Investigation into the circumstances surrounding the death of a man during March 2010 at Brigstocke Road Approved Premises

Report by the Prisons and Probation Ombudsman for England and Wales

September 2010

This is the report into the circumstances surrounding the death of a man on 12 March 2010 at Brigstocke Road Approved Premises, in Bristol (Approved Premises are residential hostels under the supervision of the probation service). He was found in his room at 9.00am by the regimes manager, after he failed to collect his medication. The man showed no signs of life and the emergency services were called. The police attended at 9.15am however, the police failed to inform the ambulance service of the emergency and paramedics did not arrive until 10.20am when they confirmed the man had died.

A post mortem was held at the request of Her Majesty's Coroner for Avon. The post mortem noted that the man died of Amitriptyline toxicity and ischaemic heart disease. He did not register any next of kin with Brigstocke Road. Despite enquiries by the police no relatives have been traced up to the circulation of this report. I extend my sincere condolences to the staff and residents of Brigstocke Road and those touched by his death.

A clinical review of the man's healthcare whilst at Brigstocke Road was commissioned from Bristol Primary Care Trust (PCT). I am grateful to them for carrying out that review.

The investigation was carried out by one of my investigator's. I would like to thank the Brigstocke Road Approved Premises regimes manager, the premises manager and staff for their assistance with this investigation. Furthermore, I am appreciative of the help of Avon and Somerset Probation Trust.

I make two recommendations, the first commending the staff at Brigstocke Road for the care they afforded to the man during his time there and following his death. The second recommendation is to the National Probation Service to develop guidance in the event of the death of a resident without next of kin. I make one point of good practice in relation to the professionalism of a staff member of Brigstocke Road.

This final report notes that both recommendations have been accepted by Avon and Somerset Probation Trust and the National Offender Management Service on behalf of the National Probation Service.

Thea Walton
Acting Deputy Prisons and Probation Ombudsman **September 2010**

CONTENTS

Summary 4

The investigation process 5

Brigstocke Road Approved Premises 6

Key findings 7

Issues 11

Conclusion 14

Recommendations 15

SUMMARY

The man was released on licence from HMP Erlestoke in November 2009 to Brigstocke Road Approved Premises following a conviction for Arson. He was allocated a key worker and was supervised by Avon and Somerset Probation Trust. He was seen by mental health services to continue this support in the community. He was prescribed medication for depression, anxiety, abdominal disease and pain relief. His medication was dispensed to him daily by staff at Brigstocke Road.

It was evident that he became agitated and anxious when faced with decision making and struggled to become self sufficient with his day to day living. The man made full use of community based activities and was a regular visitor to a day unit for those with mental health problems. He attended church on Sundays and received support from nuns working with this church.

The man received a warning when alcohol was found in his room, although he denied using it on a regular and daily basis. A meeting with multi disciplinary agencies to review his future was cancelled when it was thought he was under the influence of alcohol. A second meeting was also cancelled for the same reason however, a short while later, the man tested negative for alcohol on a breath test. It was documented by Brigstocke Road staff that his demeanour, when anxious, could be similar to that of someone under the effect of alcohol.

On the evening of 8 March 2010, the man was seen having a late supper in the communal kitchen. He was pleasant and said he was soon going to bed. The following morning he did not attend the office for his medication. A member of staff went to his room and found him, on the floor, with no pulse and cold to touch. The police and ambulance were called for and on arrival of the police into the man's room, it was noted that in both the police and the member of staff opinion that the man had died. An ambulance arrived sometime later, and confirmed this. The man did not register any next of kin at Brigstocke Road, and did not talk about family to staff. Staff arranged a funeral service for him.

There are two recommendations, the first to commend the staff at Brigstocke Road for their care of the man during his short time there and following his death. The second recommendation for the National Probation Service to develop guidance in the event of the death of a resident with out next of kin. One area of good practice refers to the professionalism of a staff member of Brigstocke Road.

THE INVESTIGATION PROCESS

1. The investigation into the man's death was opened by my investigator on 17 March 2010 when she visited Brigstocke Road. There she met the regimes manager and reviewed the man's probation service file. My investigator asked for copies from that file to be sent to her. Later, she visited the room where the man had been found on 9 March.

2. Copies of the Ombudsman's notices of investigation and terms of reference had been sent to Brigstocke Road in advance of my investigator's visit. Up to the circulation of this report there has not been any response to those notices.

3. On 10 March a clinical review was commissioned from Bristol PCT. Further enquiries were made with the PCT on 10 May and a doctor was appointed as a clinical reviewer. On 29 April, my investigator visited Brigstocke Road and interviewed three members of staff and the man's offender manager.

4. The man had no next of kin registered with Brigstocke Road. A copy of this report will be retained by my office should any family or relatives make contact in the future.

BRIGSTOCKE ROAD APPROVED PREMISES

5. Brigstocke Road Approved Premises in Bristol are four Victorian houses joined together through inter communal doors. The premises have rooms for 28 adult male residents, 14 on full board accommodation and 14 places for self catering residents. The premises take offenders, on release from prison, who are deemed to be of high risk to the public.

6. There are seven full-time staff covering shifts between 8.00am-9.30pm and two probation service officers working night shift. Additionally there is a manager, regimes manager and administration support.

7. All residents register with community based doctors and their medication is prepared by a local pharmacy. It is kept in a secure cabinet in the main office and residents attend the office at specific times during the day to receive their allotted dose of medication, which is stored in individual dosette boxes. (A dosette box is clearly labelled for each day and contains the correct amount of medication to be dispensed. All the dosette boxes are prepared by the pharmacist prior to being delivered to Brigstocke Road.)

8. Offender Managers from the Bristol probation office visit Brigstocke Road regularly to supervise offenders and those whose offender managers are based outside the Bristol area.

9. Brigstocke Road has links into the community to provide activities and opportunities for residents to progress their rehabilitation and address their offending behaviour.

10. This is the first death I have investigated at Brigstocke Road since my office took over this responsibility in 2004.

KEY FINDINGS

11. The man was born in 1963 and was a single man. Very little is known about his past personal history apart from information held in his Offender Assessment and Systems (OASys) document which recorded he had a difficult childhood. (An OASys document details the offender's custodial/probation history along with personal information and offending behaviour.) The man did not have contact with any relatives and found it difficult to make and retain relationships. Before being taken into custody, he was living in the Bath area and received help from the community mental health team for anxiety and paranoia. In 2008, the man was convicted of arson and sentenced to 45 months imprisonment.

12. Following a remand at HMP Bristol, the man was transferred to Erlestoke. In January 2009, a mental health nurse wrote in his medical notes that the man was well known to the mental health service whilst he was in HMP Bristol. The nurse noted that he felt unable to cope with decision making and when asked to do so would panic. His prescription of anti anxiety medication which included Amitriptyline and Citalopram would continue, in addition to regular reviews with the mental health service. It was further noted that the man was prescribed Omeprazole for a gastric condition and ibuprofen for pain relief.

13. The man was allocated work in the gardens at Erlestoke, a job he enjoyed and he settled into a routine. His bi monthly reviews with the mental health service continued until August when he spoke to a mental health nurse and expressed anxiety over his forthcoming release and future plans. The nurse reassured him that this would be considered by the multi-disciplinary services.

14. Two weeks later, the man told a mental health nurse he was having night terrors and hearing voices but he had no thoughts of self harm. The nurse spoke to a doctor and Quetiapine was prescribed. (Quetiapine is an anti psychotic medication)

15. A counsellor met with the man at the end of August and they discussed his concerns over his forthcoming release. He was given some exercises and coping mechanisms to reduce his anxiety. The following day it was noted that the man appeared to be calmer. His sessions with the counsellor and mental health nurses continued until he was released, on licence, from Erlestoke on 4 November.

16. The man was allocated a place in Brigstocke Road Approved Premises and arrived there the same day. He was met by a probation service officer, who completed the paperwork for his stay. The man did not offer any details of next of kin to be registered with Brigstoke Road.

17. The following day, the man had an assessment interview with a psychiatrist and a mental health social worker. At the interview the man said he experienced panic attacks, anxiety, low mood and hearing voices. However, he had not taken any illegal medications or alcohol for two years and his physical health had improved. It was agreed that having a structured routine

would be beneficial for his mental and physical well being. A referral was made for him to be seen by an assessment and intervention team. He also registered with a doctor at a surgery close to Brigstocke Road.

18. On 26 November, an initial Multi-Agency Public Protection Arrangements (MAPPA) meeting was held to discuss actions to ensure the man's safety and that of the public. (MAPPA is a multi-disciplinary panel drawn from the probation service, police and other interested parties to monitor offenders who are deemed to be a risk to the public.)

19. A further MAPPA meeting took place on 10 December, when it was decided that the man was to receive full support from the community mental health team and assistance from his key worker at Brigstocke Road. His offender manager was based in Bath, therefore an offender manager from the Bristol probation service took over supervision of his care whilst he was resident in Brigstocke Road. His supervisor was subsequently replaced by in January 2010.

20. The man settled into a routine at Brigstocke Road. For the first few months he was resident on a full board basis and took his meals at the premises. Later, he moved into the self catering area where he cooked his own meals. He was not totally independent and staff would assist him by allowing him to have some meals with the full board residents.

21. As part of a structured day to day routine the man attended the Compass Centre, a day provision funded by the National Health Service which offers activities and resources for people with mental health conditions. The man learnt to play the guitar and took part in art class. He attended mass on a Sunday and was offered help by the nuns at the church. He also liked to visit charity shops and was considering some form of voluntary work.

22. The man's probation service officer told my investigator that whilst he was not the man's designated key worker, he knew him extremely well and they had built a good working relationship. He said that the man became very anxious when faced with decision making and was concerned over his future plans for moving on from Brigstocke Road. The probation service officer helped the man to keep his own diary sheet so he could plan his time and prepare for any forthcoming meetings. He added that the man could have bad days with low mood these did not last long and with encouragement from staff he would soon be back in control. He attended his doctor's appointments and reported daily to the office for his medication.

23. A multi-disciplinary meeting was held in February to assess the man's progress. However, the meeting was cancelled when it became known that he had consumed alcohol. The regimes manager told my investigator that the man had also been found in possession of alcohol in his room. This was against Brigstocke Road's house rules. The man was given a warning about possessing alcohol on the premises. The regimes manager said the man was not a heavy drinker though he liked a drink in the evenings, and was seemingly using alcohol when he felt under pressure.

24. A Bristol offender manager saw the man at Brigstocke Road to supervise his licence conditions on a regular weekly basis. The offender manager told my investigator that the man had a lack of trust in people and found it difficult to build relationships. Nevertheless, they had worked well together although the offender manager felt that the man still had some way to go before he would be ready for a move into community living.

25. In early March, a meeting was arranged with a housing provider. Before the meeting the man asked the probation service officer if he could be present to offer him support. The officer was unable to attend and the regimes manager agreed to act as support for the man at that meeting. Due to a family emergency, the regimes manager was also unable to attend. The meeting was again postponed as it was thought that the man was under the influence of alcohol. On return to Brigstocke Road, the man took a breath test which proved negative for alcohol. The probation service officer told my investigator that the man's erratic behaviour at this meeting was more than likely due to anxiety.

26. On 8 March, a probation service officer at the approved premises reported for night duty at Brigstocke Road. As part of his duties he would check all the residents were in the premises before curfew time of 11.00pm. The man was seen by the officer and took an alcohol breath test which proved to be negative. (Breath tests are taken randomly if there is suspicion or previous issues of alcohol use with residents.)

27. The officer carried out a check of the premises and at around 11.10pm saw the man in the kitchen area eating some soup. They exchanged pleasantries and the officer carried on with his duties. The following morning the officer's shift finished at 8.15am and he did not see the man before he left..

28. The probation service manager and the regimes manager were on duty on the morning of 9 March. The probation service manager was in the office handing out medication at around 8.30am. He had not seen the man that morning, which was unusual as he was an early riser and would come to the office for his medication. He was also aware that the man had a meeting at 9.00am with his offender manager and that he should be ready. When the regimes manager came into the office the prison service manager told him that the man had not been down for his medication and he should be checked. The regimes manager told the probation service manager to carry on with the residents' medication whilst he went to see the man.

29. About 8.50am, the regimes manager went to the man's room. He knocked on the door and called the man's name but got no reply. The regimes manager unlocked the door and on entering the room saw the man lying on the floor near his bed. There was some fluid around his face. He checked for a pulse but could not find one. Whilst checking for a pulse the regimes manager noted that the man was cold and there were no signs of life.

30. The regimes manager left the room and went immediately to his office. He telephoned the emergency services and asked for the police and ambulance service. The operator put him through to the police. He told them that, in his opinion, he had found one of his residents dead. The police operator told the regimes manager they would inform the ambulance service.

31. The regimes then went to the main office and asked the probation service officer to come with him and to shut the medication cabinet. Both men went to the man's room and the probation service officer checked the man for any signs of life, of which he said there were none. They left the room and locked it until the arrival of the police.

32. The police arrived at Brigstocke Road around 9.15am and went to the man's room with the regimes manager. The police established no signs of life. The ambulance did not arrive until 10.20am when paramedics pronounced death. I understand the police have carried out their own enquires as to why the ambulance service took so long to respond to the regimes manager's emergency call.

33. In company with the police, the regimes manager searched the man's room. He told my investigator that the man's television was on and it looked as if his bed had not been slept in. A bottle of vodka was found in his refrigerator with a small amount missing.

34. The regimes manager made contact with his senior managers in Avon and Somerset Probation Trust and two managers attended Brigstocke Road to support staff. Later that morning, a meeting of residents was called in the residents' meeting room and they were told of the man's death. All residents were offered support from staff.

35. No next of kin details were recorded in either the man's prison or probation files. Police have also been unable to trace any relatives. The man had not spoken to staff about any family and only offered scant information about a previous relationship with a woman in Bath.

36. Staff at Brigstocke Road made arrangements for the man's funeral. The probation service officer made a framed tribute and read a poem at the service. Floral tributes were made by the administration manager. The funeral was attended by staff and residents at Brigstocke Road, probation service staff and the man's friends from a community centre. Following the service the centre arranged a wake to which all were invited.

ISSUES

Clinical review

37. A review of the man's clinical records was commissioned from Bristol PCT. A doctor carried out that review on behalf of the PCT. A post mortem examination was undertaken and the cause of death was noted to be Amitriptyline toxicity and ischaemic heart disease. (A higher than therapeutic level of Amitriptyline and coronary heart disease.) Further investigations also recorded that the man's liver was massively enlarged, which might be due to alcohol misuse or active hepatitis C. The high levels of Amitriptyline were noted to be 1.03 milligrammes per litre (levels greater than one are associated with serious toxicity). Low levels of alcohol and diazepam were recorded. The pathologist commented:

    > "However, Amitriptyline is also cardio toxic and even in modest overdose can cause cardiac arrhythmias. This patient also had severed coronary artery disease as noted above which would also predispose to cardiac arrhythmia." (Irregular heart beat)

38. A summary of the man's medical care noted that he had no recorded history of ischaemic heart disease in his prison or community primary care medical records.

39. The post mortem report indicated a degree of Amitriptyline toxicity found in a sample taken from the man contributed to his sudden death. The clinical reviewer considered whether the prescribing was appropriate and confirmed that the dosage of 50 milligrammes per night was well within safe limits. (Amitriptyline is licensed to be prescribed up to 150 milligrammes per day.) Furthermore, the man's medication was reviewed regularly by his community doctor during the last few months of his life. His medication was prescribed in weekly prescription scripts, dispensed and then handed to Brigstocke Road staff.

40. The man received his medication from staff daily and there was no indication that he was non compliant with taking his medication. The clinical reviewer's conclusion is:

    > "There is evidence of holistic care from the primary care medical team. The man died suddenly of Amitriptyline toxicity and ischaemic heart disease. He was found on the morning of 9 March 2010. There is no evidence of any factors that could have prevented this death."

Care of the man at Brigstocke Road

41. It has been well documented that the man had mental health problems which caused him anxiety, some paranoia and at times to be low in mood. He regularly attended doctor's appointments and was taking prescribed medication to address and help his mental health. Despite the medication,

staff at Brigstocke Road noted, and told my investigator that he still had periods of erratic and agitated behaviour.

42. It was found that the man had been using alcohol in February 2010, which was against the rules of Brigstocke Road. He had received a warning for being in possession of alcohol. The probation service officer told my investigator that he had been upset by this and was only taking a glass of wine in the evenings. However, following his death a bottle of vodka, was found in his room from which a small amount had been drunk.

43. The man had settled into a routine of day to day activities within the community close to Brigstocke Road. He attended a community centre and enjoyed taking part in guitar lessons and art classes. He was a regular churchgoer and received support from the nuns. His offender manager told my investigator that meetings were taking place to assess his needs and future plans for a move to community living.

44. The man was concerned about his future and what it held for him. At interview, the offender manager told my investigator that in his opinion the man still had some way to go before he could be considered for residency away from Brigstocke Road.

45. The probation service manager spoke at great length during interview about the support he and the staff offered to the man. He told my investigator that the man was mostly cheerful and open to advice from staff. When his mood did alter staff would soon become aware of this change in personality and encouraged him to be positive.

46. I note as good practice the professionalism shown by the probation service officer in building a positive and trustful relationship with the man

9 March 2010

47. The probation service officer knew that the man had an appointment with his offender manager at 9.00am that morning. When he did not come down for his medication, as was his usual routine, the probation service officer alerted the regimes manager and he went to find him. When he discovered the man, on the floor of his room, with no signs of life, the emergency services were contacted.

48. The police arrived shortly after the telephone call but the ambulance service failed to arrive until one and half hours later. I understand from the regimes manager that the police have conducted their own enquiry as to why the ambulance was delayed. I do not have any further information as to the outcome of that enquiry. The regimes manager had checked the man and found no sign of life. This was supported by the probation service officer and later by the police. Nevertheless, the late arrival of the ambulance raises concerns and I hope that this matter has been resolved so that any future emergencies are dealt with appropriately and in timely fashion.

Following the man's death

49. The man did not offer any details of next of kin to either the prison or probation service. Very little was known about his personal history and he did not talk about his personal life to staff. The police were unable to trace any next of kin.

50. The administration manager at Brigstocke Road made enquires with the local authority and coroner's office to ascertain the procedures for financing man's funeral costs. No formal instructions have been circulated to assist managers of approved premises in the steps of dealing with the death of a resident where there is no next of kin. I therefore make the following recommendation.

    The National Probation Service should develop guidelines for approved premises, detailing the processes and procedures for the funeral arrangements of residents without next of kin.

51. The man's funeral was arranged by the staff at Brigstocke Road. They went to great lengths to ensure that he was given a respectful and dignified ceremony. Staff duties were changed so they could attend the service and participate fully. Residents also attended to pay their respects. Following the funeral the man's offender manager emailed my investigator to tell her that it had been a well attended service. The community centre kindly provided refreshments afterwards and a choir sang their tribute to the man.

52. Whilst it is unfortunate that no next of kin could be traced, the man's life was celebrated by his friends and those he trusted.

    I commend the staff of Brigstocke Road for their compassion in arranging a funeral service for the man and the overall care they afforded him whilst he was a resident.

CONCLUSION

53. The man had mental health problems which were documented whilst he was in prison and subsequently when he moved to Brigstocke Road. He was prescribed medication to help his symptoms but still had periods of agitation and anxiety when he felt under pressure. It was recorded that he had been warned about having alcohol in his possession and alcohol was found in his room following his death. However staff believed he was not a heavy drinker and used alcohol as a support mechanism when he was under stress and faced with making decisions.

54. The clinical reviewer observes in his clinical review that the man had a history of ischaemic heart disease and no symptoms of such disease were described in either his prison or primary care (community) medical records. The findings of the post mortem examination indicated that the man had high levels of Amitriptyline in his body which contributed to his sudden death from heart disease. It is evident that he suffered from mental health problems and it is unclear whether the man took an overdose of Amitriptyline, which he may have saved from his daily allocation, on the evening of 8 March.

55. I commend the staff at Brigstocke Road for the care they afforded to the man which was followed through in arranging his funeral service. I make one recommendation to the National Probation Service to develop guideline on funeral arrangements for residents without next of kin. One area of good practice refers to the professionalism of a member of Brigstocke Road.

RECOMMENDATIONS

The Chief Executive of Avon and Somerset Probation Trust

I commend the staff of Brigstocke Road for their compassion in arranging a funeral service for the man and the overall care they afforded him whilst he was a resident.

Accepted

The National Probation Service

The National Probation Service should develop guidelines for approved premises, detailing the processes and procedures for the funeral arrangements of residents without next of kin.

Accepted