

Monday 24 May

24. At approximately 2.20pm, Mr Tyrer complained of feeling breathless with sore and numb legs. After seeking advice from NHS 111, a residential support worker arranged for an ambulance to take Mr Tyrer to the Countess of Chester Hospital.

25. At hospital, x-ray results did not show any abnormalities. A blood test result showed a raised neutrophil account (a sign that Mr Tyrer had an underlying infection). Hospital doctors discharged Mr Tyrer at 7.30pm. Mr Tyrer arrived back at the AP at 7.50pm. He told staff that he had bought a bicycle from someone outside the hospital and cycled back to Bunbury House. He did not express any concerns to AP staff about his health and said that he was not prescribed any medication in hospital.

26. AP staff completed a curfew check at 11.00pm and staff gave Mr Tyrer a pillow. The AP manager told us that staff did not record any concerns about Mr Tyrer.

CCTV shows Mr Tyrer speaking to staff and entering his room at approximately 11.05pm. This was the last time he was seen before he died.

Tuesday 25 May

27. A residential worker told the investigator that she had begun the mandatory residents check at 9.00am. When she got to Mr Tyrer's room, she knocked on the door, but Mr Tyrer did not respond. She opened the door and saw Mr Tyrer lying on his bed unresponsive with vomit on his face and a white tinge around his mouth. She immediately called for help and another residential worker attended. She called for an emergency ambulance.

28. Both residential workers started CPR and used an automated external defibrillator, which administers electrical shocks to restore a normal rhythm to the heart if any is found. The defibrillator found no shockable rhythm, so the AP staff continued with CPR.

29. At approximately 9.10am, the paramedics arrived and took control of Mr Tyrer's care. At 9.18am, the paramedics pronounced Mr Tyrer dead.

30. Following his death, police officers found non-prescribed medication in Mr Tyrer's possession, which paramedics confirmed was a heroin substitute.

Contact with Mr Tyrer's family

31. In line with National Probation Service guidance, the police visited Mr Tyrer's father at his home and informed him of his son's death. Later that morning, the AP manager contacted Mr Tyrer's father by phone and offered his condolences and support. In the days that followed, he maintained contact with Mr Tyrer's family.

32. In line with national guidance, the Probation Service offered a contribution to the costs of Mr Tyrer's funeral.

Support for prisoners and staff

33. After Mr Tyrer's death, the AP manager debriefed all the staff to ensure they had the opportunity to discuss any issues arising, and to offer support.

34. The AP manager held a meeting with the residents at the AP to tell them of Mr Tyrer's death and to offer them support.

Post-mortem report

35. The post-mortem report gave Mr Tyrer's cause of death as sepsis with acute fatty liver. Mr Tyrer also had a lower respiratory tract infection which did not cause but contributed to his death.

36. The pathologist noted that the results of a hospital blood test showed that he had a raised neutrophil account. This indicated an underlying inflammatory condition, with an infection being the most likely cause.

37. Post-mortem toxicology tests found the presence of quetiapine (an anti-psychotic medication) in Mr Tyrer's urine. The pathologist said this was not detected in Mr Tyrer's blood and was unlikely to have affected Mr Tyrer at the time of his death.

Findings

Clinical care

38. Mr Tyrer did not have any pre-existing medical conditions when he arrived at Bunbury House, and he was not prescribed any medication. Mr Tyrer agreed to register with a GP and to engage with support for his substance misuse. He was fully compliant with the AP rules.

39. The day before he died, Mr Tyrer went to hospital after complaining of shortness of breath and sore and numb legs. Hospital investigations indicated that he had an underlying infection, and he was discharged from hospital a few hours later. Mr Tyrer did not express any concerns when he arrived back at the AP. Staff did not find any prescribed medication in Mr Tyrer's room after he died.

40. The post-mortem report gave Mr Tyrer's cause of death as sepsis with an acute fatty liver. Mr Tyrer also had a lower respiratory tract infection. Despite not being prescribed any medication, toxicology tests found the presence of an anti-psychotic medication in his system. The post-mortem report also said that police officers found non-prescribed medication in Mr Tyrer's possession which paramedics confirmed was a heroin substitute. Mr Tyrer was not prescribed any medication in prison and was not in possession of any medication at Bunbury House.

41. When AP staff found Mr Tyrer unresponsive in his room, they immediately called for an ambulance and started resuscitation procedures.

42. We are satisfied that staff could not have foreseen or prevented Mr Tyrer's death.

43. We make no recommendations.

Inquest

44. The inquest, heard on 2 November 2023, concluded that Mr Tyrer died from natural causes.

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