Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ramon Gomez, a resident at Bradshaw House Approved Premises, on 9 April 2022

A report by the Prisons and Probation Ombudsman

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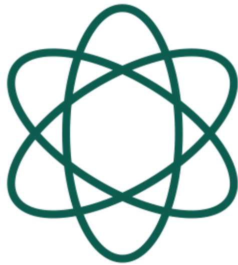
Our vision

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

OGL

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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 Ramon Gomez died on 9 April 2022 of combined drug toxicity while a resident at Bradshaw House Approved Premises (AP) in Bury. He was 51 years old. I offer my condolences to Mr Gomez's family and friends.

Mr Gomez had a long history of substance misuse. Regular drug testing was one of his licence conditions when he was released to the AP. On two occasions, he tested positive for prescription medication that had not been prescribed to him. I am satisfied that these incidents did not meet the threshold for recall to prison. However, I am concerned that the AP never received the results of two drug tests due to administrative errors by AP staff.

On the evening of 8 April, Mr Gomez admitted that he had taken methadone (an opioid used as a heroin substitute). I am concerned that AP staff did not administer naloxone (a medication that can reverse the effects of opioids) to Mr Gomez when they found him unresponsive on the morning of 9 April.

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

Kimberley Bingham
Acting Prisons and Probation Ombudsman **November 2022**

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Summary

Events

1. On 29 December 2021, Mr Ramon Gomez was released from prison on licence to live at Bradshaw House Approved Premises (AP) in Bury. He had a history of substance misuse and regular drug testing was one of his licence conditions.

2. In mid-January 2022, staff suspected that Mr Gomez had taken illicit substances and staff subsequently found some unknown tablets in his room. He admitted that he had obtained them illicitly. Staff gave him a verbal warning.

3. On 28 January, Mr Gomez had a drugs test. His notes for this test say he tested positive for unauthorised opioids and that he said he had bought codeine from an unidentified source, to self-medicate. His key worker issued him with a notice of concern. However, the test was subsequently declared void because it was out of date. On 14 February, Mr Gomez tested positive for dihydrocodeine, a prescription opioid drug that he had not been prescribed, but tests taken on 11 and 28 March and 4 April were negative. (The AP did not receive the results for Mr Gomez's drug tests taken on 24 February and 1 March due to administrative errors, following a change in labelling protocols which had not been drawn to the attention of the AP staff).

4. On 3 April, Mr Gomez failed a breath test and two days later, AP staff found alcohol in his room, along with prescription painkillers that had not been prescribed to him. His key worker put him on the first stage of a behaviour improvement plan.

5. On 7 April, Mr Gomez harassed a female member of staff at the AP and made inappropriate remarks to her. Staff told him he would not be able to make his weekly visit to his next of kin's home.

6. On the evening of 8 April, Mr Gomez returned to the AP intoxicated. He admitted that he had taken 20ml of illegally acquired methadone (an opioid medication used as a heroin substitute). AP staff consulted with the NHS 111 helpline, who said they would send an ambulance. However, a doctor later phoned back and said they were not worried about the quantity of methadone taken and would not send an ambulance. They advised AP staff to monitor Mr Gomez and to call back if he vomited, turned pale or started behaving oddly.

7. Mr Gomez appeared to become less intoxicated during the evening and staff found no drugs or alcohol in his room when they checked at around 11.00pm. They last checked on Mr Gomez at around 1.00am on 9 April. He was talking to his next of kin on the telephone at the time and indicated that he was alright.

8. During a welfare check at around 6.50am, staff found Mr Gomez slumped in his bed. They promptly called an ambulance and started cardiopulmonary resuscitation (CPR). At around 7.05am, paramedics arrived and took over. They detected a faint pulse, administered naloxone (a medication that reverses the effects of opioid drugs) and they took Mr Gomez to hospital. However, he died shortly afterwards.

9. The post-mortem report concluded that Mr Gomez died from combined drug toxicity.

Findings

10. We are satisfied that the AP staff responded appropriately when they found that Mr Gomez had taken illicit substances and that these incidents were not sufficient to recall him to prison. However, we are concerned that the results of two drug tests were not received due to administrative errors by AP staff and that another drug test result was not recorded on nDelius, the electronic system used by probation staff.

11. In the few days before his death, Mr Gomez's behaviour deteriorated further. While the Head of the Central Lancashire Probation Delivery Unit told the investigator that the deterioration in his behaviour and his substance misuse could have led to his recall, a meeting had been scheduled for Monday 11 April to discuss Mr Gomez's behaviour, by which time Mr Gomez had died. There was therefore no realistic opportunity to consider follow-up actions in time to consider a recall to prison or other actions which might have removed the opportunity for Mr Gomez to obtain the drugs that led to his death.

12. We are concerned that AP staff did not administer naloxone to Mr Gomez when they found him unresponsive. Naloxone is available in the AP and guidance says AP staff should administer it after making sure an ambulance is on its way.

Recommendations

- The Manager of Bradshaw House AP should ensure that drug test results are obtained, recorded on nDelius, and actioned as appropriate.
- The Manager of Bradshaw House AP should ensure that staff are aware of the guidance on administering naloxone and the importance of acting without delay whenever there is a possibility that a resident has overdosed on opioids.

The Investigation Process

13. The investigator issued notices to staff and residents at Bradshaw House informing them of the investigation and asking anyone with relevant information to contact him.

14. The investigator obtained copies of relevant extracts from Mr Gomez's prison, probation and medical records.

15. We informed HM Coroner for Greater Manchester North of the investigation and have sent the Coroner a copy of this report.

16. The Ombudsman's family liaison officer contacted Mr Gomez's next of kin to explain the investigation and to ask if they had any issues that they wanted us to consider. Mr Gomez's next of kin asked why Mr Gomez was not taken to hospital after he told staff at the AP that he had taken methadone. This issue is addressed in our report.

17. The initial report was shared with Mr Gomez's next of kin. They did not make any comments.

18. The initial report was shared with the National Approved Premises Team. They identified some inaccuracies regarding drug testing results which have been corrected in this final report. Their action plan is annexed to this final report.

Background Information

Bradshaw House AP

19. Approved premises (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.

20. Bradshaw House AP is a Psychologically Informed Planned Environment (PIPE). This means that it places an emphasis on the living environment, with a focus on relationships and individual and group interactions, with regular focused key worker sessions. The environment aims to maximise ordinary situations and to approach these in a psychologically informed way to support people in their transition to a non-offending lifestyle. Bradshaw House AP is accredited by the Royal College of Psychiatrists as an Enabling Environment (an environment in which a set of key principles and values are employed to foster productive relationships and promote wellbeing). The clinical lead at Bradshaw House AP is a Health and Care Professions Council (HCPC) registered forensic psychiatrist. Each resident is allocated a key worker to oversee their progress and wellbeing. The key worker should also ensure that residents adhere to licence conditions and the premises rules. Staff are on duty at Bradshaw House AP 24 hours a day.

Previous deaths at Bradshaw House AP

21. We are not aware of any previous deaths at Bradshaw House AP.

Key Events

22. On 25 June 2007, Mr Ramon Gomez was given an Imprisonment for Public Protection (IPP) sentence for wounding and sexual assault, with a minimum term to serve of one year and seven months. (An IPP sentence is an indeterminate sentence. IPP prisoners must serve a minimum term (tariff) before they can apply to the Parole Board for release.) Mr Gomez had a long history of substance misuse before his conviction which was linked to his offending, especially alcohol. He also had several incidents of substance misuse while in prison.

23. Mr Gomez was sent to a Category D prison, HMP Haverigg, on 9 December 2020. Category D prisons, also known as open prisons, have a lower security rating and have an important role in preparing prisoners for release.

24. On 9 November 2021, the Parole Board directed that Mr Gomez should be released to Bradshaw House Approved Premises (AP). Staff at Haverigg were concerned about Mr Gomez's attitude after this decision as he stopped engaging with work and activities designed to help with his return to society, such as day release from prison. His Prison Offender Manager (POM) telephoned his Community Offender Manager (COM) on 23 November to pass on her concerns.

25. On 25 November, prison staff received the results of a drug test Mr Gomez took on 17 November. He tested positive for gabapentin, which he was not prescribed. (Gabapentin is a prescription medication used to treat epilepsy and nerve pain but it is also widely abused as it can enhance the euphoric effects of other drugs, such as opioids.) The Head of Offender Management at Haverigg, passed on his concerns about Mr Gomez's suitability for release to the Public Protection Casework Team. However, they said that the Parole Board's decision could not be reversed and that if necessary, extra licence conditions should be used to manage Mr Gomez in the community.

Bradshaw House AP

26. On 29 December, Mr Gomez was released from Haverigg on licence to live at Bradshaw House AP in Bury.

27. Mr Gomez was released from prison with prescription medication, including codeine (an opioid painkiller for stomach and shoulder pain) and mirtazapine and paroxetine (antidepressants). He was not allowed to keep and administer his medication at the AP and collected them from staff every day.

28. Mr Gomez drank some alcohol on his way to the AP. His key worker, who was a probation service officer, told him that he needed to abstain from alcohol completely and comply with his licence conditions.

29. On 14 and 15 January 2022, staff suspected that Mr Gomez had taken illicit substances. On 15 January, staff searched his room and found unbranded tablets. The following day, he admitted to obtaining prescription drugs on the street (dihydrocodeine (an opioid painkiller) and zopiclone (a sleeping tablet)) and handed over some dihydrocodeine tablets to staff. His key worker referred Mr Gomez to his COM, and asked what action was going to be taken.

30. On 18 January, his key worker attended a probation management oversight discussion about Mr Gomez's risk, which determined that he had not reached the threshold for recall and that no action was required at that time, although it might be in the future. However, AP staff gave him a verbal warning about his behaviour on 24 January.

31. On 27 January, AP staff searched Mr Gomez's room and found empty packets of the prescription drug pregabalin, which he was not prescribed. (Pregabalin is prescribed for epilepsy, nerve pain and anxiety but it is also widely abused as it can enhance the euphoric effects of other drugs, such as opioids).

32. On 28 January, Mr Gomez had a drugs test at the AP. Although there was an indication in his records that he had tested positive for unauthorised opioids, the test was subsequently declared void as it was out of date. At the test he admitted to buying codeine from an unauthorised source. His key worker discussed this with Mr Gomez and issued him with a notice of concern.

33. Mr Gomez tested positive for dihydrocodeine on 14 February but tested negative on 11 and 28 March and 4 April. (The AP did not receive the results for Mr Gomez's drug tests taken on 24 February and 1 March due to an administrative error.)

34. On 1 April, when AP staff went to collect Mr Gomez's prescription from a pharmacy, they discovered that Mr Gomez had deceptively obtained a pregabalin prescription from his GP. They spoke to the GP and told Mr Gomez that his prescription had been stopped.

35. On 3 April, Mr Gomez failed a breath test, and on 5 April, AP staff found alcohol in his room along with the prescription painkiller methocarbamol, which he was not prescribed. His key worker issued him with a verbal warning and notified his COM. She also consulted with the manager of the AP and put Mr Gomez on the first stage of an improvement plan (which aimed to help him improve his behaviour in the AP).

36. On 7 April, Mr Gomez harassed a female member of staff outside the AP and made inappropriate remarks to her. As a result, staff from the AP told him that he would not be able to make his weekly visit to his next of kin's home. However, in correspondence the PPO received from Mr Gomez's next of kin, it appears that Mr Gomez met them that day, although it is not clear where.

Events of 8-9 April

37. On 8 April, Mr Gomez left the AP at around 1.00pm and returned at around 6.30pm, visibly intoxicated. When AP staff questioned him, he eventually admitted to having taken 20ml of methadone (a heroin substitute), which he said he had bought from someone in the community. Staff contacted the NHS 111 urgent healthcare service with their concerns about Mr Gomez. The call handler who responded said that an ambulance would be sent to the AP as it was uncertain what Mr Gomez had taken. However, a doctor phoned back later and said they were not worried about a 20mg dose of methadone and were happy for AP staff to monitor Mr Gomez. However, they said that if his presentation changed, he vomited, started to behave irrationally or looked pale, they should call 111. The doctor confirmed that Mr Gomez should not receive any of his own prescribed medication. None had been given in line with the AP's own protocols.

38. After returning to the AP, Mr Gomez remained mainly in the communal areas and so staff were able to monitor him for much of the evening. AP staff checked his room at around 11.00pm but found no alcohol or anything else of concern. Mr Gomez became progressively less intoxicated through the evening. Staff monitored him for approximately six and a half hours. A member of the AP staff last checked on him in his room at around 1.00am when he saw him having a lengthy telephone call with his next of kin. Mr Gomez replied positively to him and by this time, he felt he had no further cause for concern.

39. At around 6.50am the next day, the member of the AP found Mr Gomez slumped in his bed during the morning welfare check. He quickly called an ambulance and started cardiopulmonary resuscitation (CPR) following instructions from the emergency call handler. At around 7.05am, paramedics arrived and took over. They detected a faint pulse, and they took Mr Gomez to hospital. However, he died shortly afterwards.

Contact with Mr Gomez's family

40. From the time Mr Gomez was released from prison, AP staff and Mr Gomez's COM had good contact with Mr Gomez's next of kin. Mr Gomez went to his next of kin's house once a week, and all of his meetings with his COM took place there.

Support for residents and staff at the AP

41. A Senior Probation Officer debriefed staff and offered support on the day of Mr Gomez's death. She also spoke to residents who knew Mr Gomez and they received support from other duty staff, including offering checks on them. Staff spoke to a vulnerable resident who was friendly with Mr Gomez and there was good support for both residents and staff in the following days.

Post-mortem report

42. Toxicology results showed that Mr Gomez had taken multiple drugs before he died, including methadone, pregabalin, codeine, mirtazapine, paroxetine, oxycodone, and at least one type of benzodiazepine. Only codeine, mirtazapine and paroxetine were prescribed to him. The pathologist concluded that Mr Gomez died from combined drug toxicity. The post-mortem also found that Mr Gomez had fatty liver disease (a condition where too much fat in the liver can cause it to stop working properly) and left ventricular hypertrophy (a condition affecting the efficiency of the heart muscle to pump blood around the body). Both these conditions did not cause Mr Gomez's death but contributed to it.

Findings

Substance abuse

43. Drug testing was one of Mr Gomez's licence conditions. He was tested at the AP on 28 January (initially noted as positive for unauthorised opioids but the test was subsequently declared void because it was out of date), 14 February (positive for dihydrocodeine), 24 February (void), 1 March (void), 11 March and 28 March (both negative). Mr Gomez was not prescribed dihydrocodeine and had admitted to staff previously that he had obtained it illicitly. He was given a verbal warning followed by a notice of concern when his drug test came back positive. Given that Mr Gomez tested negative on 11 and 28 March and 4 April, we consider that the action taken was appropriate and there was insufficient reason to recall him to prison.

44. However, we are concerned that no drug test results were received for the tests taken on 24 February and 1 March. The AP Manager said this seemed to be the result of a change in the labelling requirements for the test samples to be sent off to the laboratory, which was not noticed at first by staff. We are also concerned that the 11 March result was not uploaded onto nDelius, the electronic system used by probation staff. We recommend:

    The Manager of Bradshaw House AP should ensure that drug test results are obtained, recorded on nDelius, and actioned as appropriate.

Assessment of escalation of Mr Gomez's risk

45. As discussed above, we are satisfied that Mr Gomez's substance misuse did not reach the threshold for recall to prison.

46. However, on 7 April, Mr Gomez's risk escalated significantly when he harassed a female member of AP staff. The Head of Central Lancashire Probation Delivery Unit, said that this incident, in conjunction with Mr Gomez's alcohol and drug relapses, could have resulted in his recall to prison. However, as this happened so close to his death, and prior to his meeting with the AP Manager on 11 April, she was unaware of the escalation in Mr Gomez's behaviour. We agree that there was no realistic opportunity to consider follow-up actions in time to consider a recall to prison or other actions which might have removed the opportunity for him to obtain the drugs that led to his death.

Naloxone

47. Naloxone is a medicine that blocks the action of opioids in the body. It is used in emergency situations to reverse breathing difficulties that can occur when a person overdoses on opioids. It can save a person's life if it is used quickly after they have overdosed.

48. Mr Gomez died after taking a combination of drugs, including several opioids (methadone, codeine and oxycodone). Bradshaw House AP had naloxone on the premises, but staff did not use it on Mr Gomez. It was not administered to him until paramedics arrived. AP staff said that they took their instructions from the emergency call handler who guided them through cardiopulmonary resuscitation (CPR) and did not ask them to administer naloxone.

49. The guidance to AP staff on the use of naloxone says that if a casualty is not breathing and opioid overdose is suspected, staff should make sure an ambulance is on its way, then administer 30 chest compressions and then administer naloxone. As AP staff have naloxone available to them, they should use it in line with the guidance and should not wait for the ambulance call handler to advise them. Naloxone causes no harm to a person who has not taken opioids so should be used, even if it is unclear whether the situation is an opioid overdose. We recommend:

The Manager of Bradshaw House AP should ensure that staff are aware of the guidance on administering naloxone and the importance of acting without delay whenever there is a possibility that a resident has overdosed on opioids.

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