Independent investigation into the death of Mr David Gaskell a resident at Bunbury House Approved Premises, on 14 February 2018

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
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.

I carry out investigations to understand what happened and identify how the organisations whose actions I oversee can improve their work in the future.

Mr David Gaskell died from heroin toxicity in his room at Bunbury House Approved Premises on 14 February 2018. He was 28 years old. I offer my condolences to Mr Gaskell’s family and friends.

Mr Gaskell had been released from HMP Liverpool and had been at Bunbury House less than 48 hours before he died. He attended the hostel as directed, and a member of staff took him through the initial phase of the induction process. He had no health issues, was not prescribed any medication and had no history of self-harm. While in custody Mr Gaskell had successfully completed a drug rehabilitation programme. There was no evidence or intelligence to indicate Mr Gaskell used drugs in prison before his release.

One of Mr Gaskell’s licence conditions required him to engage with substance misuse services to provide support, and to prevent a relapse into drug use. He also received the alcohol and substance misuse policies at Bunbury House. I am satisfied that staff at Bunbury House could have done no more in the circumstances.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman  September 2018
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Summary

Events

1. On 13 February 2018, Mr David Gaskell was released on licence from HMP Liverpool to live at Bunbury House Approved Premises, Ellesmere Port. Mr Gaskell was serving a prison sentence of nine years and six months for causing death by dangerous driving.

2. Mr Gaskell had no health issues, was not prescribed any medication and had no history of self-harm. While in custody Mr Gaskell had successfully completed a drug rehabilitation programme for drug abuse, and there was no evidence or intelligence available to indicate that he had been using drugs in prison before his release.

3. Mr Gaskell spent most of 14 February away from Bunbury House but complied with his curfew. At 11.00pm, a member of staff found him unresponsive in his room and requested an ambulance. Staff carried out cardiopulmonary resuscitation until paramedics arrived. The paramedics arrived at 11.08pm and took over emergency treatment. At 11.33pm they pronounced Mr Gaskell dead.

4. Police found evidence of drug use in Mr Gaskell’s room. A post-mortem examination confirmed that the cause of Mr Gaskell’s death was morphine (heroin) toxicity and that Mr Gaskell had drunk alcohol and used cocaine and heroin before his death.

Findings

Assessment of risk

5. We cannot say whether Mr Gaskell intended to take his life or whether the overdose was accidental.

6. We found that staff at Bunbury House appropriately assessed Mr Gaskell’s risk of self-harm in line with national instructions. While in custody, Mr Gaskell had successfully completed a drug rehabilitation programme for drug abuse. There was no evidence or intelligence to indicate Mr Gaskell used drugs in prison before his release. One of Mr Gaskell’s licence conditions required him to engage with substance misuse services to provide him with support and to prevent a relapse into drug use. He also received the alcohol and substance misuse policies at Bunbury House.

7. Mr Gaskell received his induction and went out, as he was entitled to. Issues of drug abuse were discussed and Mr Gaskell gave no indication to staff of his intentions. It would have been hard for the AP staff to have done more in the circumstances.
The Investigation Process

8. The investigator issued notices to staff and residents at Bunbury House informing them of the investigation and asking anyone with relevant information to contact him. No residents responded.

9. The investigator visited Bunbury House on 20 February. He obtained copies of relevant extracts from Mr Gaskell’s probation records.

10. The investigator interviewed three members of staff at Bunbury House in March.

11. We informed HM Coroner for Cheshire of the investigation. He gave us the results of the post-mortem examination and toxicology results and we have sent the coroner a copy of this report.

12. One of the Ombudsman’s family liaison officers contacted Mr Gaskell’s mother to explain the investigation and to ask whether there were any matters she wanted the investigation to consider. Mr Gaskell’s mother wanted to know the chronology of events on the day of her son’s death. Mr Gaskell’s mother received a copy of the initial report. She pointed out one factual inaccuracy. This report has been amended accordingly.
Background Information

Bunbury House Approved Premises

13. 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.

14. Bunbury House, in Ellesmere Port, is managed by The National Probation Service. It has 23 single rooms. All meals are provided and there is a communal area for dining and socialising and areas for group work. Each resident is allocated a key worker/offender supervisor to oversee his progress and well-being, and to ensure that residents adhere to licence conditions and the premises’ rules. Probation Service employees are on duty at Bunbury House 24 hours a day.

Previous deaths at Bunbury House

15. Mr Gaskell's death was the first death to occur at Bunbury House.
Key Events

16. On 18 July 2011, Mr David Gaskell was convicted of causing death by dangerous driving and sentenced to nine years and six months in custody. Mr Gaskell had a history of drug abuse and he successfully completed a drug rehabilitation programme while at HMP Liverpool. There was no evidence or intelligence to indicate Mr Gaskell was using drugs in prison before his release. Mr Gaskell had no history of self-harm at any time while in custody.

17. On 13 February 2018, he was released on licence from Liverpool. Mr Gaskell’s licence conditions required him to live at Bunbury House Approved Premises (AP), Ellesmere Port. He had a curfew requiring him to be at Bunbury House between 9.00pm and 7.00am every day. He was required to report to AP staff at 3.00pm each day. Mr Gaskell was required to engage with substance misuse services to provide him with ongoing support to prevent a relapse into drug use. He was also not permitted to have any contact with three named individuals.

18. When Mr Gaskell arrived at Bunbury House he received an induction from a keyworker. He was told about, and issued with copies of, the AP rules, given details of the facilities, regime, fire and health and safety procedures, the alcohol and substance misuse policy and the support available from AP staff. Mr Gaskell signed to say he understood, and that he had received copies of the rules and policies. Mr Gaskell was also informed of his specific licence conditions, restrictions and signing/curfew times and the medication policy. The keyworker recorded that Mr Gaskell was not prescribed any medication.

19. The keyworker explained to the investigator that there is a national curfew for all residents of approved premises of 11.00pm to 6.30am. At Bunbury House a check is made on all residents at 11.00pm. Residents are required to be in their rooms by midnight. In addition, staff conduct walk round checks of the building during the night.

Wednesday 14 February

20. Mr Gaskell spent most of the day out of Bunbury House. He returned to sign in, as required, at 3.00pm, then left and returned by 8.00pm. CCTV footage confirms that Mr Gaskell entered his room at 8.00pm.

21. The keyworker told the investigator that he had begun the mandatory 11.00pm residents check. When he got to Mr Gaskell’s room he opened the door and could see Mr Gaskell slumped in a sitting position at the end of the bed. He said that Mr Gaskell was unresponsive and appeared unconscious. He raised the alarm and a colleague immediately called an emergency ambulance. They started cardiopulmonary resuscitation (CPR) and used an automated external defibrillator, which administers electrical shocks to restore a normal rhythm to the heart if any is found. The defibrillator found no shockable rhythm, so the AP staff continued with CPR.

22. North West Ambulance Service records confirm that the 999 call was received from Bunbury House at 11.01pm, and paramedics were despatched at 11.04pm. When paramedics arrived at Bunbury House at 11.08pm, they took over Mr Gaskell’s care. At 11.33pm, the paramedics pronounced Mr Gaskell dead.
23. The investigator has liaised with Cheshire Police who confirmed that evidence of drug use was found in Mr Gaskell’s room. Cheshire Police also confirmed that Mr Gaskell did not leave a suicide note.

Contact with Mr Gaskell’s family

24. In line with National Probation Service guidance, the police visited Mr Gaskell’s mother and informed her of her son’s death. Later that morning, the area AP manager contacted Mr Gaskell’s mother by phone and offered the establishment’s condolences and support. In the days that followed, she maintained contact with Mr Gaskell’s family and, in line with national guidance, the Probation Service offered a contribution to the costs of the funeral.

Support for residents and staff

25. The AP manager held a meeting with residents following the incident to inform them that Mr Gaskell had died and offered them support. He offered support to all staff, including those staff not on duty at the time of the incident.

Post-mortem report

26. A post-mortem examination confirmed that the cause of Mr Gaskell’s death was morphine (heroin) toxicity. It was noted that the toxicology results confirmed that Mr Gaskell had drunk alcohol and used cocaine and heroin before his death.
Findings

Assessment of risk

27. Mr Gaskell had a history of drug abuse and he had successfully completed a drug rehabilitation programme while at HMP Liverpool. There was no evidence or intelligence to indicate Mr Gaskell used drugs in prison before his release. Mr Gaskell had no history of self-harm at any time while in custody.

28. When Mr Gaskell arrived at Bunbury House on 13 February, a keyworker gave him copies of the AP’s alcohol and substance misuse policies, and discussed his specific licence conditions, specifically the requirement to engage with substance misuse services. The keyworker assessed that Mr Gaskell was not at risk of self-harm and he was not prescribed any medication. We consider this assessment was appropriate as Mr Gaskell had never self-harmed while in prison custody and gave no indication of his intention to use drugs in the community.