PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the death of a resident at Brigstocke Road Approved Premises in the Avon and Somerset Probation Trust, in September 2011

Report by the Prisons and Probation Ombudsman for England and Wales

November 2012

This is the report of an investigation into the death of a man at Brigstocke Road Approved Premises, Bristol. He died in September 2011, two days after his arrival, having been discovered unresponsive in his room. The post mortem report concluded that the cause of death was hypertensive heart disease (caused by high blood pressure). I offer my condolences to his family and friends.

The investigation was carried out by one of my investigators. A clinical reviewer was commissioned to carry out a review of the man's medical care in custody. Staff at Avon and Somerset Probation Trust cooperated fully with the investigation. I apologise for the delay in issuing this report.

The man was nearing completion of a two year custodial sentence when he died at Brigstocke Road. He had been released from prison just two days earlier. There was no evidence of hypertension during the man's time in prison. However, abnormal cholesterol test results and those from electrocardiograms were not followed up. Although the clinical reviewer concludes this did not impact on the man's death, these were missed opportunities to find out whether the irregularities were caused by any underlying medical conditions.

It is also of concern that, by the end of his sentence, the man had three separate medical records which had not been merged together or cross-referenced. Despite this, he was prescribed appropriate medication and given adequate care in the week before his release. Once released, staff at the approved premises made considerable efforts to engage with him in the short time he was there. However, he was not drug tested in line with local policy, nor was he reminded about the increased risk of overdose or asked directly whether he had any thoughts of self-harm or suicide.

Nevertheless, I have concluded that staff at Brigstoke Road could not have been expected to predict the man's sudden decline in health. When he was found to be unresponsive, staff acted in a calm and competent manner and those who knew the man were well supported following his death.

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 August 2009 the man was remanded into custody for an offence for which he was later sentenced to two years imprisonment. The man had a history of mental health problems, including a diagnosis of schizophrenia. He had misused drugs since the age of 13 and had no stable accommodation. In prison, he was often subject to suicide and self-harm monitoring procedures. He found it difficult to cope and socialise with other prisoners and often moved wings within a prison or to another establishment. In August 2010, he was released to Ashley House Approved Premises, Bristol. However, within days he was required to return to prison.

2. During his subsequent time in prison, the man continued to receive mental health input, was prescribed antipsychotic medication, had his substance misuse problems addressed and completed anger management work. His blood pressure was within the normal range but electrocardiograms and cholesterol tests indicated abnormal results. There is no evidence that any further treatment or investigation was considered. Although the clinical reviewer concludes that this would not have contributed to his death, it is an aspect of the man's care which could have been better.

3. When released to Glogan House Approved Premises, Taunton in August 2011, the man managed, in the main, to comply with its rules. However, around a month after his arrival, he allegedly assaulted another resident and was sentenced to two weeks imprisonment. He spent the following week in HMP Exeter where a new medical record was started, rather than using the existing one, which contained much information relevant to his care.

4. During this week, his offender manager made thorough preparations for him return to the community. When released to Brigstocke Road, Bristol on 23 September, he seemed anxious and unable to concentrate. Staff tried to put him at his ease and ensure his concerns were addressed. Contrary to local policy, he was not drug tested on arrival or the following day, neither was he reminded of the increased risk of overdose following his release from prison. He was also not asked directly about thoughts of suicide or self-harm, although the member of staff completing the induction made her own assessment about this. The next day, the man did not get out of bed although he was supposed to sign in every two hours. Staff checked on him at these times and said they would have referred the man's non-compliance to the manager on Monday (it was the weekend).

5. We conclude that, although the procedures were not strictly followed, staff acted in a reasonable manner and could not have predicted the man's rapid deterioration in health. The following morning the man was found unresponsive in his room and despite staff, paramedics and a doctor attempting to save him, he was declared dead a short while later. The post mortem report concluded that

he died of natural causes, namely hypertensive heart disease (heart disease due to high blood pressure). The support received by staff and the family, following his death, was commendable.

THE INVESTIGATION PROCESS

6. The Ombudsman was formally notified of the man's death on 26 September 2011. Notices were subsequently issued to both staff and residents at Brigstocke Road Approved Premises, informing them of the investigation process and giving them the opportunity to contact the investigator with any relevant information. No one came forward as a result.

7. The investigator visited Brigstocke Road on 5 October and spoke to the (Regional Approved Premises Project Manager) and the Premises Manager. She also interviewed the regimes manager, and two probation service officers (PSO). In addition, a resident was interviewed at his own request. The investigator was also provided with the documents relating to the man. Since the man had not long been released from HMP Exeter, she also obtained documentation relating to his time in custody.

8. On 15 November, the investigator returned to Brigstocke Road to interview two PSOs, and a probation officer. She also telephoned another probation officer, on 29 November and provided the Regional Approved Premises Project manager with written feedback on the investigation the same day.

9. The investigator spoke to a DC about the police involvement in the death. While they regarded the man's death as unexplained, they did not consider there to be any suspicious circumstances.

10. The investigator wrote to the local Coroner's office to inform them of the investigation. HM Coroner will be provided with a copy of our report. The investigator received a copy of the post mortem report on 4 January. The results of this post mortem were unexpected and led to the investigator to seek advice from the Department of Health. Following this consultation, we decided that a clinical review was needed to investigate the man's clinical care while in prison. This review was due on 4 April. A two week extension was agreed on 10 April and the review was received on 25 April. We apologise for the delay in issuing our draft report.

11. One of our family liaison officers contacted the man's aunt to explain the purpose of the investigation and invite her to put forward any questions or concerns. The man's aunt did not wish to raise any issues nor did she make any comment when provided with a draft copy of this final report.

BRIGSTOCKE ROAD APPROVED PREMISES

12. Some offenders are released from prison to continue serving their sentence in the community, rather than in prison. This is known as being released on licence and conditions are attached to their release. They are then supervised by the relevant probation trust and some high risk offenders are required to reside in approved premises, formerly known as probation or bail hostels. The purpose of approved premises is to provide an enhanced level of residential supervision in the community, within a supportive and structured environment, for offenders assessed as presenting a high risk of harm. While residents have to comply with their individual licence or bail conditions, curfews and the approved premises house rules, they are essentially free to go in and out of the building.

13. Brigstocke Road Approved Premises, Bristol, is one of around 100 approved premises in England and Wales. It consists of four Victorian houses joined together through interconnecting doors. There are rooms for 28 adult male residents, 14 on full board accommodation and 14 for self catering residents. The premises take offenders, usually on release from prison, who are mainly deemed to be of high risk to the public. Some medium risk offenders are also accepted

14. There are seven PSOs covering shifts 24 hours a day and two additional security assistants working overnight. Additionally there is a manager, regimes manager and office manager. There are always at least two members of staff on duty, at least one of whom must have had basic first aid training. At night, in line with national guidance, Brigstocke Road has “double waking cover”. This means there is always one PSO and one night security officer who are both awake. At the start and end of their shifts there is a thirty minute overlap between staff so that a handover can be provided.

15. Residents have to abide by a curfew from 11.00pm until 6.00am. They are required to sign in at reception at predetermined intervals. (The man was initially required to sign in every two hours during the day.) After the first few days, once a resident has had time to settle in and demonstrate good behaviour, the frequency can be reduced by the offender manager according to the offender’s risk and progress to date.

16. Offender managers (probation officers) from the local probation office visit Brigstocke Road regularly to supervise offenders. However, the man was supervised by an offender manager from Taunton probation office as this was where he wanted to return after moving on from the approved premises.

17. The man is the third resident to die at Brigstocke Road since the Ombudsman began investigating deaths in approved premises in 2004. The first of these residents died of heart failure in March 2010. The second died in July 2011 and was an apparently self-inflicted death which took place outside the approved

premises, but while the person was resident there. Both reports reflect well on Brigstocke Road and raise no issues relevant to this investigation.

KEY EVENTS

18. The man had an unsettled and traumatic childhood. He began to misuse cannabis at the age of thirteen and left school without any qualifications. As he got older he started taking amphetamines, heroin, crack cocaine and other drugs. He had a history of offending related to this drug misuse. The man was homeless at the time he committed the most recent offence, after a breakdown in his accommodation following a recent release from prison. He had previously been evicted from a number of different hostels due to his misuse of drugs and violence.

19. From around the age of fifteen, the man reported hearing voices telling him to do things. It was assessed to have been linked to his cannabis misuse but also occurred when he was low in mood. By 2009, when he was 18, the man described an increase in these voices, which instructed him to hurt himself and others. It was assessed that these voices were a reaction to past trauma and low self esteem.

20. The man was remanded into custody at HMP Exeter on 17 August 2009 for an alleged offence. It was noted he was low and depressed when seen in the first night centre. Although he had no thoughts of self-harm he was eager to die. The man was made subject to Assessment Care in Custody and Teamwork (ACCT) procedures, which remained open until the end of the year. (ACCT is the suicide prevention system used by prisons to identify and support prisoners who are thought to be at risk of self-harm and/or suicide.)

21. The man spoke to Listeners and was given the Samaritans phone on a number of occasions. (Listeners are selected prisoners trained by Samaritans to provide confidential emotional support to fellow prisoners in distress. The Samaritans phone is a dedicated mobile telephone which can be used by prisoners to call the Samaritans.) At times he found it difficult to get on with his cell mate or other prisoners so frequently moved wings or was not deemed suitable to share a cell.

22. During September 2009, the man self-harmed by cutting and also by tying his bed sheet around his neck. He complained that he was being bullied by other prisoners and was hearing voices.

23. The man was sentenced to 24 months imprisonment at Taunton Crown Court on 16 November 2009 and returned to Exeter Prison. Just over a week later, on 26 November, he transferred to HMYOI Portland. He continued to be monitored within the ACCT process until 25 December, when it was recorded that he seemed more settled and had no thoughts of self-harm. ACCT monitoring was stopped. (He was subject to further periods of ACCT monitoring, intermittently during his imprisonment.)

24. The clinical reviewer notes that the man was morbidly obese and on every occasion his weight was recorded. He was repeatedly advised on diet and lifestyle and attended the gym approximately weekly. He also continued to smoke despite being offered regular advice and on two occasions during his time in prison was prescribed nicotine replacement therapy.

25. On 14 January 2010, the man was referred to the mental health in-reach team. He told staff that he continued to hear voices which instructed him to harm himself and others. The man had been treated with risperidone (an anti-psychotic drug) and subsequently quetiapine (another anti-psychotic). This started to become effective around April, with a reduction in the voices.

26. The man transferred from Portland to HMP Parc on 12 July and was released on 16 August to Ashley House Approved Premises, Bristol. However, within days of this release, he had tested positive for cocaine, made threats to burn down Ashley House and did not take his medication. He was recalled and taken to HMP Bristol on 20 August. He continued to be prescribed quetiapine and received mental health input.

27. On 21 September, the man transferred from Bristol to Portland. Three days later, a panel of the Parole Board recommended he should not be re-released soon due to the risks (drug misuse, mental health) being unmanageable in the community. His release was set for August 2011.

28. The clinical reviewer notes that the man had electrocardiograms (ECGs) – used to measure the electrical activity of the heart in October and December. There was no recorded reason why these were done or if any treatment was needed as a result.

29. The man told staff that other prisoners had been bullying him for his medication and he had been experiencing an increase in hallucinations. As a result, staff ensured that the man took his medication while they were present and asked him to consider having his medication injected (depot injections).

30. In December 2010 and January 2011, the man had cholesterol tests which indicated some abnormal results. These were not followed up with further investigation or treatment.

31. A forensic assessment report prepared by a consultant forensic clinical psychologist at Portland, dated 11 March 2011, states that the man's interactions with others made him vulnerable to being bullied by other prisoners. As a result he had been placed on every wing at Portland and was about to move to Parc. The doctor noted that the man had functioned well in prison as a result of the boundaries set and was compliant with his medication. The doctor also diagnosed post-traumatic stress disorder (a severe anxiety disorder following exposure to a traumatic event) due to events from his childhood.

32. The man also told the doctor that he had anger management problems and a low frustration tolerance. He said he got angry when his needs were not met or he was 'let down' by others and admitted to threatening or hurting others when angry. Community Psychiatric Nurse (CPN) from the prison mental health inreach team, had been carrying out anger management sessions with the man. He also told the consultant forensic clinical psychologist that he would like to receive depot injections rather than continue on his oral medication.

33. On 23 March 2011, a conduct in custody report noted that the man had been engaging with the Counselling, Assessment, Referral and Throughcare service (CARATs), who provide alcohol and drug misuse services and was motivated and keen to change.

34. The man transferred to Parc on 5 April. It was noted in his reception healthscreen that his schizophrenia was well controlled on his current medication. He told the nurse that he had deliberately self-harmed in the past, mainly as a "cry for help" and had only once thought seriously about suicide. In May, the man said he was being bullied by other prisoners and was also selling his medication to them. His antipsychotic medication was subsequently changed from an oral form to depot injections, which were administered by a nurse.

35. The man transferred from Parc to Exeter on 10 August with a view to his planned release on 16 August. The prison liaised with the Community Mental Health Team (CMHT) and probation officer in preparation for his release.

36. Six days later, the man was released to Glogan House Approved Premises, Taunton. It was planned that he would live there for three weeks while he got used to being in the community and then move to more independent accommodation. The man was given his depot injection the day before his release and was also prescribed quetiapine and naproxen (an anti-inflammatory). The local CMHT visited him on several occasions while at Glogan House and offered him support. On 19 August, he was drug tested and was negative for all illicit drugs.

37. On 30 August, the man was taken to view The Grange, supported housing in Taunton, with a view to moving there. However, while at The Grange, he upset other residents and staff decided he was unsuitable to live there. The same day, he tested positive for opiates. However, records note that this may have been accounted for by the opiate-based medication (Zapain – a painkiller) he was prescribed at the time.

38. During the man's stay at Glogan House, his key worker wrote,

> "His behaviour at the Grange reflected his behaviour at Glogan House. While he managed, in the main, to keep to the hostel regime, there were complaints from other residents that he was borrowing money or tobacco or winding

someone up. He complained of boredom and that being at Glogan House was 'doing his head in'."

39. At the end of August, the man received a yellow warning for failing to sign in. A yellow warning remains active on a resident's file for a month and their offender manager is informed. If a resident receives three yellow warnings within a month, they receive a final written warning which could lead to eviction and a breach of their licence conditions. The man received two further warnings in September, for failing to sign in and not attending a residents' meeting, followed by two red warnings. As the man's key worker states,

> "Other residents started to become aware that leniency was being shown to the man due to alleged mental health difficulties and this was causing problems in itself both for other residents and for the man. It was noted by staff that the man responded well to clear boundaries and clear instructions."

40. During this time, the CMHT disclosed to Glogan House that the man had been re-assessed as not having a mental health disorder such as schizophrenia; rather he had an anti-social behaviour problem. However, he continued to be prescribed antipsychotic medication. While at Glogan House, the man attended Turning Point, a local drug agency. He told staff he had been smoking cannabis, but tested negative for this.

41. On 15 September, the man allegedly assaulted another resident in an argument over money and did not sign in as required. The police arrested the man the following day. He was considered in breach of his licence on the grounds that he had broken Glogan House's rules. He appeared at Taunton Magistrates' Court and was sentenced to two weeks' imprisonment.

42. The man was taken to HMP Exeter on 17 September. The police medical form accompanying him noted mental health issues requiring antipsychotic medication. The reception healthscreen recorded that the man was overweight, sweating and suffering withdrawal symptoms. His medical record also noted that he was irate, had poor eye contact as well as poor memory and cognition. A referral to the doctor was made. The record notes he was prescribed quetiapine and haloperidol (another antipsychotic) and had a history of heroin and crack cocaine misuse.

43. During this last week in custody, a new medical record was started for the man, with his name mis-spelt and no prison number. Healthcare staff at Exeter were not aware of his previous record which contained significant mental health issues and a risk of harm history. The new record makes no reference to the depot injections the man had previously been receiving.

44. Prescriptions of methadone, quetiapine and naproxen were recorded and the man was referred for drug treatment. The nurse who subsequently conducted the drug treatment review completed a comprehensive prescribing care plan detailing the man's goals and how he would achieve these. Medical staff confirmed the man's prescription of quetiapine and naproxen with his local GP surgery. The CARATs team subsequently conducted a review to discuss his substance misuse and plans for his release.

45. On 19 September, the man's offender manager in the community told him that when he was released he would live in Brigstocke Approved Premises, Bristol. He was assessed as unsuitable to return to Glogan House due to his previous behaviour. She recorded that he seemed "calm and pleased". She completed the Multi Agency Public Protection Arrangements (MAPPA) referral for the local meeting on 28 September. MAPPA are used for the management of those deemed to be of risk to the public.

46. The same day the man's offender manager in the community noted in her assessment to manage the man's risk on release that staff were to ensure he took his medication as required and he was to comply with two hourly signings initially. The man was also to be subject to random drug tests, in accordance with the approved premises' rules.

47. On 22 September, the man's offender manager again met the man, completed his release plan, discussed harm minimisation and the risks associated with overdose on release (prisoners often have a much reduced tolerance to drugs on release.) The premises manager asked the prison to release the man with a five day prescription for methadone. However, this was not possible as no doctor was available at the prison to write the prescription. The CARATs team agreed to fax the necessary documents to Bristol Specialist Drug Service (BSDS) where the man could pick up a short term prescription as long as he arrived before 4.00pm on his day of release, 23 September. The man was given a nominal appointment for 12.00pm on that day.

Brigstocke Road Approved Premises

48. On 23 September, the man was released to live at Brigstocke Road on a notice of supervision (since he was a young offender). The conditions of this were to live at Brigstocke Road, not to enter Taunton, to comply with requirements specified by his supervising officer and to attend all appointments in relation to his mental health. This notice was due to expire on 15 November.

49. The man was also required to sign in at reception every two hours, between 9.00am and 9.00pm. This was usual for new residents while they settled in, so that staff could monitor the man's whereabouts and be available to resolve any issues.

50. The premises manager welcomed the man and told him he would need an induction. The premises manager told the investigator that the man seemed "flippant" about this, saying that he knew the rules as he had recently lived at Glogan House. The premises manager said the man's main concerns were to go to BSDS to get his interim methadone prescription and to withdraw some money from a bank. He said the man seemed distracted, agitated and had a low concentration span.

51. PSO A was due to complete the man's induction at Brigstocke Road. She told the investigator that normally this would involve a one to one interview in a private room for up to 45 minutes. However, having met the man on arrival, she did not believe he would be able to concentrate for that period of time. His induction was therefore completed in a more piecemeal way. He signed Brigstocke Road's rules which included being drug tested as required, abiding by the curfew, not to bring drugs, alcohol or weapons onto the premises and to follow instructions as directed by staff. The PSO also showed the man to his room. The PSO told the investigator that she suspected the man might have misused drugs due to the way he was behaving. She said she would normally discuss the increased risks of overdose during an induction but that this did not happen with the man as the induction was not completed in the routine way.

52. Usually residents are drug tested during their induction at Brigstocke Road. However, the premises manager informed the investigator that the man was too agitated and distressed when he arrived so a test was not conducted. The man had other priorities and, in agreement with the manager, the test was scheduled for the following morning. The manager had also expected the local drug service to complete a test that afternoon. However, this did not happen.

53. The man had been prescribed seven days worth of quetiapine, Naproxen and Zapain before he left prison. He gave this to staff at Brigstocke Road as was expected. Medication is kept in a locked cabinet in the office and dispensed by staff when requested by residents. The man did not ask for any medication during his time at Brigstocke Road.

54. The CMHT in Bridgwater maintained responsibility for the man's care despite Brigstocke Road not being within their catchment since it was planned for him to move onto accommodation within their area. The CMHT had planned to visit him twice a week at Brigstocke Road, with the first appointment scheduled for 25 September.

55. The regimes manager in Avon and Somerset Probation Trust, was also in reception when the man arrived. He had met the man during his previous stay at Glogan House. He described him as "hyper" and "agitated" and when he asked why this was the case the man said it was because he had already had his methadone before leaving prison. The regimes manager thought it unlikely to be

the cause as he remembered the man being in much the same state during his stay at Glogan House.

56. The regimes manager agreed to walk with him to BSDS to get his methadone prescription. The man was given a prescription to last a few days and told to come back on 27 September for a full assessment which would take about an hour. During this appointment the drug worker also reminded the man of the increased risk of overdose and reduced tolerance to drugs he would have. The man said he had already received the same information from his CARAT worker in prison that morning. The man signed his care plan and said he did not want to hear the same information again.

57. The regimes manager told the investigator that the man seemed happy to have got the prescription and commented to him that as a result he would not have to misuse drugs. They then walked to the bank and the regimes manager said the man was agitated and fidgety. The regimes manager left him at the shops at around 1.30pm and did not see him again. When the man returned to Brigstocke Road, PSO A said he would not look staff in the eye, was constantly talking and was concerned about his finances.

58. PSO B had been told a couple of days previously that the man would be arriving that day and that he would be the man's keyworker. (Keyworkers are the first point of contact for residents to deal with any issues or queries and they have weekly meetings together.) PSO B noted that the man liked going to the gym, so he asked resident A if he would mind taking the man to the gym with him. Resident A agreed. He met the man briefly that day and thought he seemed restless, was stumbling and struggling to keep his eyes open.

59. Around an hour later, at around 3.30pm, resident A saw the man again and described him as being "in a bit of a state". He said the man was mumbling and his impression was that he was "intoxicated with drugs". The man told resident A that he had taken methadone, Valium (a drug used to treat anxiety), Subutex (an opiate blocker) and had been smoking cannabis. The resident told the investigator that he said to staff that if he had returned to the hostel in a similar state he would be drug tested and recalled to prison. He said that the staff replied that the man had been tested. The resident was unsure which staff he spoke to and staff the investigator spoke to could not recall having this conversation.

60. The premises manager also saw the man around this time. He did not believe he was under the influence of drugs and resident A also had no concerns in this regard. In fact he thought the man seemed "happier" and more "buoyant" than when he had first arrived.

61. PSO A saw the man again at dinner time, around 5.00pm, when he told her he did not want any food as he had already eaten. She said he seemed calmer and she was unsure whether her initial instinct that he may have misused drugs was correct. Resident A said the man was trying to "latch on to people" at dinner. He told the investigator he thought that the man's condition was deteriorating and he was "falling around". Sometime between 7.00pm and 8.00pm the resident and another resident, resident B, were going for a walk and the man asked if he could go with them. They agreed and all left the hostel. The three residents sat down in a square near the hostel and the man asked if anyone fancied "skinning up" as he had some "weed". Resident A told the investigator that he made a cannabis "spliff" for the man and all three of them smoked it.

62. Resident A told the investigator that two men he had never seen before approached the three of them and asked if they knew where they could buy "stuff" (which resident A took to mean drugs). The man then walked away with the two men and resident A and resident B returned to Brigstocke Road. Resident A did not have any further contact with the man. At around 9.40pm that evening, PSO C tested the man for alcohol. The result was negative.

63. A resident, who wished to remain anonymous, told a member of staff that the man had come into his room to talk around 11.15pm that evening. However, since it was past the curfew time of 11.00pm and residents were not supposed to be in each other's rooms the resident said he did not wish to talk to the man, who then returned to his own room. The resident said he had seen the man earlier in the day whom he thought was anxious but had relaxed as the evening had progressed.

64. The next day, PSO B started work at 7.30am. He received a handover in relation to all the residents and was told it had been a quiet night and the man had arrived the day before. PSO B explained that, while staff encourage residents to take their medication, the responsibility lies with residents to do so. The man did not request any of his medication from staff when he was at Brigstocke Road. He also did not collect his methadone from the pharmacy that morning.

65. The key fob system in Brigstocke Road on each resident's room and other doors means that there is a computerised record of who and when a person enters the room. Residents' fobs only open their own rooms and staff have universal fobs.

66. At 9.19am, PSO B completed a check of Brigstocke House to make sure that the residents were all well and the rooms acceptable. This is completed every morning and night. He checked on the man who was lying on his bed asleep. He tried to introduce himself as the man's keyworker and asked him to come downstairs to sign in, but the man remained snoring and asleep. The PSO took this as a sign that the man wanted to continue to sleep, so within a minute he left the room.

67. PSO B again went into the man' room at 11.26am and said he needed to talk to him about being at Brigstocke Road. He told the investigator that the man "grunted" in response and did not speak. The PSO again went to see the man at 12.21pm to tell him about the lunch shortly being provided for residents. Again he said the man "grunted" in response. A drug test was not carried out that morning, as had been agreed the previous day, since the man refused to get out of bed or engage with him.

68. At 2.43pm, PSO B went into the man's room. The man had moved position on the bed and again he only responded with a "grunt" and what the PSO perceived to be fake snoring noises. The PSO shook the man on his left arm and pulled him towards him. The man rolled onto his back and made a noise which the PSO thought was him pretending to be asleep and again assumed he wanted to be left alone.

69. The last time the PSO went into the man's room was at 7.11pm. He was still lying on his back and gave the PSO no cause for concern. He told the man he would have to record that he had not got out of bed all day and was not cooperating. Again the PSO said he received a grunt in response.

70. PSO B clarified to the investigator that when the man did grunt, he was doing it in reaction to his voice and not doing it constantly as he would have expected if someone was in distress and needed help. He did not see the man's eyes as he was on his back or facing the other direction. However, he had known residents to stay in bed all weekend before so did not consider it to be overly concerning that the man had not got up to sign in at reception.

71. When Probation Officer A started work at Brigstocke Road around 9.00pm, he was given a handover by PSO B and was told that the man had not left his bed all day. The man was due to sign in downstairs again at this time. Once again, he did not do so but staff failed to check on him, as would be expected, at this time.

72. Just before 11.00pm, probation officer A secured the premises and set the alarm. He then completed the curfew check which ensures all residents are in the hostel and well. He entered the man's room using his fob and said "curfew check". The man was lying on his back on his bed. The PSO said he asked him if everything was "OK" to which the man replied, "yeah, fine". The probation officer then said "good night" and left the room.

73. Probation Officer A said that the man looked quite sweaty, a "bit miserable in his tone" and abrupt. He explained that the approved premises is usually warm so he thought the man may have been hot as it was a particularly warm day, or was sweating as he was abstaining from drugs and had not collected his methadone. The probation officer had no concerns for the man's wellbeing at the time and

believed he just wanted to go to sleep. He told the investigator that he would have called an ambulance had he been concerned for the man's welfare.

74. PSO D arrived at work on 25 September, at around 7.30am. She was given a verbal handover by probation officer A, who told her that the man had not left his room for the whole of the previous day. PSO D told the investigator that this did not particularly concern her since she had known residents, particularly younger ones, to stay in their beds all day. The PSO explained that while it is a condition that residents sign in at reception, they cannot be forced to do so. It is normally of more concern if the resident cannot be located in the building at the sign in time. In cases such as that of the man, the matter would have been referred to the premises manager on Monday (since the manager does not work at weekends) for any further action. The premises manager said had this happened when he came into work on Monday, he would have spoken to the man himself to try and resolve any issues and motivate him to sign in downstairs, or issued him a warning if required.

75. At 9.13am, PSO D went to the man's room to complete the morning check. On entering the room, she noticed that the man was very pale, had blotchy skin, froth at the mouth and his eyes were very dark and half closed. She immediately believed the man had died. She tried to rouse him by putting her hands on his chest and pushing him slightly and calling his name. She received no response. She placed her ear over his face to see if he was breathing, but could hear nothing. She said his left arm was to the side of him and was solid and immovable. She believed rigor mortis had set in.

76. PSO D immediately went downstairs and called an ambulance. She informed her co-worker what had happened and asked him to wait by the front door to let the ambulance in. The emergency responder told PSO D to try and resuscitate the man so she returned to his room to try and get him onto the floor to start resuscitation (resuscitation should always be completed on a solid surface). However, she was unable to do so because of his weight. She returned downstairs to get her co-worker to help her but the paramedics had arrived by this time and they took over efforts to try and save the man.

77. Meanwhile, PSO B had arrived at Brigstocke Road at around 9.20am where he was met by a group of residents outside who told him that a new resident had died. The PSO went straight inside, spoke to PSO D, got some gloves and a resuscitation shield and went straight to the man's room. However, the paramedic had already arrived and confirmed that they believed the man was dead as rigor mortis had set in. A doctor arrived by air ambulance shortly afterwards who pronounced the man dead.

78. The regional approved premises project manager explained that one Assistant Chief Officer (ACO) is on duty at nights at weekends covering both Avon and Somerset and Devon and Cornwall Probation Trusts. While he was not on duty

that weekend, staff telephoned him since he managed Brigstocke Road. He immediately made his way to the Approved Premises as did premises manager who was also told of the man's death around the same time.

79. The ACO spent the morning checking staff's welfare and gave staff involved the option to go home. However, staff wished to complete their shifts. The regional approved premises project manager also arranged for a counsellor from an external practice to be available to staff should they want to talk to her confidentially.

80. During the morning of 25 September, the premises manager spoke to residents who had already become aware of the man' death. Between him and PSO D they identified those residents who would have been more affected by the man's death and supported them appropriately. Resident A told the investigator he was offered bereavement counselling and felt supported by staff at the hostel. All residents were informed of the man's death the next day (26 September) at the Monday morning meeting. Both Glogan House and Brigstocke Road planned to put memorials to the man in their gardens. All staff and residents the investigator spoke to felt adequately supported after the man's death.

81. The regional approved premises project manager consulted with the CMHT and police and it was decided the police would tell the man's next of kin, his aunt, about his death. Police went to her address immediately. He telephoned the man's aunt the following day and visited her the day after that, along with a colleague. He and the premises manager remained in contact with the man's aunt and offered financial support with the cost of the funeral. The regional approved premises project manager wrote and read the eulogy at the man's funeral at the request of his aunt and the premises manager also attended.

82. On 28 September, the Probation Trust's headquarters received a fax from the doctor on the air ambulance responding to the emergency call regarding the man. His letter states that on his arrival at Brigstocke Road it was clear that the man had been dead for "some time". The doctor was concerned that the man had been severely unwell for around 24 hours and that more should have been done to help him the day before.

83. The post mortem report, received by this office on 4 January, concluded that the man died of natural causes, namely hypertensive heart disease (heart disease due to high blood pressure). The only drug detected in the man's blood was methadone, which was not assessed to be at a lethal level.

ISSUES

Clinical care in prison

84. The clinical reviewer concludes that the man had regular advice on weight loss and smoking reduction. His blood pressure was appropriately monitored at normal intervals and there were no abnormally high readings indicating hypertension.

85. In October and December 2010, while at Portland, the man had ECGs taken which, in the clinical reviewer's opinion, show left ventricular hypertrophy (enlargement of the heart muscle). The clinical reviewer notes that:

> "There is no written clue in the medical records relating to the reason for the ECGs being done. There is no record of conclusions being drawn from the recordings and of any resultant action. Although the copies of the medical records I have seen are poorly defined I believe that the ECGs show an abnormality which might have been acted upon. Action appropriate would have been referral for a cardiac ultrasound (echocardiogram) to assess left ventricular size and function, or a referral to a cardiologist for a second opinion. However I do not believe that the fact that he was in custody adversely affected those decisions."

86. The clinical reviewer also explains that cholesterol tests done during the man's time at Portland show a high level of harmful cholesterol and low levels of protective cholesterol, with a relatively normal level of total cholesterol. The reviewer concludes that these abnormal readings could have been a result of being prescribed quetiapine. There was no record of whether consideration was given to stopping the medication.

87. In light of these findings, the clinical reviewer recommends that Portland reviews the clinical records for twenty prisoners selected at random. It is certainly of concern that appropriate referrals were not made or decisions documented following important clinical tests. We make the following recommendation in support of the clinical reviewer's findings:

The Head of Healthcare at HMYOI Portland should ensure that further clinical assessments or referrals are made following any abnormal test results and that these decisions are clearly documented on the prisoner's clinical record.

88. The post mortem examination revealed that the man's heart was "grossly enlarged". The pathologist concluded that the cause of death was hypertensive cardiomegaly (heart enlargement due to high blood pressure). The clinical reviewer writes:

> "At interview Dr A stated that sudden death due to natural causes was still his conclusion despite the normal blood pressure readings taken in prison, and that sudden death was a very common finding in even young adults with significantly enlarged hearts. It was noted that toxicology tests were performed and there was no indication of drug overdose.
>
> It is impossible to be certain why the man had such pronounced cardiomegaly (enlarged heart), that led to his death. His gross obesity and smoking were undoubted contributing factors. One possible but very unlikely conclusion is that there is systemic error in blood pressure recording in prison."

89. The clinical reviewer states that, if the man did die of hypertensive heart disease, it would be extremely unlikely that he did not have significantly high blood pressure in the 12 months before his death. In his clinical review the clinical reviewer recommends that blood pressure equipment at Portland is checked to ensure it is giving accurate readings. Although there is no evidence that the equipment was faulty, we agree that this would be advisable as a precautionary measure and we have informed the Head of Healthcare about the clinical reviewer's concerns.

SystmOne record

90. SystmOne has gradually replaced handwritten records and other computer systems in all public sector prisons over the last few years as the clinical record for prisoners. However, contracted out prisons still rely on other systems or, as in the case of Parc, handwritten notes.

91. We have not had access to the medical record for the man relating to the period before he was convicted from 17 August 2009 to 26 November 2009. It is concerning that when the man transferred to Portland on 26 November 2009 a new record was started. Without having access to the previous record it is impossible to determine why this was the case.

92. This subsequent record covers the period from 26 November 2009 to 16 August 2011, with the period he was in Parc from April 2011 to October 2011 covered by handwritten notes. When the man was recalled and returned to Exeter a new SystmOne record was started with a different surname and no prison number. It is apparent that records were not checked sufficiently for these documents to be cross-referenced and merged. This may also be, in part, due to an older style of prisoner number associated with the original records.

93. Despite this, the man was prescribed quetiapine when in Exeter and given seven days dosage when released in September 2011. However, there is no reference to the depot injections he had been receiving. It seems unlikely that, given that

he was only in prison for a few days, his care was significantly compromised. In addition, staff had access to the man's core prison record.

94. However, a more robust approach is needed to ensure previous records do not exist on a new arrival by double checking spellings of names and cross checking these against dates of birth and prison numbers. It would also be useful for staff to reference handwritten notes from another prison on SystmOne so that clinical staff are aware of their existence.

The Head of Healthcare at HMP Exeter should ensure SystmOne is comprehensively checked to see whether a previous clinical record exists for all new prisoners.

Pre-release preparations

95. It is clear that the man had complex needs including mental health issues, substance misuse and a lack of stable accommodation. The man's offender manager had been his offender manager for much of his sentence and persevered in trying to ensure his needs were met when released into the community. On the final occasion the man was released, she had only around a week to ensure all these arrangements were in place.

96. Despite this, the man's offender manager made thorough preparations for the man's release. She ensured he had access to a methadone prescription, transport to Brigstocke Road as well as accommodation there, mental health input and for his belongings to be picked up from Glogan House and taken to Brigstocke Road. Along with Brigstocke Road staff, she also ensured the man had potential accommodation to move on to. She completed a thorough assessment of the risks the man presented and referred him to the local MAPPA. She reinforced to the man the importance of complying with Brigstocke Road rules and the consequences if he did not. These were thorough pre-release preparations.

Clinical care at Brigstocke Road

97. The man was prescribed a number of different medications, including anti-psychotic drugs, which he gave to staff on arrival at Brigstocke Road, in line with the Probation Trust's policy. It was the man's responsibility to request his medication from staff when he needed it. The man made no such request while at Brigstocke Road. Staff told the investigator they would generally remind a resident if they noticed they had not asked for their medication but it was ultimately the residents' responsibility to remember to request it.

98. On the day he was released, the man was also prescribed methadone which he needed to collect each morning from the local pharmacy. However, he did not do so the morning after he was released. Again, this was his responsibility.

99. We have given consideration as to whether a more robust system is needed to ensure residents take their medication. When the man had stopped taking his medication on previous occasions, his mental health deteriorated and sometimes he became a risk to himself or others. The man's offender manager included in her risk management plan that Brigstocke Road staff should ensure that the man took his medication. However, staff did not have a proper opportunity to encourage the man to take his medication since he remained in bed all day on 24 September and did not engage with staff. Ultimately, we are of the opinion that it was the man's responsibility to ensure he took his medication. In any event, we conclude that this non-compliance with medication was not relevant to the man's death.

100. The day after the man arrived at Brigstocke Road he refused to get out of bed all day. This was despite his agreement to sign in at reception every two hours. PSO B checked on the man every two hours and tried to motivate him to come downstairs. The man gave virtually no response to the PSO but did acknowledge him and gave him no reason to think he was unwell.

101. At 9.00pm that day, staff failed to check on the man as would be expected as he had not signed in at reception. However, the premises manager told the investigator that he was satisfied the man did not leave his room or the approved premises at this time since he would have been seen by staff. Nevertheless it is important to ensure that there is a robust system to ensure all residents are checked in line with their signing in requirements. However, the probation officer checked on him two hours later, just after 11.00pm. Again he was given no reason to be concerned and the man verbally responded to the probation officer to say he was "fine".

102. We are aware that the air ambulance doctor who responded to the emergency the following day has criticised PSO B, believing that either he had not been trained correctly in first aid or had not followed that training. We understand that the doctor considered that they should have noted that the man was ill the day before and acted accordingly. However, it is our conclusion that PSO B and the probation officer did as was expected in their position. Between them, the man received regular checks and did not voice any concerns to either member of staff or appear to them to be any distress.

103. When asked, staff told the investigator that, although not a common occurrence, it would not be concerning for someone who has just been released from prison to stay in their bed at the weekend. This was particularly the case for younger residents who staff said can take longer to begin complying with approved premises' rules.

104. When the man was discovered to be unresponsive the following day, it is our view that staff acted calmly and competently. The emergency services were contacted immediately and arrived quickly. Brigstocke Road staff did not have

sufficient time to begin attempting to try and resuscitate the man, although they were preparing to do so when paramedics arrived. Staff did all they could in attempting to save the man's life.

105. The Probation Trust's policy is that at least one member of staff who has been trained in first aid should be on duty at all times. Brigstocke Road adhered to this policy with valid first aid certificates for PSO D, PSO B, the co-worker, the regimes manager, premises manager and PSO A. This first aid training is repeated every three years and includes resuscitation and checking for signs of life. In fact, since the man's death it has been decided that all staff should be first aid trained and ensuring the remaining staff are trained has commenced. This is a welcome decision.

Management of risk of suicide and self-harm

106. The man had been subject to ACCT procedures on several occasions while in custody, including when before he was released to Glogan House in August 2011. When the man returned to Exeter the following month he was not subject to suicide and self-harm monitoring procedures. This was appropriate in the circumstances and the man consistently denied any thoughts of self-harm or suicide during this week at Exeter. However, documentation regarding his previous risk of suicide or self-harm was provided to the approved premises and also contained within the Offender Assessment System (OASys) document completed by the man's offender manager.

107. Avon and Somerset Probation Trust's policy for reducing sudden death and self-harm of approved premises residents notes that the OASys document from the referring officer must ensure information regarding self-harm is adequately addressed in the supervision and risk management plans. The OASys completed by the man's offender manager clearly documents previous issues with self harm or suicide and risk management included engaging with the CMHT, abstaining from drug misuse and for Brigstocke Road staff to ensure the man took his medication as required.

108. Approved premises then have to complete their own local risk management plan derived from the offender manager's plan detailing what work will be done in the approved premises. Although this was not formalised in the man's case, staff had sufficient information regarding the man's risk of suicide and self-harm to make informed judgements about his care. Staff at Brigstocke Road also collected the man's complete file from Glogan House, along with an update from his keyworker. The premises manager had also been updated by the man's offender manager who had spoken to staff at Exeter prison, before the man's release.

109. The Approved Premises Manual (2011) states that there must be an assessment of self-harm issues at induction. PSO A said that the man gave her no cause for

concern in this regard. However, she assessed the man to be anxious, since he could not concentrate or look her in the eye and she suspected he may have misused drugs. Best practice, given the man's history, would involve asking the resident directly if they have any thoughts of suicide or self-harm. This issue is addressed further below.

Substance misuse

110. The man had a well documented history of substance misuse. Staff at the prison and his offender manager ensured that he had received his methadone before leaving the prison and would be able to obtain a prescription the same day to cover the weekend. The man had also been warned of his likely reduced tolerance and increased risk of overdose before he left Exeter. One of his main concerns when arriving at Brigstocke Road was to get his methadone prescription. Staff were sensitive to this and escorted him to his appointment with BSDS. He obtained his prescription and was again warned about the increased risks of overdose. The man did not collect his methadone from the local pharmacy the following day. This was the man's responsibility.

111. Avon and Somerset Probation Trust's reducing death and self-harm policy notes,

> "One of the main causes of deaths amongst AP residents is a drug overdose, often due to reduced tolerance after release from prison. AP managers must ensure that at induction advice and guidance is given to all residents on reduced drug tolerance following release from custody. Advice on reducing risk of overdose and on harm minimisation must be included in a leaflet for residents, which should include contact details for Bristol Drugs Project, Somerset Drugs Service, and other drugs advice agencies. All new residents should be drug tested if drug misuse is an identified risk factor and referred as required to drug support in line with Avon and Somerset Probation Trust Approved Premises drug management guidelines."

112. As already indicated, the man's induction was completed in a number of stages since he was anxious on his arrival at the hostel and staff assessed he would not be able to concentrate for a protracted one to one session. We find no fault with this method, which was sensitive to the man needs. However, he was not reminded by Brigstocke Road staff of the increased risk of overdose. PSO A commented that maybe she should have covered this and it would form part of a more standard induction but she had found it difficult to get the man to focus.

113. The man had been reminded of the increased risk of overdose both before he left the prison and at BSDS and commented to the drugs worker that he did not want to be told again. Furthermore the post mortem tests indicated only methadone at a non-toxic level in the man's blood. Therefore the issue of overdose was not a factor in his death.

114. The National Manual for Approved Premises suggests a checklist of items for induction to ensure nothing is missed. This would have been useful in the man's case, both to ensure that he was reminded about the increased risk of overdose and accidental self-harm, as well as being asked about any thoughts of deliberate self-harm or suicide.

The Manager of Brigstocke Road Approved Premises should ensure an induction checklist is used with all residents when they first arrive to include information on deliberate and accidental self-harm and suicide including the increased risk of overdose.

115. The Probation Trust's drug and alcohol policy instructs that,

> "Residents shall be tested for drug use at induction where substance misuse is an identified risk factor (see induction procedure) and residents shall be tested thereafter in accordance with drug testing procedure and the dictates of the risk management plan."

116. Substance misuse was identified as an issue for the man and he should have been tested at induction. However, due to the man's demeanour it was decided not to drug test him on arrival. This decision was sanctioned by the manager, who told the investigator that, in this instance, he had believed BSDS would test him or that he would be tested the following morning. The man was tested for alcohol the evening of his arrival, despite this not being a documented issue for him. It would have been beneficial to test him for drugs, at least at this stage.

117. BSDS did not drug test the man on 23 September. The following day he did not leave his bed and no drug test took place at the approved premises. While we are sympathetic to the difficulties staff had when inducting the man, it is our opinion that he should have been drug tested as soon after his arrival as possible. His risk of re-offending and harm to others and himself was linked to his substance use problems by the man's offender manager in her offender assessment. The man did not refuse to give a drug test and he was compliant with an alcohol test. He had signed the approved premises rules which included him consenting to drug testing.

118. One member of staff suspected he might have misused drugs on the day of his release and a resident told the investigator they witnessed him doing so. This same resident said he spoke to a member of staff about the man earlier in the day and commented that he would have been tested and recalled if he was in a similar state to the man. This resident told the investigator that the member of staff told him that the man had been drug tested. We were unable to verify that this conversation took place.

119. Substance misuse was not a causal factor in the man's death. Nevertheless, given the Trust's policy to test at induction where relevant and one member of staff's suspicions that the man had misused drugs, it is surprising this was not

done. The premises manager told the investigator that he interpreted "at induction" as meaning as soon as possible but at least within the first 24 hours. We make the following recommendation:

The Manager of Brigstocke Road Approved Premises should ensure that the local policy regarding drug testing of residents is followed. This includes drug testing new residents, where drugs are an indicated risk factor, within the first 24 hours of arrival.

Staff and family support

120. After the man's death, it was agreed with the CMHT that the police would inform his aunt. The following day, the regional approved premises project manager telephoned her and went to see her the next day. He remained in contact with the man's aunt, offered financial assistance with the funeral and gave a eulogy at her request. The support offered to the family by both him and other members of staff appears to have been exemplary. In addition, memorials were going to be placed at both Glogan House and Brigstocke Road in memory of the man.

121. Staff and residents the investigator spoke to had also felt well supported since the man death. At least one resident had been offered bereavement counselling and a counsellor from a private practice specially attended the approved premises in case anyone wanted to talk to her confidentially.

CONCLUSION

122. It is clear that the man had complex needs which both the Prison Service and the Probation Trust tried to address, including accommodation difficulties, mental health issues and misuse of substances. The man found it difficult to cope, both in prison and in the community and was recalled twice to custody after a deterioration of his behaviour following release.

123. It is alarming that a 20 year old man died from natural causes just two days after being released from prison. While aspects of the man's care in prison could have been better handled, the clinical reviewer concludes that, he did not believe that there was any deficiency in his health care which would have contributed to the man's death.

124. Although we have made recommendations about the care the man received at Brigstocke Road, these would not have led to a different outcome and it is concluded that his death was not foreseeable.

RECOMMENDATIONS

1. The Head of Healthcare at HMYOI Portland should ensure that further clinical assessments or referrals are made following any abnormal test results and that these decisions are clearly documented on the prisoner's clinical record.

   HMYOI Portland has accepted this recommendation. The Head of Healthcare at HMYOI Portland will ensure that further clinical assessments or referrals are made following any abnormal test results and that these decisions are clearly documented on the prisoner's clinical record.

2. The Head of Healthcare at HMP Exeter should ensure SystmOne is comprehensively checked to see whether a previous clinical record exists for all new prisoners.

   HMP Exeter has accepted this recommendation. The prison number is entered in System One in Reception. If the prisoner has existing electronic notes these will be retrieved. If the above does not occur, the prisoner may have two sets of records. This is amended every morning after the C-Nomis upload. The notes are then merged together by the administrative staff therefore making the record whole.

   Paper records should be supplied by the sending prison. If they are not sent then they are requested. A list of non-system one prisons will be compiled and a protocol written for contacting them to ascertain if all paper records have been supplied. Notes summarisers are currently working in the Devon Prisons. This process will commence at HMP Exeter once it is completed at Dartmoor. Further training will be given to nursing staff in registering patients on System One. In particular, looking for previous records.

3. The Manager of Brigstocke Road Approved Premises should ensure an induction checklist is used with all residents when they first arrive to include information on deliberate and accidental self-harm and suicide including the increased risk of overdose.

   Avon and Somerset Probation Trust have accepted this recommendation.

4. The Manager of Brigstocke Road Approved Premises should ensure that the local policy regarding drug testing of residents is followed. This includes drug testing new residents, where drugs are an indicated risk factor, within the first 24 hours of arrival.

   Avon and Somerset Probation Trust have accepted this recommendation.