

**Prisons &
Probation**

Ombudsman
Independent Investigations

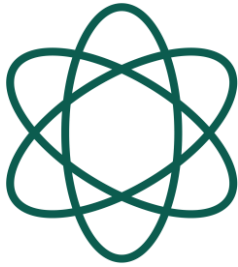
Independent investigation into the death of Mr Christopher Coleman on 13 March 2022, following his release from HMP Risley

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

OGI

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Summary

1. 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.
2. Since 6 September 2021, the PPO has been investigating post-release deaths that occur within 14 days of the prisoner's release.
3. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.
4. Mr Christopher Coleman died of a blood clot in his lung, caused by a blood clot in a deep vein, on 13 March 2022 following his release from HMP Risley. He was 42 years old. I offer my condolences to those who knew him.
5. The clinical reviewer found that the care Mr Coleman received at Risley was equivalent to that which he could have expected to receive in the community.
6. Mr Coleman's death was due to natural causes. However, he had a history of substance misuse and relapsed around the time of his death. Because Mr Coleman had completed his detoxification programme and stopped using methadone, Risley's substance misuse team gave him limited advice in preparation for his release. Probation staff did not provide harm reduction advice or remind Mr Coleman that he could be issued with naloxone (a drug to reverse an opiates overdose) at his first probation appointment. In their review of Mr Coleman's death, North West Probation acknowledged that more could have been done to support Mr Coleman. However, we note that there is no policy requirement for them to do so and therefore do not make a recommendation.
7. Since Mr Coleman's death, Risley have committed to providing overdose awareness and naloxone information in release paperwork. We are satisfied that this new process, if implemented effectively, will help to reduce the risks for individuals being released with a risk of substance misuse.

The Investigation Process

8. NHS England commissioned an independent clinical reviewer to review Mr Coleman's clinical care at Altcourse and Risley.
9. The PPO investigator obtained copies of relevant extracts from Mr Coleman's prison and probation records.
10. The investigator interviewed Mr Coleman's Community Offender Manager. The clinical reviewer and investigator interviewed healthcare staff and the Head of Healthcare from HMP Altcourse.
11. We informed HM Coroner for Cheshire of the investigation. They gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
12. The Ombudsman's family liaison officer contacted Mr Coleman's partner to explain the investigation and to ask if she had any matters she wanted us to consider. She did not reply.
13. The initial report was shared with HM Prison and Probation Service (HMPPS). They noted some factual inaccuracies, which have been amended in this report.

Background Information

HMP Risley

14. HMP Risley is a male category C prison which houses around 1,100 prisoners. Greater Manchester Mental Health NHS Trust provides the healthcare and mental health services at the prison. Change, Grow, Live (CGL) provide substance misuse services. Release planning is provided by Interserve Justice.

HM Inspectorate of Prisons

15. The most recent inspection of Risley was in November 2020. Inspectors reported that pre-release preparation was good and included helping prisoners find a community GP, prescribing medication for post-release, harm minimisation advice and provision of naloxone (an opiate reversal agent that can be used in the event of an overdose).
16. However, the inspectors also reported that only 32% of prisoners who were expected to be released within three months said that they had received support with their preparation. The inspectors found that this might have been due to communication methods. They found that staff had limited face-to-face contact and planning was taking place through written correspondence only. Not all prisoners completed the paper questionnaires and therefore planning often relied on information already held by the prison rather than up to date information directly from the prisoner.

HM Inspectorate of Probation

17. The most recent inspection of the North West Division of the National Probation Service was in July 2020. Inspectors found that contact was good for those leaving custody. In 69% of the sample casework, the service user was meaningfully involved in planning. In 79% of sample casework, planning took the service user's personal circumstances into account. In 69% of sample casework, the planning set out how all of the licence requirements would be delivered.

Key Events

Background

18. On 21 July 2021, Mr Christopher Coleman was convicted of burglary offences and sentenced to 16 months in prison. On 28 July, Mr Coleman transferred to HMP Altcourse.
19. At his initial healthcare screening, Mr Coleman disclosed a range of health conditions including a history of deep vein thrombosis (DVT - a blood clot that develops within a deep vein in the body, usually in the lower limbs). He had last received treatment for DVT one week prior to his reception at Altcourse. The reception nurse found a discoloured and tender bulge on Mr Coleman's right lower ankle and asked for advice from a senior nurse. The senior nurse advised that Mr Coleman be assessed in hospital, but he said no. Mr Coleman also shared his history of substance misuse and asked to complete a detoxification program. The nurse asked the prison GP to follow up on Mr Coleman's history of DVT during his substance misuse appointment later that day.
20. Later that evening, the prison GP (who also runs the substance misuse clinic) met with Mr Coleman as planned. He prescribed methadone (a drug to help with heroine withdrawal) and agreed that Mr Coleman needed hospital care for his DVT. Mr Coleman said he did not want to go to hospital. Healthcare did not revisit Mr Coleman's suspected DVT, and we found no other issues recorded in his medical notes.
21. On 29 July, Mr Coleman started a drug harm reduction program. On 24 September, Mr Coleman decided to end his methadone prescription.

Pre-release planning

22. On 18 October, Mr Coleman transferred to HMP Risley. At his initial health screening, healthcare staff recorded that he had not taken illicit drugs since entering prison. On 25 October, a Change Grow Live (CGL - a community drug and alcohol support service) peer mentor met with Mr Coleman and discussed harm reduction, overdose awareness and that naloxone (a medicine that rapidly reverses an opioid overdose) could be provided on release. The peer mentor recorded that no referral to CGL was required, and Mr Coleman received no further support while at Risley.
23. On 09 August 2021, Mr Coleman was allocated a Community Offender Manager (COM).
24. On 20 January 2022, the COM met Mr Coleman to discuss preparations for his release. Mr Coleman was involved in the planning and stated that he was keen to engage with probation, intended to stay away from drugs and did not plan to reoffend.
25. On 7 March 2022, Mr Coleman was allocated a new Community Offender Manager. She received a short handover from the previous COM.
26. On Friday 11 March 2022, Mr Coleman was released from Risley.

27. A Police Constable met Mr Coleman at the prison gate and took him to his first probation supervision appointment with North West Probation. (The PC was part of the Integrated Offender Management (IOM) Team supporting Mr Coleman as a prolific and persistent offender. The IOM system provides additional monitoring for those presenting a high risk of re-offending).

Post-release

28. At the initial probation supervision appointment, the COM explained Mr Coleman's licence conditions and Mr Coleman signed to say that he understood. They discussed temporary accommodation in a hotel, and she organised a housing appointment with Northwich council (the area he wanted to live in) on 15 March. She provided Mr Coleman with the date and time of his next probation appointment and reminded him about his appointment with the Westminster Drug Project (a community-based drug and alcohol support service), which was due to take place on 15 March. She did not discuss with Mr Coleman the risk of overdose and drug tolerance because Mr Coleman had not used illicit drugs for some time.
29. The PC took Mr Coleman to his temporary accommodation and dropped him off just before 1.00pm.

Circumstances of Mr Coleman's death

30. On 12 March, Mr Coleman's partner told police that the previous day Mr Coleman had travelled to Northwich to see her. They had spent time together and used drugs. She said that when she woke up the following morning, she found that Mr Coleman had died.
31. On 14 March, the PC informed North West Probation that Mr Coleman had died.

Post-mortem report

32. The post-mortem report concluded that Mr Coleman died of pulmonary embolus (a blood clot that had travelled to the lung) caused by deep vein thrombosis. The post-mortem toxicology screen found that Mr Coleman had taken heroin and cocaine close to the time that he died, but this had no impact on his death.

Findings

33. The clinical reviewer concluded that the clinical care Mr Coleman received was equivalent to that which he could have expected to receive in the community. She made recommendations to improve care planning processes at Risley that the Head of Healthcare should address.
34. Mr Coleman shared his history of deep vein thrombosis (DVT) at his initial healthcare screening. He said he had received treatment for DVT one week prior. Prison nurses completed an assessment and suggested that he be taken to hospital for further tests, but Mr Coleman declined. Mr Coleman's DVT was not revisited by the healthcare teams at Altcourse or Risley. The clinical reviewer concluded that this was reasonable because Mr Coleman showed no clinical signs of DVT and did

not report any symptoms which could have been caused by DVT prior to or following release.

35. Mr Coleman had a history of substance misuse and had used drugs around the time that he died. While this did not cause his death, we are concerned that staff did not ask Mr Coleman if he would like a naloxone kit before he was released, to reduce the risk of overdose. Mr Coleman's COM arranged for him to receive substance misuse support in the community, four days after his release. She reminded Mr Coleman of his appointment when they met on 11 March. However, CGL and probation staff did not remind Mr Coleman that naloxone was available or give him any information about the dangers of relapse to reduce risks in the interim period. This was because Mr Coleman was no longer receiving active support from CGL, having finished his methadone prescription.
36. Since Mr Coleman's death, Risley has acknowledged that they could have provided more harm reduction support and overdose awareness information prior to release. CGL have committed to provide overdose awareness and naloxone information with release paperwork in future. We are satisfied that this new process, if implemented effectively, will help to reduce the risks for all individuals with substance misuse issues who are being released, regardless of the status of their engagement with services.
37. In their death under supervision review, North West Probation also acknowledged that Mr Coleman could have received more harm reduction support at his probation induction. We recognise that there is no requirement for probation officers to do so and therefore do not make a recommendation.

Susannah Eagle
Deputy Ombudsman

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