

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Dwayne Gilling, a resident at Brigstocke Road Approved Premises, on 6 January 2021

A report by the Prisons and Probation Ombudsman

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Dwayne Gilling was found dead in his room at Brigstocke Road Approved Premises (AP) on 6 January 2021. He was 38 years old. I offer my condolences to Mr Gilling's family and friends.

The pathologist was unable to determine why Mr Gilling suddenly died. He had no drugs or alcohol in his system, there was no evidence of injury or that his death was self-inflicted and no physical disease or condition that might have caused his death.

We found that Mr Gilling was well-managed in his short period at Brigstocke Road. When staff found him, he showed signs unequivocally associated with death and their decision not to try to resuscitate him was appropriate.

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

Sue McAllister CB
Prisons and Probation Ombudsman

July 2021

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Summary

Events

1. Mr Gilling was released on licence to Brigstocke Road AP in Bristol from HMP Portland on 21 December 2020.
2. Staff twice found him in possession of alcohol over the New Year period, and he was tested on suspicion of having used cannabis. The test result was negative. He did not present management issues to staff and he appeared to be committed to focusing on activities designed to help his rehabilitation.
3. Mr Gilling appeared to be in good spirits when he was last seen on 5 January shortly after 11.00pm. He was found dead in his room the next day at the morning check. Staff did not attempt to resuscitate Mr Gilling and paramedics attended quickly and confirmed his death.
4. The pathologist was unable to determine a physical cause of Mr Gilling's death. Toxicology results showed he was not under the influence of alcohol or drugs when he died.

Findings

5. Mr Gilling was well managed during his period at Brigstocke Road AP.
6. Staff acted promptly to call an ambulance. Mr Gilling showed signs unequivocally associated with death and the decision not to try to resuscitate him was appropriate and in line with Resuscitation Council guidance.
7. We make no recommendations.

The Investigation Process

8. The investigator issued notices to staff and residents at Brigstocke Road AP informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
9. The investigator obtained copies of relevant extracts from Mr Gilling's probation service records and CCTV from 5/6 January 2021. Due to restrictions in place during the COVID-19 pandemic, she interviewed three members of staff by telephone in February and March 2021. She spoke at length to the AP manager and also interviewed Mr Gilling's offender manager (probation officer). Further information was obtained from South West Ambulance Service.
10. We informed HM Coroner for Avon of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
11. Our family liaison officer wrote to Mr Gilling's next of kin, to explain the investigation and to ask if they had any matters they wanted the investigation to consider and if they would like a copy of our report. We did not receive a reply and we have not sent them a copy of this report.

Background Information

Brigstocke Road Approved Premises

12. Brigstocke Road AP in Bristol is one of around 100 approved premises in England and Wales. It consists of five Georgian houses joined together through interconnecting doors. There are rooms for 25 adult male residents, 12 on full board accommodation and 13 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.
13. Number 10 Brigstocke Road, where Mr Gilling lived, is a three-bedroom house. It has its own TV room and kitchen, but residents tend to socialise across all five houses.

Previous deaths at Brigstocke Road

14. Mr Gilling's is the fourth death at Brigstocke Road that we have investigated but the first since 2011. There are no similarities between Mr Gilling's death and the previous deaths.

Key Events

15. Mr Dwayne Gilling had a history of alcohol and substance misuse, depression, post-traumatic stress disorder (PTSD) and anxiety. On 21 December 2020, he was released on licence from HMP Portland to Brigstocke Road AP. This was his second period on licence from an eight-year sentence imposed in 2014 for robbery and possession of an imitation firearm.
16. Mr Gilling made significant progress in addressing his substance misuse issues in his last year in prison and was nervous about returning to the community. On 28 December, he moved to a room in 10 Brigstocke Road, after complaining that his original room was on a noisy landing.
17. On 31 December, Mr Gilling was given a warning after staff found a bottle of cognac in his room. On 2 January, a friend delivered a bag of food to Mr Gilling. Staff asked to look through it and found it contained cider.
18. On 3 January, Mr Gilling was drug tested after staff became suspicious that he had been using cannabis in another resident's room. (The result, received on 8 January after Mr Gilling had died, was negative.)
19. On 4 January, Mr Gilling had a meeting with a residential worker. Mr Gilling said he was struggling with being around other people with substance misuse issues. The residential worker said they agreed some purposeful activities to help Mr Gilling focus on rehabilitation. Mr Gilling also said he was unhappy with his medication and the residential worker advised him to make an appointment for a telephone call with his GP.

5/6 January 2021

20. The investigator watched CCTV from 5/6 January. Mr Gilling talked to other residents in the kitchen and made himself some food. A residential worker arrived to complete a night check. He said that Mr Gilling seemed in good spirits. He was playing music in his room and told the residential worker that he had just made himself some toast. At 11.07pm, Mr Gilling went to his room for the last time.
21. At 9.45am the next day, a residential worker looked into Mr Gilling's room to make her morning check. She said Mr Gilling was face down on the floor. She pressed her personal alarm to alert her colleague and called Mr Gilling's name. He did not respond. She shouted for her colleague to call an ambulance.
22. Mr Gilling was cold and stiff. He was wearing shorts and post-mortem staining was visible on his legs. Staff did not attempt cardio-pulmonary resuscitation as Mr Gilling had clearly died. Paramedics arrived and confirmed that Mr Gilling was dead.
23. South Western Ambulance Service records showed the 999 call was received at 9.52am and the paramedics arrived at Brigstocke Road three minutes later at 9.55am.

Contact with Mr Gilling's family

24. Mr Gilling did not provide the AP with a next of kin. The police identified Mr Gilling's cousin and broke the news of his death to them by telephone mid-morning on 6 January. Mr Gilling's uncle contacted the AP manager the same afternoon. The AP manager remained in telephone contact with Mr Gilling's uncle and aunt and arranged for Mr Gilling's property to be collected. The Probation Service offered to make a financial contribution to Mr Gilling's funeral in line with national guidance.

Support for residents and staff

25. After Mr Gilling's death, the AP manager debriefed the staff involved in finding Mr Gilling and offered support. All of the staff interviewed said they were satisfied with the support offered to them after Mr Gilling died. The AP informed the other residents that Mr Gilling had died and offered support.

Post-mortem report

26. The pathologist found no external signs of trauma or underlying natural disease to account for Mr Gilling's death. The toxicology report showed that he was not under the influence of drugs or alcohol when he died. The pathologist concluded that the cause of death was undetermined.

Findings

Management of Mr Gilling at Brigstocke Road

27. We did not identify any issues with the management of Mr Gilling during his short period at Brigstocke Road. He was drug tested after suspicions were raised that he had used cannabis and he was spoken to at length after incidents when alcohol was discovered in his room. He was prompted to contact his GP when an issue arose over his medication and he was encouraged to put his energies into activities that would promote successful rehabilitation into society. Sadly, he seemed keen to do this and in positive spirits when he died.

The Emergency Response

28. A residential worker requested an ambulance promptly and paramedics were quickly at the scene.
29. The European Resuscitation Council Guidelines for Resuscitation 2010 state that “Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile ...” Attempting resuscitation in these circumstances is distressing for staff and is not in accordance with the principle that the deceased be treated with respect and dignity.
30. Mr Gilling showed signs unequivocally associated with death and the decision not to attempt resuscitation was therefore appropriate.
31. We make no recommendations.

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