

**Investigation into the death of a man
in October 2011 while a resident at
Bowling Green, an approved premises under the
management of the Cumbria Probation Area**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

November 2012

This is the report of the investigation into the death of a man who was found unresponsive in his room at Bowling Green Approved Premises in October 2011. He was pronounced dead at Cumberland Infirmary. The post mortem showed that his death was caused by high levels of methadone, diazepam and nordiazepam (all of which can affect the breathing) combined with patchy bronchopneumonia (an infection of the main airways of the lungs and swelling of the lung tissue). I offer my condolences to his family and friends.

This investigation was undertaken by one of my investigators. Staff at Bowling Green cooperated fully with the investigation. I apologise for the delay in issuing this report.

The man had been at Bowling Green for four months by the time of his death. He was a drug user and was on a methadone maintenance programme. He was also prescribed medication for chronic obstructive pulmonary disease (lung disease), high blood pressure and a back complaint. Staff at the approved premises were often concerned about his welfare, as he regularly appeared over-sedated, and they appropriately raised their concerns with the man's doctor, Carlisle Drug and Alcohol Recovery Team and his offender supervisor.

The investigation found that Bowling Green staff tried to educate the man about the risks of taking illicit drugs and unprescribed medication, but I am concerned that on one occasion the man did not hand in his prescribed methadone, as he was required to do, and staff did not follow this up. Sadly, the man's death seems to have been an inevitable consequence of his addiction to drugs and it appears there was little more staff could have done to have prevented it.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

November 2012

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SUMMARY

1. In May 2011, the man was granted conditional release from prison having served four years of an eight year sentence. He was subject to a licence condition that he reside at an approved address. He arrived at Bowling Green approved premises in Carlisle on 31 May.
2. The man had a long history of drug abuse and was on a supervised methadone maintenance programme. In addition, he was prescribed other medication by the community doctor for chronic obstructive pulmonary disease, high blood pressure and back pain. His medication was issued to him by Bowling Green staff each day.
3. In August, the staff became concerned that the man regularly appeared over-sedated and wrote to his doctor to highlight their concerns. A search of the man's room at the beginning of September found medication which was not prescribed to him (which was against the rules of residence). The man was warned of the possible consequences and dangers of his actions.
4. On 25 September, when non-prescribed medication was found in the man's room a second time, and staff were again concerned that he seemed over-medicated, he was placed on self-harm monitoring procedures. A few days later, staff were sufficiently reassured to end the monitoring. It is a concern that the man was also found in possession of prescribed methadone which should have been held by staff at Bowling Green for supervised self-administration.
5. On 30 September, the man returned to the premises shortly before 11.00pm. The member of staff on duty thought that he seemed unsteady on his feet and intoxicated and suggested that the out of hours doctor be telephoned. The man refused the suggestion. The member of staff checked the man three times during the night and saw that he was asleep in his chair.
6. By 11.30am the next morning, the man had still not collected his prescribed medication, so a member of staff went to his room to remind him. The man was found unconscious in his chair and had no pulse. An ambulance was called and staff tried to resuscitate him. Paramedics arrived and took over the man's care and transferred him to hospital where a doctor pronounced that he had died.
7. Toxicological analysis of the man's blood and urine detected the presence of a number of substances, including high levels of methadone, diazepam and nordiazepam. A consultant pathologist concluded that his death was due to the combination of these drugs and their detrimental effect on respiratory function and patchy bronchopneumonia.

8. We conclude that staff appropriately managed the man's apparent use of illicit and unprescribed medication. Short of his recall to prison they could have done little more to prevent his death. However, it is a concern that staff at the approved premises were unaware that he had not handed in his prescribed methadone for Sunday 25 September which should have been stored securely and issued under supervision. We make one recommendation about this. We make a further recommendation about establishing local arrangements for delivery or collection of prescribed medication from pharmacies to the approved premises.

THE INVESTIGATION PROCESS

9. One of the Ombudsman's investigators visited Bowling Green on 13 October 2011 and met several of the staff including the manager of Bowling Green. The investigator also met the man's father and brother who visited Bowling Green that day. The investigator explained the role of the Ombudsman to them. The man's family did not have any specific issues that they wished the investigator to consider in the investigation.
10. Notices about the investigation were displayed in the premises inviting staff and residents to contact the investigator should they wish to do so. No residents came forward to speak to the investigator.
11. The investigator returned to the premises on 3 November 2011 and interviewed six members of staff. He provided feedback on his initial findings to the premises' manager.
12. HM Coroner for North and West Cumbria was informed of the investigation. The post mortem was not received from the Coroner on 12 June 2012 which held up the issue of this report. We are sorry for this delay. The investigation report will be sent to the Coroner to assist with his enquiries.
13. The investigator contacted police investigators who attended Bowling Green immediately after the man's death. The police confirmed that there was no third party involvement.
14. One of the Ombudsman's family liaison officers contacted the man's family. They reiterated that they did not have any concerns or issues that they wished the investigation to address.

BOWLING GREEN APPROVED PREMISES

15. Bowling Green is an approved premises in Carlisle, managed by the Cumbria Probation Trust. Approved premises were formerly known as probation and bail hostels. They provide an enhanced level of residential supervision in the community, in a supportive and structured living environment. Residents must be aged over 18 and include those who have committed serious, violent and dangerous offences and who have completed the custodial part of their sentence. The majority of residents are required to stay as a condition of a court order or prison licence.
16. Bowling Green can accommodate up to 24 male residents on bail, community orders or on licence following prison sentences. Communal areas, including corridors, are covered by CCTV.
17. All residents are subject to curfew conditions. Standard curfew hours are from 11:00pm to 6:00am but other curfew hours may be enforced for particular residents. In addition, some residents might be required to sign in at the premises at a specified time in the day. During the day, residents are free to go out unaccompanied, although they must state where they are going and must sign out when they leave and sign in upon their return. Residents are strictly forbidden from bringing alcohol or illicit drugs into the premises, but can consume alcohol away from the premises.
18. Staffing at Bowling Green includes managerial staff, offender supervisors (previously known as key workers) and support staff. Two members of staff remain on the premises through the night and their duties include checking that residents are in their rooms during the curfew hours.
19. Residents register at one of the local doctors' surgeries. As part of the conditions of residence, most prescribed medications are held by the premises and issued by staff to residents daily. Controlled medication, such as methadone, is generally given to residents under supervision at the local pharmacy. All medications that residents are not allowed to keep in their own possession have to be handed in to staff at the approved premises for retention and issue under supervised self-administration.

Assessment, Care and Teamwork (ACT)

20. Assessment, Care and Teamwork is the system used by the National Offender Management Service in approved premises to identify, monitor and support residents at risk of self harm. Any member of staff can start the ACT process by raising a Concern Form, explaining the reasons for their concern. An Immediate Action Plan is written by the premises manager and, within 24 hours, an ACT assessment is carried out by an appropriately trained member of staff.

21. After the ACT assessment has taken place, an ACT case review is held to determine what measures should be taken to monitor and support the resident effectively. The resident attends the case review and is encouraged to contribute to the decisions being made. An ACT care plan is drawn up detailing the actions required to keep the resident safe and identifying who is responsible for carrying out each action. Case reviews are held at regular intervals to review the actions and the resident's level of risk.

Previous Deaths

22. The man's death was the second at Bowling Green in 2011. The other resident died while away from the premises and in very different circumstances to those of the man.

KEY EVENTS

23. The man was born in Cumbria in March 1971. He suffered from chronic obstructive pulmonary disease (COPD), high blood pressure and back pain from an old injury to his spine. (COPD is a progressive condition which causes irreversible damage to the lungs and produces symptoms such as wheezing, breathlessness and increased sputum production, making the patient at increased risk of chest infections. The disease is characterised by periods of stability with intermittent worsening of symptoms and deterioration over time.) The man had long standing problems with drug misuse, including heroin.
24. The man had served several custodial sentences. In November 2007, he was sentenced to eight years imprisonment for serious offences. He was granted conditional release from HMP Haverigg on 31 May 2011. When a prisoner is granted conditional release, they are normally required to live at an approved address. The man was found a place at Bowling Green approved premises in Cumbria.
25. On his release from Haverigg, he was given seven days' supply of his medication, which was handed to Bowling Green staff. His prescribed medication was dihydrocodeine (opiate pain relief), pregabalin (for chronic pain relief), salbutamol (for COPD), tiotropium (for COPD), furosemide (for high blood pressure), ranitidine (for gastric conditions) and zopiclone (sleeping tablet). A risk assessment was carried out and staff decided that the man should not keep any medication in his possession and that it would be issued to daily.
26. On 1 June, a doctor from St Paul's Medical Practice visited the man to begin the process of registering him with the practice. That same afternoon, the man saw a Carlisle Drug and Alcohol Recovery Team (DART) worker, and received his prescribed 55mls of methadone. He was asked to return the following day to be given his ongoing methadone prescription. The man was instructed to receive the methadone from Lloyds pharmacy each weekday, he would be supervised taking it. On Saturdays, he would receive that day's dose at the pharmacy and be given Sunday's dose which had to be handed in to approved premises' staff. The manager of Bowling Green said staff were required to record the date of receipt and amount of methadone. The medication was to be securely retained in a locked cabinet. Staff recorded each Sunday that it had been issued and they had witnessed the man take the methadone that day.
27. Later that afternoon, staff gave the man information about life at Bowling Green and explained the premises' rules and regulations. He signed the residents' agreement, witnessed by a member of staff. The declaration on the bottom of the form stated:

"I have read – or had read to me – these Rules. I understand and agree to abide by them. I am aware that if I do not obey these

Rules, that will be taken into account in assessing whether I should still be allowed to live in the Approved Premises, and it may result in the withdrawal of my place, return to Court, or recall to prison.”

28. The next day, the man saw the doctor from St Paul's Medical Practice to complete his registration and confirm his prescribed medication. The man was required to sign a log at Bowling Green on each occasion that he was issued his medication and a member of staff would also sign to confirm that the medication had been dispensed.
29. In the days that followed the man settled into life at Bowling Green, was monitored by staff and attended a Thinking Skills Course. He continued to be issued his medication daily.
30. On 11 June, Bowling Green staff called the emergency doctor service as the man had been vomiting black blood. The doctor advised that the man should be taken to the accident and emergency department at the local hospital.
31. The man was admitted to the Cumberland Infirmary where he remained as an inpatient until his discharge on 16 June. The man told Bowling Green staff that his blood pressure had been high but that the other tests conducted by the hospital were inconclusive.
32. The man continued to work with the DART team and, over time, his prescription of methadone was decreased to 40mls. However, at the beginning of August 2011, Bowling Green staff became concerned that the man seemed over-sedated on a number of occasions. They did not know whether he had been over-prescribed medication or was taking illicit drugs or medication outside the premises. They discussed their concerns with the doctor from St Paul's Medical Practice who visited Bowling Green on 9 August. He said he would liaise with the DART team.
33. Two days later, the doctor contacted Bowling Green by telephone to say that he had contacted the DART team and had been told that the DART doctor, had recently increased the man's prescription of methadone to 50mls.
34. On 26 August, the man was told that his application to Derwent and Solway Housing Association had been successful and they were looking to provide him with either a flat or bungalow, but that this would take some months to arrange.
35. On 7 September, Bowling Green staff conducted a routine health and safety check of residents' rooms. Staff checking the man's room found a bent spoon with a white substance on it, suggesting he had been using illicit drugs. Following the check, the man left Bowling Green to meet a friend. Staff saw the man put a carrier bag into the bins outside the premises. They retrieved the carrier bag and found that it contained

empty blister packs of dihydrocodeine, gabapentin (for chronic neuropathic pain), zopiclone, and codeine phosphate (for mild to moderate pain relief). As the man's medication was held by premises' staff and issued to him daily, they concluded that this was not medication which had been prescribed to him.

36. The following day the Bowling Green manager, issued the man a first warning letter as a result of him having medications in his possession that had not been handed over to staff. The letter concluded with the following paragraph:

“This letter constitutes a First Warning on your licence. Any further failures to comply with the Approved Premises Rules and or the conditions of your licence could result in your residency at the Bowling Green being terminated which could result in your return to prison.”

37. The Bowling Green manager also instructed staff to carry out random searches of the man's room to check for evidence of any unauthorised or illicit medication. The manager explained at interview that the warning procedure gave the man the opportunity to correct his behaviour and abide by the rules of the premises.
38. That evening, the man's room was searched again and an empty blister pack of pregablin was found.
39. Probation Service Officer A, emailed the doctor from St Paul's Medical Practice on 9 September. The Probation Service Officer reiterated staff's concerns that the man appeared over-medicated and might be taking more than his prescribed medication and methadone. He told the doctor of the recent medications finds. The Probation Service Officer wrote that the man had been complaining of aches and pains and swollen legs – which could be a sign of overdose. He explained that the man was at risk of having his licence revoked if there was future evidence of illicit drug or medication use.
40. Later that morning, the Probation Service Officer A contacted Lloyds Pharmacy in Carlisle to discuss the concerns that the man was taking someone else's prescribed medication. Pharmacy staff said individuals regularly appeared to exchange or sell their prescribed medication outside the pharmacy door, but said that there was nothing that they could do once individuals had been given their medication. (Under the Misuse of Drugs Act 1971, it is a criminal offence to sell or pass on prescribed medication.)
41. The doctor from St Paul's Medical Practice rang Bowling Green on the afternoon of 9 September and instructed staff not to issue any medication to the man if he appeared intoxicated.

42. On 16 September, St Paul's Medical practice rang Bowling Green to inform staff that the doctor from St Paul's Medical Practice had reduced the man's zopiclone prescription from two to one tablet a night. The man was told this at approximately 4.15pm and he immediately left Bowling Green to go and see the doctor. Some fifty minutes later, the doctor rang Bowling Green to say that he had relented and was willing to prescribe two zopiclone tablets a night.
43. On 25 September, a number of empty packets of prescribed medication and a methadone bottle were found in the yard of Bowling Green. This prompted an immediate search of the man's room during which staff found a Suboxone tablet (for the treatment of opiate addiction) and another medicine bottle containing what appeared to be methadone, neither of which were prescribed to the man. That day's prescribed methadone was also found. It appears that the man had not handed in his medication to staff the previous day. There is no record that staff noted or acted on this omission. The man appeared to be over-medicated again and, at 12.25pm, an ACT plan was opened.
44. The manager of Bowling Green assessed that the risk of the man deliberately harming himself was low but that there was a risk of accidental self harm if the man took additional drugs to those that he was prescribed. Because the man seemed over-medicated, staff did not issue him with his evening medication. The man was placed on hourly observations throughout the night.
45. The manager of Bowling Green discussed the medication finds with the man's offender supervisor who agreed that they should monitor the man on an ACT plan and try to gain his co-operation. They considered that the man posed a greater risk to himself than to the public and that he needed to be educated about the risks and possible consequences of his actions.
46. The next morning, the man saw the manager of Bowling Green to review the ACT document. The manager assessed that the risk remained the same. Observations were amended to every two hours throughout the night and the man was told that his room would be searched regularly. The manager explained to the man that this was being done for his own safety and wellbeing and outlined the dangers and consequences of taking more than his prescribed medication. Checks were undertaken by staff every two hours during the night and there were no concerns reported.
47. The following day, 27 September, the man attended a second ACT review with the manager of the premises and member of staff B. The man was advised to continue to be compliant with AP rules, requests to search his room and observations by staff, all of which was being done to ensure his welfare and wellbeing. Staff conducted a room search and continued with the two hourly observations through the night. There were no concerns recorded.

48. The man attended a further ACT review, conducted by the manager of Bowling Green and member of staff B, on 29 September. It was agreed that the ACT would be closed as the man had been compliant with his medication and no unauthorised substances had been found when his room had been searched. The staff reiterated that, for the man's own safety, they would not give him his medication if he appeared to be under the influence of any substance. He was also told that he must adhere to the curfew rules at Bowling Green.
49. The next day, the manager of Bowling Green completed an ACT post closure review with the man. The manager recorded that the man accepted that the staff were concerned about his welfare and that he was aware of the consequences and dangers of taking non-prescribed medication.
50. On the evening of 30 September, the man returned to Bowling Green in time for the 11pm curfew. Member of staff C was on duty and was concerned that the man was unstable on his feet, slurring his words, and seemed over-medicated. Member of staff C asked the man if he wanted the out of hours doctor to be called but he said no. Member of Staff C was sufficiently concerned about the man that he checked on him at 12.15am, 3.05am and 4.40am. On each occasion, he appeared to be asleep in his chair. In interview, member of staff C said that it was not unusual for the man to sleep in his chair and that the man was not wearing his tee-shirt and the member of staff C could clearly see his chest rise and fall so it was evident he was breathing.
51. At 11.20am the next morning, staff realised that the man had not collected his medication. A Probation Service Officer B, and another member of staff went to the man's room where they found him slumped in his chair and unresponsive. The two officers began cardiopulmonary resuscitation (CPR, the delivery of rescue breaths and chest compressions to circulate oxygen around the body) and, at 11.22am, called for an emergency ambulance. The paramedics arrived at 11.32am and, after a short assessment, transferred the man to Cumberland Infirmary where, at 11.50am, he was pronounced dead by a hospital doctor.
52. The man's family were informed of his death by Cumbria Police . The manager of Bowling Green contacted them and offered support and financial assistance towards funeral expenses. Support was made available to residents and staff who were affected by the man's death.

TOXICOLOGY AND CAUSE OF DEATH

53. After the man's death, samples of his blood and urine were tested for the presence of a range of substances. High levels of methadone, diazepam and nordiazepam were detected, indicating that they had been taken not long before the man's death. The concentration of methadone found in his blood was consistent with that found in patients on methadone maintenance therapy. Neither diazepam nor nordiazepam were prescribed to him. The levels of dihydrocodeine and zopiclone (both of which were prescribed to him) found were consistent with his prescribed doses. The toxicologist commented that the combination and concentrations of methadone, diazepam and nordiazepam present in his system were likely to have affected his breathing and levels of consciousness.

54. A post mortem examination was carried out by a consultant histopathologist (who specialises in the diagnosis and study of disease through the interpretation of cells and tissue samples). The consultant histopathologist concluded that the man's death was caused by high levels of methadone, diazepam and nordiazepam combined with patchy bronchopneumonia. The consultant histopathologist commented that, in her opinion, the patchy bronchopneumonia would not have caused death in an otherwise healthy young man, but combined with the affects of the high levels of methadone, diazepam and nordiazepam, "would be enough to cause significant respiratory depression/arrest."

ISSUES

The man's use of illicit drugs

55. The man suffered from COPD, high blood pressure and back pain and was prescribed medication. He also had a history of drug misuse and was on a methadone maintenance programme. The man was under the care of, and received treatment from, the doctor at St Paul's Medical Practice and Carlisle Drug and Alcohol Recovery Team.
56. The post mortem and toxicology examinations found that the man's death was the result of a combination of bronchopneumonia and respiratory depression, probably worsened by his use of methadone and drugs that had not been prescribed to him. Accordingly, this investigation has considered how the staff at Bowling Green responded to the man's suspected use of illicit and un-prescribed drugs.
57. In early August, staff at Bowling Green became concerned that the man was over-medicated or taking illicit drugs in addition to his medication. On 7 September, the man's room was searched and staff found evidence to indicate that he was using illicit drugs and taking medication that had not been prescribed to him. Staff found further evidence of his taking unprescribed medication the following day. The man received a first written warning that his continued use of illicit drugs would result in him losing his place at Bowling Green, which could have triggered his recall to prison. Staff raised their concerns about the man with the doctor from St Paul's Medical Practice and the DART team. They also spoke to staff at the pharmacy where the man collected his medication.
58. Probation Instruction 09/2009 says;:

"Dispensed medication (all medication)

5.1 APs must make arrangements – should such arrangements not exist already – with relevant pharmacies so that medication is delivered to the AP (or collected by AP staff). These arrangements should make provision for exceptions such as asthma inhalers and insulin. Having medication delivered (or collected) will give APs automatic oversight irrespective of whether MiP has been granted or not. This will provide a useful 'safety net' in respect of all residents, eg if there is a problem in what has been disclosed by residents, it should come to light at the point of delivery. It will also allow AP staff to accurately record all residents' medication, whether MiP or not"
59. Bowling Green did not have any such arrangement with the pharmacy for any of the man's medication, including his methadone. This would have meant that staff did not have to rely on the man and other residents handing their medication in. It would also help prevent the illicit trading of prescribed medication to and from the pharmacy.

The manager of Bowling Green approved premises should make arrangements with local pharmacies for the collection or delivery of prescribed medication.

60. On Sunday 25 September, staff conducting a room search found medication that had not been prescribed for him, along with his prescribed methadone which he had not handed in to staff the previous day as he was required to do. The man was placed on an ACT plan. The manager explained that he decided to offer the man support through the ACT process before issuing any further warnings. Staff used the process to try to educate the man about the risks and possible consequences of his actions. As the man had lived at Bowling Green since early June and was known to have drug problems, it is a concern that Bowling Green Staff had not noticed that he had not handed in his Sunday dosage of methadone the day before and tackled him about it. While it was the man's responsibility to hand his methadone this was a significant omission by staff. We therefore make the following recommendation:

The manager of Bowling Green approved premises should ensure that all prescribed controlled drugs in the premises are properly accounted for and appropriately stored at all times in accordance with the Misuse of Drugs Act 1971.

61. As the man was found with unprescribed medication in his room after having received the first warning, staff could have taken steps to instigate his recall to prison. However, due to their concerns about the man's health and wellbeing, they decided to use the ACT system to try to deter him from further illicit drug use. The post mortem results show that they were unsuccessful in this. Because of his lifestyle the man's death was not entirely unpredictable. Nevertheless he had been warned of the serious risks involved and we consider that staff at Bowling Green took reasonable steps to keep the man safe.

The emergency response

62. When the man returned to Bowling Green on the night of 30 September, staff member C thought that he seemed intoxicated. He suggested that the out of hours doctor be telephoned, but the man declined. Because of his concerns, he decided to check the man during the night. He did so on three occasions and saw that the man was asleep in his chair. We believe that staff member C took the sensible decision to monitor the man that night.
63. At 11.20am, when the man had not collected his daily medication, staff checked on him and found him unresponsive. The staff response was swift and professional and they carried out CPR until the paramedics arrived.

CONCLUSION

64. The man arrived at Bowling Green Approved Premises on 31 May 2011, having served four years in custody. He had a history of drug misuse and was on a methadone maintenance programme. He also suffered COPD and other health problems, for which he was prescribed medication.
65. When unauthorised medication was found in his room, the man was given a written warning that he needed to comply with the rules of the premises or face possible recall to prison. The staff tried to educate him about the dangerous consequences of his actions. Staff were also concerned that the man frequently seemed over-medicated. They raised these concerns with the community drugs team responsible for the man's methadone prescription and his doctor. It is a concern that the man was also found with prescribed methadone which had not been handed in to staff and appropriately stored.
66. The man's death was the result of patchy bronchopneumonia combined with the effects of drug toxicity. While we think that the man's death was a predictable outcome of his addiction to drugs, we conclude that Bowling Green staff could not reasonably have done more to prevent it.

RECOMMENDATIONS

1. The manager of Bowling Green approved premises should ensure that all prescribed controlled drugs in the premises are properly accounted for and appropriately stored at all times in accordance with the Misuse of Drugs Act 1971.

Accepted

2. The manager of Bowling Green approved premises should make arrangements with local pharmacies for the collection or delivery of prescribed medication

Accepted