

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr Sean Spencer, a resident at Ty Newydd Approved Premises, on 31 March 2024**

**A report by the Prisons and Probation Ombudsman**

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## 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



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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.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Sean Spencer died of high grade coronary artery atherosclerosis (a significant blocked artery in the heart) on 31 March 2024 at Ty Newydd Approved Premises. He was 33 years old. I offer my condolences to Mr Spencer's family and friends.

Mr Spencer was the third resident to die at Ty Newydd in three years.

Mr Spencer had been released from HMP Humber three days before his death. He had no cardiac related history and there was no evidence of cardiac issues or high blood pressure in his clinical record.

The clinical reviewer found that Mr Spencer received a good standard of clinical care.

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

**Adrian Usher**  
**Prisons and Probation Ombudsman**

**February 2025**

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## Summary

### Events

1. Mr Sean Spencer was sentenced to two years in prison for affray and threatening a person with an offensive weapon. He was released from HMP Humber to Ty Newydd Approved Premises (AP) on 28 March 2024.
2. Mr Spencer had a history of substance misuse and suffered from anxiety and mild depression. He refused to engage with the drug and alcohol treatment service (DART) at Humber.
3. Mr Spencer had a number of health conditions which were treated over the years but had no recorded history of cardiac issues.
4. As part of his induction at Ty Newydd AP, staff explained his licence conditions and the AP rules.
5. At 6.00am on 31 March, staff carried out a routine morning check on Mr Spencer and did not have any concerns. At 8.35am, the resident that shared a room with Mr Spencer, told staff that he was unresponsive in bed. AP staff started cardiopulmonary resuscitation (CPR). Paramedics arrived and confirmed that Mr Spencer had died.
6. The post-mortem examination concluded that Mr Spencer died from high grade coronary artery atherosclerosis (a significant blocked artery in the heart).

### Findings

7. The clinical reviewer concluded that Mr Spencer received a good standard of clinical care at Humber.
8. Mr Spencer had no cardiac related history and he presented as a low risk of having a heart attack in the next 10 years.

## The Investigation Process

9. HMPPS notified us of Mr Spencer's death on 31 March 2024.
10. The investigator issued notices to staff and prisoners at Ty Newydd Approved Premises informing them of the investigation and asking anyone with relevant information to contact her. No one responded. The investigator wrote to the resident who had shared a room with Mr Spencer asking him to contact her. He did not reply.
11. The investigator obtained copies of relevant extracts from Mr Spencer's prison and probation records and his medical record. She also obtained copies of CCTV and staff statements.
12. The investigator interviewed one member of staff on 10 July.
13. NHS England commissioned a clinical reviewer to review Mr Spencer's clinical care at HMP Humber.
14. We informed HM Coroner for Northwest Wales of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
15. The Ombudsman's office wrote to Mr Spencer's family to explain the investigation and to ask if they had any matters they wanted us to consider. Mr Spencer's family asked questions about his mental and physical health care at Humber. We have addressed their questions in this report and in the clinical review.
16. We shared the initial report with Mr Spencer's family. They pointed out some factual inaccuracies and we have amended this report accordingly. Mr Spencer's family also asked questions that do not impact on the factual accuracy of this report and which we have addressed through separate correspondence.
17. We shared the initial report with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

## Background Information

### Ty Newydd Approved Premises

18. 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.
19. Ty Newydd AP in Wales is managed by the National Probation Service. It holds up to 17 men in single rooms. Each resident is allocated a key worker/offender supervisor to oversee their progress and wellbeing and to ensure that residents adhere to their licence conditions and the premises rules.
20. Residents are subject to AP rules in addition to any licence conditions they have been given. They are not allowed to leave the building between 11.00pm and 6.00am. Ty Newydd is staffed 24-hours a day.

### Previous deaths at Ty Newydd

21. Mr Spencer's death was the third at Ty Newydd in three years. There were no similarities with the circumstances of the other deaths.

## Key Events

22. On 9 June 2023, Mr Sean Spencer was sentenced to two years in prison for affray and threatening a person with an offensive weapon and was sent to HMP Hull. On 29 August, Mr Spencer was transferred to HMP Humber.
23. Mr Spencer had a history of diverticular disease (a group of conditions that involve the development of tiny pouches in the colon) and underwent numerous laparotomies (surgery of the abdomen). He had a colostomy and stoma in May 2019 which was reversed three months later.
24. Mr Spencer had a history of anxiety and mild depression. He had a significant history of alcohol misuse and committed his offence while under the influence of alcohol. He was managed under Prison Service suicide and self-harm prevention measures (known as ACCT) three times after he placed a ligature around his neck and made superficial cuts to his arm.

## HMP Humber

25. When he arrived at Humber, a reception nurse noted Mr Spencer's previous medical history and that he had been prescribed sertraline (antidepressant) in the community. Mr Spencer's blood pressure, heart rate and temperature were normal. Mr Spencer denied any current thoughts of suicide and self-harm. The nurse referred him to the mental health team.
26. Between 1 September and 18 January 2024, Mr Spencer received support from the mental health team. On the 28 September 2023, a GP at the prison prescribed sertraline, although Mr Spencer did not collect his medication and told a mental health nurse that he did not feel that it was working. Mental health nurses referred him for talking therapy. Mr Spencer completed seven talking therapy sessions.
27. Mr Spencer was discharged by the mental health team on the 31 January 2024. He told a DART recovery worker that that he felt positive about being released from prison (on 28 March) and he intended to seek support in the community.
28. Mr Spencer did not present with any serious physical health concerns while at Humber.
29. A nurse saw Mr Spencer before his release on 28 March. Mr Spencer said he felt well and did not have any concerns. He refused to allow the nurse to take his physical observations for the discharge summary.
30. Among other conditions, Mr Spencer's licence said he should reside at Ty Newydd Approved Premises, attend for drug testing and attend appointments, as directed, to address his dependency on, or propensity to misuse drugs and alcohol.

## Ty Newydd Approved Premises

31. When Mr Spencer arrived at Ty Newydd AP, a residential worker and a Probation Practitioner completed his induction. Mr Spencer told staff that he intended to register with a GP. He was not prescribed any medication.

32. The residential worker completed a Support and Safety Plan (SaSP, to assess his wellbeing and risk of suicide and self-harm). Mr Spencer said that he did not have any current thoughts of suicide or self-harm.
33. Mr Spencer was allocated a shared room with another resident.
34. On 29 March, Mr Spencer's urine was tested for illicit substances. The results were received on 9 April (after Mr Spencer's death), which showed that Mr Spencer tested positive for pregabalin (used to treat epilepsy and anxiety. It can also cause users to feel relaxed in a similar way to tranquilisers or alcohol).

### **Events of 31 March**

35. At 6.00am on 31 March, a residential worker carried out a routine morning check on Mr Spencer and received a response. (Residential workers are expected to get a response which indicates the person is awake, but it does not necessarily need to be verbal.)
36. At around 8.00am, the resident that shared a room with Mr Spencer collected some bread from staff. He did not express any concerns about Mr Spencer.
37. At around 8.35am, the resident told a residential worker that Mr Spencer was unresponsive in his bed and had been sick. Staff immediately went to Mr Spencer's room. Mr Spencer was lying on his bed unresponsive. His eyes were open, and his skin was discoloured. A residential worker phoned for an ambulance.
38. Staff moved Mr Spencer on to the floor and started cardiopulmonary resuscitation (CPR). Paramedics arrived shortly after and confirmed that Mr Spencer had died.

### **Contact with Mr Spencer's family**

39. At 11.00am that day, the police notified Mr Spencer's family of his death. (It is standard practice for the police to inform the next of kin when a resident of an AP dies.) The AP manager contacted the family by phone later that day.
40. The Wales Approved Premises Area Manager was appointed as the single point of contact for Mr Spencer's next of kin. She sent a letter of condolence to Mr Spencer's next of kin on 2 April, offering support and in line with national instructions offered to contribute to the costs of the funeral.

### **Support for residents and staff**

41. The AP manager spoke to staff and residents who had had interactions with Mr Spencer and gave them information about how to access support if they needed it.

### **Post-mortem report**

42. A post-mortem examination gave Mr Spencer's cause of death as high grade coronary artery atherosclerosis (a significant blocked artery in the heart).

43. The toxicology results revealed recent use of pregabalin. The concentration in Mr Spencer's blood was higher than encountered in therapeutic use but lower than that typically associated with fatal toxicity. There was evidence in Mr Spencer's urine of prior (but not recent) use of buprenorphine and mirtazapine. The pathologist commented that the medication did not contribute to Mr Spencer's death.

## Findings

### Clinical care

44. The clinical reviewer found no evidence of cardiac issues or high blood pressure in Mr Spencer's medical record. He had no cardiac related history and presented as a low risk of having a heart attack in the next 10 years based on the physical observations recorded at his initial health screen.
45. Mr Spencer actively engaged with the mental health team and completed appropriate talking therapy sessions.
46. The clinical reviewer concluded that Mr Spencer received a good standard of clinical care at Humber which was equivalent to what he would have expected to receive in the community.

### Substance misuse

47. Mr Spencer had a significant history of alcohol misuse and staff encouraged him to attend relapse prevention sessions and arranged 1-1 support. Mr Spencer refused to engage and said he would seek support in the community.
48. The results of a drug test received after Mr Spencer's death revealed that Mr Spencer had taken medication that was not prescribed to him.
49. We make no recommendation.

## Inquest

50. HM Coroner did not hold an Inquest into Mr Spencer's death.

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