Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Paul Bromfield, a resident at Elliott House Approved Premises, on 23 December 2021

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk
T l 020 7633 4100

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 Paul Bromfield died of Sudden Unexplained Death in Schizophrenia (SUDS) on 23 December 2021, at Elliott House Approved Premises (AP). He was 41 years old. I offer my condolences to Mr Bromfield's family and friends.

We are satisfied that AP staff supported Mr Bromfield's needs, including his schizophrenia, appropriately throughout his time at Elliott House. We do not consider that they could have foreseen or prevented Mr Bromfield's death.

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

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

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Summary

Events

1. Mr Paul Bromfield was 41 years old when he died. He had a history of substance misuse and a range of physical and mental health issues, including schizophrenia.

2. On 23 November 2020, Mr Bromfield was released from custody on licence following completion of a nine-year prison sentence for wounding with intent. He was required to reside at Elliott House Approved Premises (AP), where he remained for over a year. AP staff helped Mr Bromfield manage his various medications. He was registered with community health services, who managed his healthcare while resident at Elliott House.

3. At around 8.15pm, during a routine wellbeing check, night staff found Mr Bromfield unresponsive on the floor of his room. They called an ambulance and attempted life support until paramedics arrived at 8.34pm and began performing cardiopulmonary resuscitation (CPR). At 9.30pm, paramedics confirmed that Mr Bromfield had died.

4. A post-mortem examination identified Mr Bromfield's cause of death as Sudden Unexplained Death in Schizophrenia (SUDS).

Findings

5. We are satisfied that AP staff managed Mr Bromfield's medication for both physical and mental health issues, including his schizophrenia, effectively. We do not consider that AP staff could have foreseen or prevented Mr Bromfield's death and therefore make no recommendations.

The Investigation Process

6. The investigator issued notices to staff and prisoners at Elliott House Approved Premises (AP) informing them of the investigation and asking anyone with relevant information to contact him.

7. The investigator visited Elliott House on 28 March 2022. He obtained copies of relevant extracts from Mr Bromfield's prison and medical records.

8. The investigator interviewed three members of staff at Elliott House on 28 March and completed three further interviews via video-link on 14 and 29 March.

9. We informed HM Coroner for Birmingham and Solihull of the investigation and have sent the Coroner a copy of this report.

10. Mr Bromfield's next of kin received a copy of the draft report. She did not provide any comments or factual inaccuracies.

11. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out one factual inaccuracy. This report has been amended accordingly.

Background Information

Elliott House Approved premises (AP)

12. Approved premises (formerly known as probation or 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 healthcare and are expected to register with a GP.

13. Elliott House Approved Premises is managed by the Probation Service and provides accommodation for male offenders with mental health disorders. It benefits from regular input from forensic psychiatric mental health professionals based at Reaside Clinic, which is part of Birmingham and Solihull Mental Health Trust and there is a formal service level agreement.

14. Elliott House has 20 single rooms, two lounges, a games room, kitchen, dining room and residents' laundry. Staffing includes a manager, deputy manager and support staff. All approved premises have strict rules prohibiting alcohol and illegal drugs in the buildings. This is reinforced by random room searches. Residents are responsible for their own health and are expected to register at a local GP surgery. While residents have to comply with their individual licence or bail conditions, curfews and the approved premises' rules, they are essentially free to go in and out of the building when they wish. They are required to sign out and hand in their room key when they leave and sign in on their return.

15. A key worker is assigned to each resident and works closely with them. They offer support and guidance to help the resident to comply with their licence conditions and prepare them for leaving the hostel by finding accommodation, employment, education and arranging benefits. In addition, they encourage the resident to address their offending behaviour and, where necessary, refer them to alcohol or drugs agencies. Key worker sessions with residents are held weekly. All contact is recorded and communicated with a resident's offender manager.

Previous deaths at Elliott House

16. Mr Bromfield was the first resident at Elliott House to die since June 2018. There are no similarities in our findings on the most recent death at Elliott House, which was also from natural causes.

Key Events

Background

17. Mr Paul Bromfield was 41 years old when he died. He had a long history of substance misuse and mental health issues. He also had a range of physical health problems and was prescribed numerous medications to help manage these conditions.

18. On 5 December 2016, Mr Bromfield entered HMP Dovegate after being sentenced to nine years imprisonment for wounding with intent to cause grievous bodily harm.

19. In September 2017, Mr Bromfield's mental health began to deteriorate. He began self-isolating and refusing to eat, and prison officers became concerned about his behaviour. He presented as aggressive, paranoid, agitated and distressed. Although Mr Bromfield was under the care of mental health services at the prison, he stopped collecting his medication for anxiety and became increasingly disengaged. In November, staff began monitoring him under HMPPS suicide and self-harm prevention measures, known as ACCT.

20. On 5 December, a psychiatrist assessed Mr Bromfield and diagnosed him with schizophrenia, noting that he had experienced a severe depressive episode and drug-induced psychosis. The psychiatrist referred Mr Bromfield for treatment at the Hatherton Centre in Stafford, a secure psychiatric facility for offenders with psychiatric disorders. Mr Bromfield was transferred from Dovegate to the Hatherton Centre on 16 January 2018.

21. On 23 November 2020, Mr Bromfield was released on licence from the Hatherton Centre to reside at Elliott House approved Premises (AP).

Elliott House

22. While at Elliott House, Mr Bromfield took several prescribed medications daily to treat his physical and mental health conditions, including clozapine, an antipsychotic drug to treat schizophrenia. His medications were managed and administered by AP staff. He registered with a community GP and mental health and substance misuse services.

23. In April, a consultant psychiatrist with the Reaside Clinic reviewed Mr Bromfield's medication after he had missed two doses of his clozapine and was struggling to cope with the regular blood tests he had to take while on the drug. The consultant psychiatrist prescribed Mr Bromfield olanzapine, an alternative antipsychotic medication used to treat schizophrenia, which Mr Bromfield preferred and continued to take.

24. On 18 November, the consultant psychiatrist and a community psychiatric nurse completed a joint assessment of Mr Bromfield. They recorded in Mr Bromfield's medical record that he was drowsy and depressed due to lack of progress regarding his accommodation, and that these concerns were also affecting his sleep. Despite concerns about his accommodation, they told us in interview that Mr Bromfield was mentally more stable and alert while on olanzapine. The psychiatric

nurse also said that the drowsiness was potentially linked to his sleep apnoea and that she did not think he was under the influence of any illicit substances. consultant forensic psychiatrist told us that throughout his contact with Mr Bromfield, he had no significant concerns about his mental health, “apart from him being despondent of a lack of progress.”

25. On 14 December, the psychiatric nurse assessed Mr Bromfield again at Elliott House. She recorded on his medical record that he presented as mentally well but with poor motivation. She also noted that his mood appeared euthymic, that he engaged well with good eye contact and responded appropriately.

26. On 20 December, AP staff intercepted a package addressed to Mr Bromfield containing Xanax (a sedative drug used to treat anxiety, also known as alprazolam), which he had ordered online.

27. On 22 December, after being at Elliott House for over a year, Mr Bromfield signed the relevant paperwork to move into a council flat in Stoke on Trent. His anticipated move in date was 12 January 2022.

Emergency response

28. On 23 December 2021, at around 6.00pm, a residential worker at the AP completed a welfare check on Mr Bromfield in his room. (These were being undertaken every two hours.) She raised no concerns.

29. At around 6.10pm, Mr Bromfield came downstairs to the medication room to receive his daily medication, which was dispensed to him by another residential worker. In her statement, she said that Mr Bromfield was in a very good mood and informed her that he had secured accommodation near his mother.

30. At around 8.15pm, while completing the next wellbeing check, two members of night staff, found Mr Bromfield unresponsive on the floor of his room. They could not find a pulse. They called an ambulance and attempted to restart Mr Bromfield’s heart using a defibrillator. Due to Mr Bromfield’s large physical size, they struggled to get him into the recovery position which caused a delay in their efforts to revive him. Paramedics arrived at 8.34pm and began performing cardiopulmonary resuscitation (CPR). They confirmed that Mr Bromfield had died at 9.30pm.

Contact with Mr Bromfield’s family

31. Mr Bromfield identified his mother as his next of kin. The police informed Mr Bromfield’s mother of his death on 23 December, and AP staff continued to liaise with her following his death.

Support for residents and staff

32. The AP manager telephoned all staff who had had interactions with Mr Bromfield on 24 December and provided contact details for support organisations if they wanted further support. He held a debrief meeting with all staff on 14 January 2022.

33. The AP manager met with all AP residents one-to-one, to provide follow up support after the Christmas period.

Post-mortem and toxicology reports

34. A post-mortem examination identified Mr Bromfield's cause of death as Sudden Unexplained Death in Schizophrenia (SUDS). Toxicology tests found nothing of concern in Mr Bromfield's system.

Findings

35. We are satisfied that AP staff and community healthcare services managed and supported Mr Bromfield's needs, including his schizophrenia, effectively. We did not identify any omissions in the standard of care he received. We consider that this was a tragic and unexpected death that could not have been foreseen or prevented. We make no recommendations.

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