Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael Brocklebank, a resident at Merseybank Approved Premises, on 23 September 2020

A report by the Prisons and Probation Ombudsman

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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*

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 Michael Brocklebank died on 23 September 2020 of mixed drug toxicity. He had taken an overdose of heroin and methadone and was found in his room at Merseybank Approved Premises. Mr Brocklebank was 41 years old. I offer my condolences to Mr Brocklebank's family and friends.

Mr Brocklebank had been released from prison to the approved premises a week earlier. Staff at the approved premises suspected he was using drugs and acted appropriately in supporting him and enforcing his licence. I have recommended that staff ensure they conduct welfare checks on residents in line with local policy. I have also highlighted the need to start CPR as soon as possible when a resident is found unresponsive.

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 **May 2021**

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Summary

Events

1. In May 2016, Mr Michael Brocklebank was sentenced to four and a half years imprisonment for robbery. He was released to Southwood Approved Premises (AP) in July 2018 and July 2019. On both occasions, he was recalled to custody after a heroin overdose.

2. On 14 September 2020, Mr Brocklebank was released from prison to Merseybank AP. After a few days, staff suspected that Mr Brocklebank was using drugs. He initially denied it but, on 21 September, admitted that he had used heroin and crack cocaine. Staff gave him a verbal warning and took a urine sample for testing.

3. On 23 September, a member of staff checked Mr Brocklebank at 7.00am. The staff member thought Mr Brocklebank was sleeping and did not check whether he was breathing or get a response from him. At 10.15am, another member of staff went to check on Mr Brocklebank and found him unresponsive. She pressed her alarm and went to get the emergency bag and telephone to call an ambulance. Other staff were already responding, so they all went back to Mr Brocklebank's room and started cardiopulmonary resuscitation (CPR).

4. Paramedics arrived and pronounced Mr Brocklebank had died at 11.11am. A post-mortem examination concluded that he died of mixed drug toxicity.

Findings

5. Although there is no evidence to suggest that Mr Brocklebank's overdose was intentional, this possibility cannot be ruled out. However, we are satisfied that staff reasonably assessed that Mr Brocklebank was not a risk to himself.

6. AP staff supported Mr Brocklebank appropriately with regards to his substance misuse. They spoke to Mr Brocklebank about his reduced tolerance to drugs and increased risk of overdose after being released from prison, although this conversation was not recorded anywhere. Merseybank AP now uses a nationally recognised template which records this information.

7. We are concerned that the staff member checking Mr Brocklebank on the morning of 23 September said they did not get a response from him.

8. We also highlight the need to start CPR as soon as possible when a resident is found unresponsive.

Recommendations

- The AP manager should ensure that staff complete welfare checks according to requirements, including getting a response from residents when necessary.

The Investigation Process

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

10. Due to COVID-19, the investigator was unable to visit Merseybank. She obtained electronic copies of relevant extracts from Mr Brocklebank's records.

11. The investigator interviewed four members of staff in November 2020. All the interviews were conducted by telephone because of the COVID-19 restrictions.

12. We informed HM Coroner for Liverpool and The Wirral of the investigation. He gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

13. One of the Ombudsman's family liaison officers contacted Mr Brocklebank's mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She asked when AP staff last checked Mr Brocklebank before he died. We address her question in this report.

14. Mr Brocklebank's mother received a copy of the initial report. She did not make any comments.

15. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out a factual inaccuracy and this report has been amended accordingly.

Background Information

Merseybank Approved Premises

16. Approved Premises (APs - formerly known as probation and bail hostels) accommodate offenders released from prison on licence and those directed to live there by the courts as a condition of bail. Their purpose is to provide an enhanced level of residential supervision in the community, as well as a supportive and structured environment. Residents are responsible for their own health and are expected to register with a GP.

17. Merseybank Approved Premises in Liverpool is managed by HM Prison and Probation Service (HMPPS). It has capacity for 24 residents (although this has been reduced to 22 residents during the COVID-19 pandemic). Residents are expected to attend daily residents' meetings and there is a curfew between 11.00pm and 6.00am. Each resident is allocated a keyworker to oversee their progress and well-being, and to ensure that they adhere to licence conditions and the AP's rules. Probation Service employees are on duty at Merseybank 24 hours a day.

Previous deaths at Merseybank AP

18. There have been two previous deaths at Merseybank: one in 2005 which was self-inflicted and the other in 2011, which was due to natural causes. These investigations raised no concerns relevant to the death of Mr Brocklebank.

Key Events

March 2016 – 13 September 2020

19. In March 2016, Mr Michael Brocklebank was arrested for robbery and remanded to custody. On 23 May 2016, he was convicted and sentenced to four and a half years in custody. Mr Brocklebank had a long history of substance misuse and associated offending.

20. On 26 July 2018, Mr Brocklebank was released from HMP Risley to Southwood Approved Premises (AP). In October 2018, Mr Brocklebank was resuscitated after a heroin overdose and was admitted to hospital. Mr Brocklebank was later recalled to custody, having tested positive for heroin and cocaine and returned to prison in December 2018.

21. On 1 July 2019, Mr Brocklebank was released from HMP Liverpool back to Southwood AP. On 7 February 2020, Mr Brocklebank was admitted to hospital following a heroin overdose. Due to his drug misuse and missing appointments, he was recalled to prison and taken to HMP Altcourse on 12 February. In March, Mr Brocklebank told his prison keyworker that the overdose had been a deliberate attempt to take his own life because his grandfather had cancer. Mr Brocklebank engaged in substance misuse work at Altcourse and tested negative for drugs. On 14 July, the Parole Board directed his release to Merseybank AP on 14 September.

22. An offender manager at Altcourse told the investigator that healthcare staff spoke to Mr Brocklebank about his reduced tolerance to drugs since being in prison and warned him of his increased risk of overdose once released. He said that Mr Brocklebank was looking forward to spending time with his family once released and he had no concerns that he was a risk to himself.

Merseybank AP, 14 September – 22 September

23. On 14 September, Mr Brocklebank was released on licence to live at Merseybank AP. Conditions of his licence included not to reoffend, to attend appointments as directed, to comply with drug tests and to sign in at the AP at 1.00pm and 5.00pm daily. Mr Brocklebank's licence and sentence were due to end on 25 October.

24. After Mr Brocklebank's arrival at Merseybank, his community offender manager (probation officer) spoke to him on the telephone rather than meeting him in person due to COVID-19 restrictions. Mr Brocklebank said he was anxious as he had been released without his medication and was tempted to buy drugs although he realised this would "get him nowhere" and he did not want to use drugs.

25. A probation service officer met Mr Brocklebank at the AP and inducted him. She was his keyworker. She told the investigator that Mr Brocklebank seemed "really happy" to be at Merseybank and was proud that he had not taken drugs as soon as he was released. They spoke about what had happened when he had previously taken an overdose. She said she discussed Mr Brocklebank's

reduced tolerance to drugs, having just been released from prison, and his increased risk of overdose. However, she did not record this conversation.

26. Since Mr Brocklebank had been released without his medication, his keyworker arranged an appointment for Mr Brocklebank to be prescribed methadone the following day. She also arranged for Mr Brocklebank's GP to prescribe the rest of his medication – for anxiety, depression, back pain and lung disease.

27. The keyworker assessed that Mr Brocklebank should not have his medication in his own possession, due to his previous overdose. He signed a form indicating that it was his responsibility to request his medication and take it under the supervision of AP staff. His medication was subsequently administered in line with his prescription.

28. On 15 September, Mr Brocklebank had an appointment with his substance misuse worker. His urine tested positive for methadone as prescribed. Mr Brocklebank said he felt optimistic about the future, rated his mood as eight out of ten and said he had no previous or current thoughts of suicide or self-harm. The substance misuse worker also spoke to him about his reduced tolerance to drugs and increased risk of overdose. He was offered naloxone (the opiate overdose antidote) to take with him to the AP, but he refused.

29. A residential support worker told the investigator that she spoke to Mr Brocklebank most days. She said that initially he seemed alright, was pleased to be out of prison and proud that he had abstained from drug misuse when first released.

30. On 18 September, another residential support worker noted in Mr Brocklebank's record that he seemed to be under the influence of an unknown substance. She noted that his speech was slurred and he was drowsy. She emailed the community offender manager and Merseybank staff about her concerns. Another member of staff checked Mr Brocklebank, who denied using drugs.

31. On 21 September, the AP manager sent an email to the community offender manager indicating that staff suspected Mr Brocklebank was using drugs. He wrote that Mr Brocklebank had seemed under the influence of drugs the day before and that morning. He asked the offender manager to speak to Mr Brocklebank and request that he engaged with substance misuse services or he was likely to lose his place at the AP. The offender manager also spoke to Mr Brocklebank directly and tried to encourage him to stop using drugs. Mr Brocklebank denied that he had been using drugs, so the offender manager decided to test him.

32. At 2.00pm that day, the community offender manager spoke to Mr Brocklebank. Mr Brocklebank said that he had used heroin and crack cocaine. He was remorseful and said it was a one-off lapse. The offender manager gave him a verbal warning and said any further drug use would result in further enforcement.

33. At 4.55pm, a residential support worker took a urine sample from Mr Brocklebank to be tested for drugs. Mr Brocklebank admitted to using crack cocaine and heroin the previous evening. She told the investigator that he seemed disappointed with himself and was apologetic. She updated AP staff and the

community offender manager via email. The keyworker replied that she would discuss it with Mr Brocklebank the following day. (She had been due to meet with him that day, but her appointment had clashed with his appointment with the offender manager.)

34. On 22 September, staff noted in the handover sheet that Mr Brocklebank was behaving unusually and kept apologising to staff for using drugs. At 1.00pm, Mr Brocklebank met his senior probation officer (SPO). He said he had just been to see his grandfather who was terminally ill. The SPO noted that Mr Brocklebank did not appear well and looked like he had been using illicit drugs. Mr Brocklebank's mother called the SPO while she was with him and said she was concerned about him. Mr Brocklebank said he was concerned where he would move to from the AP and he was advised to speak to AP staff about this.

35. The Southwood AP manager was at Merseybank meeting with staff. He saw Mr Brocklebank in passing and knew him from his previous stays at Southwood. He spoke to Mr Brocklebank and told him that there was now space for him at Southwood. Mr Brocklebank had not gone there straight from prison as there were no vacancies. Staff said that he was looking forward to the move.

36. The keyworker saw Mr Brocklebank around 7.20pm (she had been due to finish work at 7.00pm). She said they would have a keyworking appointment the next day. She said that Mr Brocklebank seemed happy and had just paid his rent. He told her that he had been honest about his drug use but was going to get help. She had no concerns about him.

37. A residential support worker started work at 7.30pm along with a colleague. At 8.35pm, Mr Brocklebank asked him to book him a taxi which he did. Mr Brocklebank returned at 10.20pm. He said that Mr Brocklebank seemed "fine".

38. At 11.00pm, the residential support worker started to do the AP checks. This involves ensuring that every resident is in the AP and checking every bedroom. Mr Brocklebank went up the stairs before the support worker with two other residents. One of them asked Mr Brocklebank if he wanted to go for a cigarette but Mr Brocklebank said that he did not feel well, was tired and wanted to go to bed. He went into his bedroom and the support worker locked his bedroom door. The support worker told the investigator that he had no concerns about Mr Brocklebank.

39. Every hour overnight, the residential support worker or his colleague walked around the AP to check that there was no excessive noise or obvious issues in the AP. He said there were no concerns with Mr Brocklebank that night.

Events of 23 September

40. On 23 September at 7.00am, the residential support worker checked the AP residents. He opened Mr Brocklebank's door and saw that he was lying on his back with no covers on him facing the door. He thought that he was sleeping, had no concerns and left the room, locking the door behind him. He could not recall what Mr Brocklebank was wearing but, in a statement, recorded that he was definitely wearing something on his top. He did not notice anything wrong

with Mr Brocklebank but told the investigator that he did not check whether Mr Brocklebank was breathing or get a response from him.

41. Unfortunately, it was not possible for the investigator to view the CCTV footage of the residential support worker's welfare check since there was a technical issue when it was downloaded. The AP manager reviewed the CCTV.

42. At around 10.15am, Mr Brocklebank's mother telephoned Merseybank and told a residential support worker that Mr Brocklebank was not answering his telephone. Mr Brocklebank's mother asked if he had taken his medication. The support worker checked the administration sheet, discovered he had not, so went straight to Mr Brocklebank's room. She knocked on his door, but he did not respond so she unlocked the door and went in.

43. Mr Brocklebank was lying on his back on his bed and did not respond to her. His head had fallen to the side and it looked like he had vomit around his mouth. Mr Brocklebank was only wearing underpants and had no covers on him. The residential support worker immediately thought that Mr Brocklebank was dead as he was pale, and his lips were blue. She activated her personal alarm and ran downstairs to get the first aid bag and telephone to call an ambulance. As she went downstairs another support worker and the AP manager were coming upstairs with the bag and telephone in response to her alarm.

44. They went into Mr Brocklebank's room, assessed his condition, could not detect a pulse and started cardiopulmonary resuscitation (CPR). The AP manager telephoned for an ambulance and asked someone to get the defibrillator. He and the support worker estimated it was around 30 seconds between when she activated her alarm to when they started chest compressions. The 999-call handler asked them to move Mr Brocklebank to the floor, which they did, and staff remained on the telephone until the paramedics arrived.

45. The residential support worker returned with the defibrillator which staff attached and followed its directions. Staff took it in turns to continue with chest compressions until the paramedics arrived twelve minutes after the AP manager had called them. Paramedics inserted an airway and administered naloxone and adrenalin. At 11.11am, paramedics pronounced that Mr Brocklebank had died.

46. Police seized drug paraphernalia from Mr Brocklebank's room along with what looked like crack cocaine. On 28 September, Mr Brocklebank's drug test results from 21 September were returned. They were positive for cocaine and heroin.

Contact with Mr Brocklebank's family

47. While the paramedics were at the AP, Mr Brocklebank's mother telephoned. The AP manager told her what was happening. Mr Brocklebank's brother then arrived at the AP very shortly after Mr Brocklebank had died. The manager told him what had happened. Mr Brocklebank's brother said that he would ring his mother. Mr Brocklebank's mother later telephoned the AP and spoke to the manager, who passed on his condolences. The AP area manager remained in contact with Mr Brocklebank's mother and offered her a contribution to the funeral expenses, in line with Probation Service policy.

Support for residents and staff

48. After Mr Brocklebank's death, the AP manager debriefed staff to ensure they had the opportunity to discuss any issues arising, and to offer support. A clinical psychologist held a further debrief a few days later. The manager told the other residents what had happened and offered them support.

Post-mortem report

49. The pathologist concluded that the cause of Mr Brocklebank's death was mixed drug toxicity with pneumonia.

50. Heroin and methadone were found in Mr Brocklebank's system at a level which the toxicologist concluded was likely to have contributed to his death. The toxicology results indicated that Mr Brocklebank had taken heroin shortly before he died. The methadone was at a level above therapeutic use and there was also evidence that Mr Brocklebank had taken cocaine shortly before he died.

51. The toxicology tests also found relatively high levels of pregabalin (used for nerve pain, epilepsy and anxiety) and dihydrocodeine (an opiate-based painkiller) and the toxicologist concluded that these drugs (which Mr Brocklebank had been prescribed) may also have contributed to his death. Quetiapine (an antipsychotic drug) and diazepam (a tranquiliser) were also found in his system but at a level unlikely to be related to his death. He had not been prescribed these medications.

52. Mr Brocklebank also had hepatic cirrhosis (scarring of the liver caused by liver disease and other conditions). The pathologist concluded that this may have contributed to Mr Brocklebank's death but did not cause it.

Findings

Assessment of risk of suicide and self-harm

53. The post-mortem report concluded that Mr Brocklebank died as a result of mixed drug toxicity. While there is no evidence to suggest that the overdose was intentional, this possibility cannot be ruled out and we have therefore considered whether staff adequately assessed Mr Brocklebank's potential risk of harm to himself.

54. Mr Brocklebank had previously taken two heroin overdoses, in October 2018 and February 2020. A month after the second overdose, Mr Brocklebank told prison staff that it had been a deliberate attempt to take his own life due to finding out his grandfather had cancer.

55. No staff the investigator spoke to were concerned that Mr Brocklebank was a risk to himself and he told a substance misuse worker that he had no thoughts of suicide or self-harm on release. Mr Brocklebank had some risk factors for suicide and self-harm such as suffering from anxiety and depression and his previous overdoses. However, he was pleased to be at Merseybank and said he wanted to make progress with his life. We are satisfied that staff's assessment that Mr Brocklebank was not at risk of suicide or self-harm was reasonable.

Substance misuse

56. Mr Brocklebank had a long history of substance misuse. Staff said that initially he seemed to be coping well with release from prison but then his behaviour changed, and they suspected he was using drugs. After initially denying it, he admitted that he had used drugs but said he wanted to continue to work with staff at the AP.

57. The AP manager told the investigator that AP staff assess how to work with residents on an individual basis. If a resident acknowledges their drug use and accepts help, staff will do their best to work with them rather than recall them to prison. He also said that if the situation becomes too chaotic or cannot be safely managed and a resident is not engaging with substance misuse services, staff will consider withdrawing their place at the AP.

58. Staff were trying to support and work with Mr Brocklebank. He had been given a verbal warning and knew that further drug use could lead to him being recalled to prison. We are satisfied that this approach was appropriate.

59. The toxicology report also found quetiapine and diazepam in Mr Brocklebank's system which he had not been prescribed and must have obtained illicitly. Pregabalin and dihydrocodeine, which Mr Brocklebank had been prescribed, were also found at a level which may have contributed to his death. Staff gave Mr Brocklebank this medication in accordance with his prescription and it has not been possible to determine why these levels were higher than would be deemed safe. It is possible that Mr Brocklebank had supplemented his prescription with illicitly obtained drugs.

60. With regard to Mr Brocklebank's reduced tolerance to drugs and risk of overdose after he was released from prison, the keyworker told the investigator that she spoke to him about this on the day he was released. However, this is not recorded on the induction document, nor is there a specific space for doing so. Mr Brocklebank's substance misuse worker also spoke to him about this the following day.

61. Although we are satisfied that staff acted appropriately in warning Mr Brocklebank about his reduced tolerance to drugs following his release from prison, we are concerned there was no specific space to record this information on the induction template. Following a death at another AP in 2019, we were assured that all APs would be using the same induction template nationally which includes space to evidence these discussions. It is therefore disappointing that this template was not being used at Merseybank at the time of Mr Brocklebank's death. However, since that time the AP has implemented the use of this national template, so we make no recommendation about this.

Naloxone

62. Naloxone is the emergency antidote for overdoses caused by heroin and other opiates or opioids (such as methadone, morphine and fentanyl). The main life-threatening effect of heroin and other opiates is to slow down and stop breathing. Naloxone blocks this effect and reverses the breathing difficulties. It can be administered by injection or nasal spray.

63. Naloxone is a prescription-only medicine, so pharmacies cannot sell it over the counter. But drug services can supply it without a prescription, and anyone can use it to save a life in an emergency. For example, drug services can supply naloxone for use in an emergency to a family member or friend of a person using heroin, or to an outreach worker or a hostel manager whose clients include people who use heroin. We have previously recommended that it should be available in all APs.

64. HM Prison and Probation Service (HMPPS) are currently in the process of providing naloxone to all APs. By the end of April, they aim to have provided it to 67% of APs nationally, including Merseybank. We cannot say whether the use of naloxone might have changed the outcome for Mr Brocklebank, but we are pleased that steps are being taken to make it available in APs nationally. We therefore make no recommendation about this.

Checks on Mr Brocklebank

65. Mr Brocklebank was last seen going into his room at 11.00pm on 22 September. On 23 September around 7.00am, a residential support worker checked Mr Brocklebank. He thought Mr Brocklebank was sleeping and, although he could not remember in interview what Mr Brocklebank was wearing, had recorded in a statement that he was wearing a top. He told the investigator that he did not check Mr Brocklebank was breathing nor did he get a response from him.

66. The AP manager told the investigator that they have a "rouse response policy" at the AP. This means that if staff cannot see if a resident is breathing, they are

expected to get a response. He said that the support worker had told him that he could see Mr Brocklebank breathing.

67. Around three hours later, when Mr Brocklebank was found unresponsive, he was not wearing a top. Clearly if the residential support worker's initial statement is correct, this means that Mr Brocklebank must have been alive during the earlier check. Regardless of this, we are concerned that he told the investigator that he did not check that Mr Brocklebank was breathing or get a response from him at 7.00am, in line with the AP's own policy. We therefore make the following recommendation:

The AP manager should ensure that staff complete welfare checks according to requirements, including getting a response from residents when necessary.

Emergency response

68. On 23 September, a residential support worker left the AP office to check on Mr Brocklebank after receiving a telephone call from his mother. She did not take the emergency bag with her, as she said she thought she would be making a quick check and then returning to the telephone call. She said this was a common request from residents' families. The AP manager told the investigator that whenever staff leave the office, they should take the emergency bag with them.

69. When the residential support worker discovered Mr Brocklebank was unresponsive, she pressed her personal alarm and immediately left his room to get the emergency bag and telephone an ambulance. Other staff quickly responded and estimated they started CPR within around 30 seconds of her activating the alarm.

70. The AP manager acknowledged that ideally staff should start CPR as soon as possible but also suggested that Ms Mullen might have been in shock. Given the very short delay in starting CPR, we do not make a recommendation. However, we highlight the need to start CPR as soon as is safely possible when a resident is found unresponsive.

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