Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Patrick Manson, a prisoner at St Christopher's House Approved Premises, on 27 March 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 deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO

WHAT WE VALUE

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 Patrick Manson died on 27 March 2021, having been found unresponsive in his room in St Christopher's House Approved Premises in Newcastle. It is likely that he died after inhaling butane gas. Mr Manson was 23 years old. I offer my condolences to Mr Manson's family and friends.

Mr Manson was released from prison on 23 March and was only at St Christopher's House for a few days. During that time, he spent more time outside the approved premises than he was supposed to during the COVID-19 pandemic, but otherwise did not present any problems.

We found no reason for approved premises staff to have identified that Mr Manson was at particular risk and we do not make any recommendations.

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 **March 2022**

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Summary

Events

1. Mr Patrick Manson was released from prison on 23 March 2021. He had a history of substance misuse and suffered from depression and anxiety. He arrived at St Christopher's House Approved Premises that afternoon.

2. During his induction, staff explained the approved premises' rules and Mr Manson handed over his mental health medication for staff to give him, in line with his prescription.

3. Over the next few days, Mr Manson registered with a local GP surgery, and had appointments at the bank and the police station. AP rules were that residents should only spend an hour out of the premises per day because of COVID-19 restrictions. Mr Manson was out for longer, and staff reminded him of the rules. Staff gave him his medication as prescribed and watched him take it.

4. Mr Manson was due to have a meeting with his key worker on the morning of Friday 26 March. He went out shortly before the meeting and did not return. He did not answer calls from staff until 2.10pm. His key worker noted on his file that she intended to issue him with a warning the following Monday.

5. Mr Manson returned to the AP that evening. He gave no sign of being intoxicated, so was not drug tested or breathalysed. He spent the evening in his room and did not collect his medication. When staff made a welfare check at 11.00pm, he was on the telephone and indicated that he was okay.

6. When staff made a welfare check at 7.45am the following morning, Mr Manson was unresponsive. They called an ambulance, but Mr Manson was clearly dead and had been for some time.

7. Post-mortem tests showed that Mr Manson choked after vomiting, probably due to inhaling butane gas.

Findings

Substance misuse

8. Mr Manson did not show signs of intoxication at any time, so was not subject to drug or alcohol tests. Post-mortem tests showed he had unprescribed drugs in his system when he died, and he was in possession of cannabis, but we did not find any evidence that staff should have suspected drug use prior to Mr Manson's death.

9. Post-mortem tests also indicated that Mr Manson may have taken his mental health medication outside the directions for his prescription. In line with normal practice, AP staff retained his medication when he first arrived, gave him his prescribed daily dose and watched him take it. We consider that AP staff took reasonable steps to ensure that Mr Manson took his medication in line with his prescription.

Emergency response

10. When staff found Mr Manson unresponsive, they called an ambulance immediately. Mr Manson was clearly dead, and we are satisfied that staff made an appropriate decision not to attempt resuscitation.

Recommendations

11. We do not make any recommendations.

The Investigation Process

12. The investigator issued notices to staff and prisoners at St Christopher's House Approved Premises informing them of the investigation and asking anyone with relevant information to contact him. No one did.

13. The investigator obtained copies of relevant extracts from Mr Manson's probation records. He interviewed six members of staff at St Christopher's House, and Mr Manson's offender manager. He liaised with Northumbria Police on available evidence and the police investigation.

14. We informed HM Coroner for Newcastle-upon-Tyne of the investigation. She gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

15. One of the Ombudsman's family liaison officers contacted Mr Manson's next of kin to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Solicitors acting for the next of kin asked about support for Mr Manson, and about checks in the Approved Premises.

Background Information

St Christopher's House Approved Premises

16. Approved premises (previously known as probation hostels) mostly accommodate offenders released from prison on licence and those directed there by the courts as a condition of bail or community orders. 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.

17. St Christopher's House in Newcastle is run by the St Vincent de Paul Society charity, rather than the National Probation Service, and is funded directly by the Ministry of Justice. Each resident is allocated a key worker.

18. St Christopher's has capacity for 21 residents, but during Coronavirus lockdowns eight rooms are out of commission to allow staff and residents to abide by social distancing measures. The lockdowns had an effect on residents' purposeful activity, so staff increased activities in the AP. Residents without mobile phones were provided with one so they could be contacted for key work, among other things.

HM Inspectorate of Probation

19. HM Inspectorate of Probation's annual report was published in December 2020. Inspectors noted that the probation service had responded admirably to the COVID-19 pandemic.

Previous deaths at St Christopher's House

20. Mr Manson was the first resident of St Christopher's House to die since 2010.

Key Events

21. In July 2019, Mr Patrick Manson was convicted of robbery and subsequently sentenced to 46 months imprisonment. He had a history of drug and alcohol misuse. He had depression, anxiety and attention deficit hyperactivity disorder, and was prescribed mirtazapine (an antidepressant sometimes used to treat anxiety). In January 2020, he was managed under Prison Service procedures to support those at risk of self-harm (known as ACCT).

22. As Mr Manson approached release, he did not have a confirmed release address. He told his offender manager (probation officer) that he was concerned about being homeless. It was agreed that he would need support not to return to his previous lifestyle. Consequently, one of the terms of his licence was that he should live at St Christopher's House Approved Premises (AP). Information about Mr Manson's medical history was included in his Offender Assessment System (OASys) report, which was part of his referral to the approved premises.

23. Mr Manson also discussed his history of substance misuse and agreed with his offender manager that he would work with Newcastle Treatment and Recovery (local drug and alcohol support services) after his release to prevent a relapse.

St Christopher's House AP

24. Mr Manson was released on licence from HMP Northumberland on 23 March 2021. When he arrived at the AP, a member of staff explained his licence conditions, the AP rules and the drug and alcohol policy. Mr Manson signed agreement to the AP's policies. Mr Manson told her that he felt well and was pleased to be out of prison. She explained that staff were able to assist him with administration, such as Universal Credit claims. He said he understood that he could talk to staff if he had any problems or needed any assistance and said that he had support from his brother. There was nothing to suggest that Mr Manson was under the influence of anything, so he was not given a drug test.

25. The member of staff noted on Mr Manson's induction form that he was at risk of self-harm when under the influence of drugs or alcohol. He had suffered from depression and anxiety and had used substances to deal with those feelings in the past. Mr Manson told her that he had no thoughts of self-harm at that time. She noted that he was prescribed mirtazapine to manage his anxiety and depression. She noted that staff should monitor Mr Manson's welfare and put in place extra checks if there were any concerns.

26. Residents at St Christopher's House hand in any medication to AP staff until their key worker assesses whether they should hold their medication in their own possession. Staff keep it securely and dispense it to the resident in line with their prescription. Mr Manson had been issued 14 mirtazapine tablets as he left HMP Northumberland, and he gave the member of staff 14 mirtazapine tablets.

27. That afternoon Mr Manson went to the local shops. His brother had provided him with a mobile telephone, and Mr Manson asked staff if he could call his brother the next morning from the AP telephone to obtain the unlock code. He spent the evening in his room.

28. At 10.40pm, Mr Manson asked for his medication. A member of the AP staff gave Mr Manson his prescribed dose of mirtazapine. In interview, the member of staff said that he watched Mr Manson take his medication and that he had no reason to suspect that Mr Manson had not actually taken it as directed.

29. On the morning of 24 March, Mr Manson went briefly to local shops, then to the bank. Staff emailed a letter to the Holmside Medical Centre to confirm that Mr Manson had made contact to register with a GP, and they included an application and questionnaire that Mr Manson had completed. Mr Manson went to get a vaccination to protect him against COVID-19, but after finding a lengthy queue, he said he decided to return another time. He received his benefits that day, and in the afternoon and evening he said he visited family. On return he was reminded that COVID-19 restrictions meant that he was only supposed to leave the AP for up to an hour. Mr Manson said he understood and would comply in the future. There were no signs that he had consumed any alcohol, so he was not breathalysed.

30. On Wednesday 24 March, Mr Manson had a telephone meeting with his offender manager. They discussed support available for Mr Manson's substance misuse, and his plans to live with his brother when he left the AP. Mr Manson did not raise any specific issues, and in interview the offender manager described the conversation as positive.

31. A member of AP staff gave Mr Manson his prescribed dose of mirtazapine at 9.39pm. In interview, she said that Mr Manson took his medication in her presence and that she had no reason to suspect that he did not take it as directed.

32. On the morning of 25 March, Mr Manson went to the bank, then to a police station to collect his clothes from when he had been arrested. He was angry to discover that they had been destroyed. Through the evening, he was on the telephone to his brother.

33. Mr Manson was due to have a key work session with his key worker that day. A specific time had not been set, and she could not find Mr Manson as he had left the AP. When he returned to the AP, she spoke to him and they agreed that they would have the session at 9.00am the following morning.

34. A member of staff gave Mr Manson his prescribed dose of mirtazapine at 9.05pm on 25 March. She told the investigator that she saw Mr Manson take his medication and had no reason to suspect otherwise.

35. At approximately 8.55am on the morning of Friday 26 March, Mr Manson asked his key worker to let him out of the AP. (During the COVID-19 pandemic the AP door was locked, and residents had to be let in and out by staff.) His key worker reminded him that they were due to meet shortly, and Mr Manson said he was only going to the shop. He did not return, and although staff called his mobile telephone several times, he did not answer.

36. At approximately 2.10pm, the key worker called Mr Manson, and he answered. She reminded him that they had been due to have a meeting. Mr Manson seemed untroubled by this. She told the investigator that his attitude during the conversation, the background noise and his history of using alcohol made her wonder if he had been drinking. Mr Manson had not returned to the AP by the time she finished her shift, so she noted on his record that on the coming Monday she

planned to issue him a warning for missing the meeting. She asked staff in the meantime to explain to him that current rules were that residents should not stay out for longer than an hour.

37. Mr Manson returned to the AP at 5.03pm. A note on his record showed that he was "fine" and spent the evening in his room. There were no signs of him being intoxicated or under the influence of anything, so he was not tested for drugs or alcohol.

38. At 11.00pm, two members of staff made wellbeing checks on the residents. One said Mr Manson was sitting on his bed using his telephone when she checked on him. He indicated that he was okay, and she said goodnight and closed the door. Mr Manson did not come to staff's attention again during the night.

39. During the COVID-19 pandemic, the next scheduled round of welfare checks was at 7.45am on 27 March. These were carried out by two members of staff. When they arrived at Mr Manson's room, one staff member knocked, then opened the door. Mr Manson was kneeling on the floor over the bin. She called to him and shook him by the shoulders, but Mr Manson was cold, and his body was stiff. She ran to the office and told her colleague to call an ambulance.

40. The member of staff tried to move Mr Manson into a lying position on the floor so she could apply a defibrillator, but he was too inflexible, and she could not move him. Another staff member had returned with the emergency services operator on the telephone, and the first staff member spoke to her. The operator advised her to use the defibrillator, but she explained that it was clear to her that he had died. The operator asked her to check Mr Manson, then accepted that resuscitation was not appropriate as there were signs of rigor mortis. The ambulance crew arrived and, at 8.35am, confirmed that Mr Manson had died.

41. Police attended the approved premises. They found some gas cannisters in Mr Manson's room, which were assumed to have contained butane gas. There was a small piece of burnt silver foil but no further drug paraphernalia. There was a plastic bag containing a small amount of cannabis in Mr Manson's sock.

Contact with Mr Manson's family

42. Police identified Mr Manson's mother as his next of kin and informed her of Mr Manson's death. Mr Manson's mother visited the AP on 29 March. In line with guidance, the AP offered a financial contribution to the costs of Mr Manson's funeral.

Support for residents and staff

43. After Mr Manson's death, managers debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. All staff were informed of Mr Manson's death and advised where to access support if necessary.

44. Key workers spoke to all residents in St Christopher's, offering support and highlighting where they could find further support if they wanted.

Post-mortem report

45. The post-mortem report concluded that Mr Manson's death was due to aspiration of gastric contents (inhaling vomit), probably due to butane gas abuse. The pathologist said that Mr Manson had apparently inhaled butane gas, which caused him to lose consciousness and then vomit. This blocked his airways, causing low blood oxygen levels, which can lead to sudden death.

46. Post-mortem toxicology tests showed a high level of mirtazapine in Mr Manson's death, close to levels associated with fatality. This was suggestive of increased use before his death after a period of lower use and may have contributed to a reduced level of consciousness. Levels of olanzapine (an antipsychotic which Mr Manson had not been prescribed) were within the range of therapeutic use.

Findings

47. The AP had prepared for Mr Manson's arrival and he seemed to settle in well. He signed compacts accepting the AP rules. During his brief time in the AP, he was not disruptive, and staff had no concerns about his behaviour. During his induction staff helped him apply to register at the local GP surgery, and explained that assistance was available to him with administrative tasks if he needed it.

48. At the point in the COVID-19 pandemic when Mr Manson arrived at the AP, the rules were that residents were only to leave for specific purposes and for no more than one hour, once per day. Mr Manson exceeded that more than once, despite having signed up to the AP's rules. This did mean that for long periods during his time as a resident, staff did not know what Mr Manson was doing or who he was seeing.

49. His key worker recorded that she was going to give him a warning, but Mr Manson died before this could happen. We are satisfied that this was an appropriate response, given that there was no evidence that Mr Manson was taking illicit substances.

Substance misuse

50. During the COVID-19 pandemic, drug and alcohol testing was suspended in Approved Premises nationally. Testing was only carried out when there was a suspicion that residents were under the influence of drugs or alcohol.

51. At no time in his short stay in the AP did anyone consider that Mr Manson showed signs of intoxication. He was therefore not subject to drug or alcohol tests. Mr Manson's attitude to his missed appointment on 26 March made his key worker wonder whether he may have been drinking. On his return to the AP, however, staff felt that there was no sign that he was under the influence of anything, so he was not tested.

52. Post-mortem tests showed the presence of butane gas in Mr Manson's system, along with medication that had not been prescribed to him. He also had cannabis hidden in his sock. There were no traces of alcohol, although this might have been affected by the length of time between Mr Manson's death and the post-mortem toxicology tests. We did not, though, find any evidence to suggest that staff should have suspected that Mr Manson was using illicit substances before his death.

53. Post-mortem tests showed a high level of mirtazapine in Mr Manson's system, suggesting increased use prior to death. When he first got to the AP, Mr Manson handed in 14 mirtazapine tablets. Mr Manson collected his medication on 23, 24 and 25 March. He did not collect it on 26 March. When residents collect medication, they take it in front of the member of staff who gave it to them. All staff told the investigator that they gave Mr Manson his mirtazapine in accordance with his prescription and witnessed him taking it.

54. It is possible that Mr Manson may have diverted his medication (perhaps by hiding the tablets under his tongue and only pretending to swallow them) and then stockpiled it to take at a later time, but we are satisfied that staff made reasonable efforts to ensure that he had taken his medication as he was supposed to. It is also

possible that Mr Manson may have obtained additional mirtazapine illicitly, but staff had no way of knowing this.

Emergency response

55. When staff found Mr Manson unresponsive, they called an ambulance immediately. The operator advised staff to follow steps to assess how to resuscitate Mr Manson, but he was clearly dead as rigor mortis (a stiffening of the body that normally occurs two to six hours after death) had set in. We are satisfied that staff made the correct judgement not to attempt resuscitation in the circumstances.

Inquest

56. The inquest, held on 7 May 2024, concluded that Mr Manson's death was drug related.

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