PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

**Investigation into the death of a resident at Brighton Approved Premises, in September 2013**

## *Our Vision*

*‘To be a leading, independent investigatory body,*
*a model to others, that makes a significant contribution to*
*safer, fairer custody and offender supervision’*

This is the investigation report into the death of a man. The man was a resident at Brighton Approved Premises who died at the Royal County Sussex Hospital on 16 September 2013 after jumping off Brighton pier. The man was 43 years old. A post-mortem examination found that he died from multiple organ failure. I offer my condolences to his family and friends.

The investigator conducted the investigation. The staff at Brighton Approved Premises cooperated fully with the investigation.

The man had been released on licence from a lengthy prison sentence in March 2011, but was recalled to prison in October 2011. He was released again on 12 August 2013 and went to live at Probation Trust approved premises in Brighton. The man's offender manager had prepared a risk management plan to help him address his alcohol problems. The man received warnings for failing alcohol breath tests on 18 August and 13 September, and was concerned that he might be recalled to prison again.

On the evening of 14 September, the man telephoned the approved premises twice, and appeared intoxicated. The first time, in an incoherent call, he seemed to say goodbye. In the second call, he said he was going to jump off Brighton pier. The man had a new mobile telephone number which staff did not have to hand, so were unable to call him back. They immediately informed the police, but the man carried out his threat. He was rescued from the sea but, sadly, died in hospital in the early hours of 16 September.

Although the man had been monitored under the suicide and self-harm provisions in prison, there had been no concerns about his risk at the approved premises. The investigation concluded that staff could not have predicted or prevented his actions. However, it is a concern that although he had failed alcohol tests twice he was not referred earlier to a substance misuse agency in accordance with his risk management plan as originally envisaged, or that the plan was not revised to reflect later decisions about his management.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

**Nigel Newcomen CBE**
**Prisons and Probation Ombudsman** **August 2014**

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## SUMMARY

1. The man was sentenced to 10 years imprisonment in 2005, for robbery and serious assault. He was released on licence in March 2011, but was recalled to prison seven months later after alleged harassment. Between December 2011 and January 2012, the man was monitored under the suicide and self-harm prevention procedures after he cut his arms.

2. In July 2013, the man was released from prison. He had an alcohol problem and his licence conditions included that he should live in Probation Trust approved premises, be tested for alcohol and attend substance misuse appointments. His risk management plan, stipulated that he should be referred to a local substance misuse agency during the week of his release and sessions should be increased if he had a positive alcohol test.

3. The man was released to Brighton Approved Premises on 12 August. The next day, he tested positive for alcohol, but was within the limit allowed. On 18 August, a breath test showed him to be above the allowed limit and staff gave him a formal warning. The man's risk assessment was not updated, as required under national guidelines.

4. After an alcohol test on 13 September, the man was again found to be over the permitted limit. He was anxious that he might be recalled to prison and staff monitored him until a decision was made. After consulting her manager, the man's offender manager decided not to recall him, but gave him a formal "Director's" warning. He was told that it was likely he would be recalled if there were any further problems. After the man received the warning on 14 September, one of the staff at the approved premises reminded him of support available if he felt he needed it, but she had no concerns about his immediate welfare.

5. The man later went out and, at approximately 6.00pm, he telephoned the premises. He sounded intoxicated and said that he had called to say goodbye, then hung up. The member of staff who took the call tried to ring him back, but the mobile telephone number listed for him was out of date. The staff did not believe that the man was a risk to himself or others, but thought that he might be intending to abscond. They planned to reassess the situation if he had not returned by his curfew time of 7.00pm. At approximately 6.15pm, the man telephoned again and said that he was about to jump off Brighton pier. The member of staff he spoke to tried to reason with him, but the man ended the call. The police were alerted but before they could reach him, the man had carried out his threat. The man was rescued from the sea and taken to hospital, where he died in the early hours of 16 September.

6. While we consider it would have been difficult to anticipate or prevent the man's actions, staff did not fulfil a requirement in the man's risk management plan to refer him to a local substance misuse agency immediately nor did they revise his plan to reflect a different course of action.

## THE INVESTIGATION PROCESS

7. The investigator issued notices to staff and residents at Brighton Approved Premises, inviting anyone with information to contact him. No one responded.

8. The investigator spoke to the manager of Brighton Approved Premises on 18 September. He visited on 2 October 2013, obtained copies of the man's records, and spoke to residents. He interviewed seven members of staff and conducted telephone interviews with the man's offender manager.

9. We informed HM Coroner for Brighton and Hove of the investigation, who provided a copy of the post-mortem report. We have sent the Coroner a copy of this report.

10. One of the Ombudsman's family liaison officers spoke to the man's sister to explain the purpose of the investigation. She wondered whether her brother was concerned that he would be recalled to prison for a long time after failing alcohol tests. She questioned whether more counselling might have helped him. She said she was grateful for the contact and support she had had from staff at the approved premises after the man died. The man's sister was provided with a copy of the draft report.

## BRIGHTON APPROVED PREMISES

11. 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. Brighton Approved Premises is run by the Surrey and Sussex Probation Trust.

12. Approved premises work to National Standards and Approved Premises Regulations. They provide enhanced residential supervision by:

- Working closely with offender managers (formerly known as probation officers);
- Providing 24 hour staff oversight;
- Monitoring curfews and ensuring compliance with rigorously enforced rules;
- Undertaking ongoing observation and assessment of attitudes and behaviour;
- Providing programmes of regular supervision, support and monitoring aimed at reducing offending behaviour and risk to the public.

13. Residents are allocated a key worker, who they meet weekly to support them and help them with any problems. Drug or alcohol tests are carried out by staff if a resident has a history of abusing substances or if it is suspected that they might have used them.

14. The man was the first resident of Brighton Approved Premises to die since the Ombudsman took over responsibility for investigating these deaths in 2004.

## KEY EVENTS

15. The man was born on 17 July 1970. He had been convicted of a number of offences from a young age, some violent and often linked to drug and alcohol use. In 2005, he was convicted of robbery and causing grievous bodily harm and sentenced to 10 years imprisonment. He was released on licence in March 2011 and, after a period in Brighton Approved Premises, lived in Littlehampton. He was recalled to prison on 7 October 2011, after an allegation of harassment. Prison records show that the man sometimes suffered from low mood and, from November 2011 to January 2012, he was subject to suicide and self-harm monitoring after cutting his arms.

16. In July 2013, the Parole Board agreed to the man's release. They noted one of his risks was alcohol use and directed that he should reside at approved premises, where he would be subject to a curfew, alcohol testing and attend substance misuse appointments, as directed by his offender manager.

17. Arrangements were made for the man to go to Brighton Approved Premises again. As part of the process, approved premises staff conducted a risk assessment which did not identify any risks of self-harm. The man's offender manager drew up a risk management plan, to refer him to substance misuse agencies for further relapse prevention.

18. The man's Offender Assessment System (OASys) plan was updated on 8 August. This noted that the man's risk would be reduced by referral to specialist counselling to address his use of alcohol. It advised that during the week of his release, his offender manager should refer him to the service local to the approved premises and, in the event of a positive alcohol test, his sessions with the substance misuse services should be increased.

19. The man was released from prison on 12 August 2013 and arrived at the approved premises that day. Another offender manager had taken over as the man's offender manager. It had been agreed that he would report to her once a week and he first saw her on 13 August. They discussed his licence conditions and the circumstances of his recall to prison as well as the approved premises' rules. He had to remain in the premises from 7.00pm to 7.00am and to sign in each day at midday. Approved premises staff conduct regular alcohol tests on residents, using a breath test to the same standard as the legal drink driving limit (35 microgrammes of alcohol per 100 millilitres of breath). The man had an alcohol test that day. The reading of 0.27 was below the 0.35 limit allowed.

20. The man registered with a local surgery. He saw a doctor on 14 August and complained of chronic back pain. The doctor certified him as unfit for work for 21 days (and at a subsequent appointment on 29 August, extended this for a further two months).

21. On 18 August, the man returned to the approved premises at 6.30pm and gave an alcohol reading of 0.50. A second test a short time later read as 0.46. The deputy manager discussed this with the offender manager. The

offender manager decided that she would give him a formal warning. She handed him a warning letter at a meeting on 20 August and discussed the consequences of further alcohol use. The man told her that he knew that he had been silly and he would not do it again. The offender manager told the investigator that, while the alcohol reading was higher than allowed, she did not feel it was excessive and so decided that a referral to a substance misuse agency was not necessary.

22. On 23 August, the man had a meeting with his key worker who told him that as he had failed an alcohol test he would be tested more frequently for a period. He assured her that it would not happen again. On 27 August, the offender manager told the man that if his alcohol use escalated, she would refer him to a suitable community alcohol agency.

23. On 1 September, the man had a review with approved premises staff. He said he had no problems with staff or residents. He had been referred for physiotherapy to help with his back pain and his application for state benefits was being processed. He did not have any accommodation arranged for when he left the approved premises, but said that he would be happy to return to the social care charity which had helped him previously. He kept himself busy by doing odd jobs around the premises and working in the garden, but was finding it difficult not having much to occupy his time. The man liked fishing and the staff said they would look at the possibility of helping him to get some equipment. The note of the review says that he had been regularly tested for alcohol with no concerns. The next day, staff approved a grant of £60 for the man to buy fishing equipment. On 3 September, he saw the offender manager and they again discussed alcohol use and future accommodation plans.

24. At a keywork session on 9 September, the man seemed to be well and was positive about the future. They discussed future accommodation and that he was looking forward to his niece having a baby, which was due soon. He was still using his time constructively, cleaning and tidying and was pleased to have been given funds to buy fishing equipment. He continued to mix well with staff and other residents. The key worker told the investigator that the man would talk to her if he ever felt down, but at this meeting he gave her no cause for concern. The note says that he had been alcohol tested and there had been no further concerns.

25. On 10 September, the man had a meeting with the offender manager, which focused on positive and negative attitudes. He told her about the money he had been given towards buying fishing equipment. The same day, he learnt that the social care charity would not help him with accommodation. He was concerned that this would mean that he would be recalled to prison, but staff assured him that it did not. One of his friends at the approved premises was recalled to prison that day. The man was upset by this and staff decided to increase the frequency of alcohol tests.

26. On 12 September, the man's niece had her baby. The man was very excited and telephoned his family. He arranged to visit and see the baby that coming Sunday, 15 September.

27. On 13 September, when the man signed in at midday, staff could smell alcohol on his breath. A relief offender supervisor, conducted a test which gave a reading of 0.43. The man was upset and anxious that he would be recalled to prison. The relief offender supervisor reassured him that this was not necessarily the case and advised him to go to his room and try to relax. A further test an hour later, gave a reading of 0.33. The relief offender supervisor also gave him a drug test, which was negative for all drugs apart from opiates, which he had been taking as prescribed medication for his back pain. The man continued to be anxious about the possibility of being recalled to prison. The relief offender supervisor explained that there were possible alternatives and asked him why he had been drinking. He said that he had just had a couple of drinks to celebrate the birth of his great-niece. The relief offender supervisor continued to try to reassure him that recall was not necessarily the next step, but when the man returned to his room she could see that he was still worried about this.

28. The deputy manager told the investigator that he did not have any concerns about the man harming himself but, because of his anxiety about the consequences of the alcohol test, he asked staff to check on him hourly to ensure his wellbeing.

29. The deputy manager was aware that he man was anxious about recall and, as it was a Friday afternoon, he wanted to resolve the issue quickly. He spoke to the offender manager, who then spoke to her manager. After consulting the Director of the Probation Trust, it was agreed that the man would be issued with a formal warning from the Director. They also agreed that the offender manager would refer him to a community-based agency for alcohol problems at a session that she had already scheduled with the man for the next Tuesday, 17 September.

30. At approximately 3.20pm, another relief offender supervisor, went to see the man in his room and told him that he would not be recalled to prison but would be given a Director's warning. The relief offender supervisor advised the man not to take any more chances and he said that he had learned his lesson. He later told the deputy manager that he was grateful that he was not being recalled. He went down to the kitchen for his dinner as usual and the relief offender supervisor checked on him through the evening and noticed nothing of concern.

31. One of the approved premises' offender supervisors, spoke to the man on the morning of Saturday 14 September, when he collected his medication. She was aware that the man had been anxious about the consequences of the alcohol test, so explained again that he would not be recalled to prison but would be given a formal warning. Although he was worried, he did not show any signs of distress. A little later, the offender supervisor spoke to him again and continued to try to reassure him and to stress that staff were there to

support him if he needed it. He said that he was not used to that level of support and appreciated it.

32. Later that morning, as the man was leaving the approved premises, The offender supervisor handed him a letter which contained the warning. The letter said that any further breaches would result in his recall to prison. He told the offender supervisor he was okay and she was not concerned about his demeanour. The man then signed out at 1.11pm and left the building.

33. At approximately 6.00pm one of the offender supervisors at the approved premises, answered the telephone and it was the man. He sounded as if he was drunk and was rather incoherent. All that the offender supervisor could make sense of was that the man said “goodbye”, then hung up. At first, the offender supervisor assumed that he meant “goodbye” as a close to the conversation. However, he then became concerned about it and wondered if the man had decided to abscond from the approved premises. The offender supervisor said that he did not at that stage have any concerns that the man would harm himself.

34. The offender supervisor collected the man’s file and tried to call him back on the mobile telephone number listed, but the number was unavailable. He then telephoned the approved premises manager and reported what had happened. Under the terms of his curfew the man did not have to be back until 7.00pm. Although he sounded as if he had been drinking, at this point they could not take any enforcement action. The approved premises manager advised the offender supervisor to keep trying to telephone the man. If he did not return within an hour he would have broken his curfew and the situation would then be reviewed. If he returned and was intoxicated then they should start the procedures to recall him to prison.

35. The offender supervisor checked that the mobile telephone number recorded on the computer system was the same number as noted on the file and was still unable to contact him. At 6.15pm, the man telephoned again. He said he was on Brighton pier and was going to jump off. The offender supervisor tried to talk him out of it, but the man said he was going to do it and ended the call. The offender supervisor telephoned 999, explained to the police what the man had said and gave them a description of him. It seems that at that point the man threw himself from the pier. At the same time another member of staff telephoned the approved premises manager at home, who decided to come into the office. While the offender supervisor was giving the police the man’s mobile telephone number, the staff member noticed that it was a different one from the one noted in the approved premises’ log book and pointed this out.

36. In order to reach the approved premises from his home, the approved premises manager had to pass Brighton pier. As he drove by, he noticed police activity on the beach and pulled over. As he went onto the beach he found that a person he assumed was the man had been taken out of the sea and was in a lifeboat. The approved premises manager approached a police officer and told him who he was and that he knew the man who had jumped. He then telephoned the offender supervisor and asked him to send him a

photograph of the man on his mobile telephone. He showed this to the police, who confirmed that the person taken from the sea was the man. The offender supervisor forwarded personal details, including those of the man's next of kin and a list of his medication, which the approved premises manager also passed on to the police and medical staff.

37. An ambulance took the man to hospital. The approved premises manager went to the approved premises to check on staff and, for the remainder of the evening, went between the approved premises, the police station and the hospital. Another member of staff had heard what had happened and went to the premises to take over from the offender supervisor.

**Informing the man's next of kin**

38. At the hospital, the approved premises manager checked with the police officers that they had not contacted the man's sister. The approved premises manager spoke to his manager and said that he did not feel comfortable contacting the man's sister as he had no information about his condition. At 8.30pm, he contacted the hospital and asked if they had contacted the man's next of kin. They had not but requested details, which the approved premises manager provided. When he telephoned the hospital at approximately 10.30pm, to check on the man's progress, he asked if the man's sister had been contacted and she still had not. The approved premises manager suggested that the hospital should do so and one of the nurses then telephoned her. The man's sister then went to the hospital with other members of his family. Approved premises staff remained in touch with the hospital. The man died in the early hours of Monday 16 September.

39. After the man's death, the approved premises manager spoke to his sister and arranged for her to visit the approved premises to see where her brother had lived. The man's funeral was held on 27 September. The approved premises and the Probation Trust were represented. The Trust offered to make a contribution to the funeral costs in line with national guidelines.

**Informing other residents of the man's death**

40. The other residents were told individually of the man's death and were offered support. The man's room-mate was offered additional support.

**Post-mortem**

41. A post-mortem examination showed that the man had died from multi-organ failure as a result of cardiac arrest. Toxicology reports showed that the man's blood contained 218mg of alcohol per 100ml of blood. The legal limit for drinking when driving is 80mg per 100ml, so the man's reading would indicate a degree of intoxication.

## ISSUES

### Management of the man's alcohol use

42. One of the conditions of the man's licence on his release from prison was that he had to comply with any requirements specified by his offender manager to address his alcohol misuse and offending behaviour. Before his release, his offender manager at the time had produced a risk management plan, which included referral to the substance misuse service local to the approved premises. It was noted in his OASys assessment that his offender manager should make this referral in the week of his release.

43. On 13 August, the man tested positive for alcohol. Although the level was within the limits allowed, it had been stated in his risk management plan that if he gave a positive alcohol reading, even within the allowed limits, any sessions already in existence with substance misuse services should be increased. At that stage, the man had not yet been referred to the substance misuse agency, but this was an opportunity for this to be considered.

44. Five days later, on 18 August, a breath test again showed the man to be over the allowed alcohol limit. As a result, the offender manager gave the man a formal warning at their scheduled meeting on 20 August. Although the alcohol reading was higher than allowed, the offender manager decided that it did not warrant a referral to a substance misuse agency at that stage.

45. The man's OASys assessment should have been updated by 2 September, within 20 days of his release from prison. By then, he had given two positive alcohol tests, one of which was above the allowed limit. This was an opportunity to consider all the circumstances of how the man was progressing since release. It would also have reminded the offender manager of the previous assessments, including the need to refer the man to a local substance misuse agency. However the update was not done.

46. When the man's alcohol test reading was again above the allowed limit on 13 September, it was agreed that he would be referred to a partner agency to address his alcohol problem. Although sessions with his offender manager had focussed on his alcohol use, this was the first reference to a referral in the month that he had been out of prison. Probation staff had therefore not followed the plans that he should be referred to a local substance misuse agency, in the first week of his release. This meant that the positive alcohol readings should result in an increase in sessions with the substance misuse services could not be met. The positive tests on 13 and 18 August were missed opportunities to refer him.

47. The offender manager became the man's offender manager very shortly before he was released from prison. She understood that the man was very anxious about the possibility of being recalled to prison and felt that she needed to build a rapport with him to work effectively. The prison had not notified her that an urgent referral to an alcohol agency was necessary and the man told her that he had undertaken alcohol work in prison. The offender

manager told the investigator that the timing of referrals to partner agencies was at the discretion of the offender manager and she did not consider that an early referral would be beneficial to building a good working relationship with the man.

48. We accept that the offender managers need to build a good working relationship with offenders to help effective rehabilitation and that it can be appropriate for offender managers to use their discretion based on their professional judgement when supervising an offender. However, it is also important to follow agreed risk management plans or alter the plan when decisions have been made to deviate from it. The man was not prohibited from drinking alcohol completely and the two occasions when his alcohol level went over the expected limit did not indicate any excessive intake of alcohol and his behaviour was not affected. Although the offender manager did not refer him immediately to a substance misuse agency, she agreed to do so in consultation with the Director on 13 September. An appointment had been scheduled for 17 September. While in retrospect it appears regrettable that this was not done earlier, we accept the explanation that this was considered to be in the man's best interests. Nevertheless, we are concerned that this was not recorded in the man's OASys and his risk management plan was not amended to reflect this decision.

**The Chief Executive of Surrey and Sussex Probation Trust should ensure that offenders are supervised in line with their risk management plans and that plans are revised to reflect any changes.**

**The man's risk of self-harm**

49. The man had been supported under the suicide and self-harm prevention measures in prison at the end of 2011 and the beginning of 2012, but since then had given no cause for concern that he might be at risk of harming himself. When allocated to the approved premises, staff there contacted the prison and conducted a risk assessment, which did not show any cause for concern. Once offenders are in the approved premises, if staff feel that they are at risk of harming themselves they will be monitored at a frequency set by the hostel duty manager and are referred to relevant external agencies as necessary. Samaritans attend the approved premises every week and run sessions for all residents. The man attended such sessions, but there were no identified concerns that the man seemed to be at risk.

50. On 13 September, when the man was anxious about the possibility of being recalled to prison, staff regularly checked his wellbeing. The deputy manager was aware of the man's anxieties and, as it was a Friday afternoon, he accelerated the decision-making process as he did not want the decision to be hanging over the man's head over the weekend. The man knew by the end of the day that he would not be recalled but was to receive a warning. This prompt action shows good consideration of the man's emotional wellbeing.

51. When the man received the warning on the Saturday morning, the offender supervisor stressed that support was available if he needed it, which the man accepted. The offender supervisor said that she had no reason to suspect that the man might harm himself and it had been made clear to him that he was not being recalled to prison at that time. In his time at the approved premises, the man had not been a control problem and had always complied with his curfew arrangements. He appears to have given staff no cause for concern about harming himself before they received the telephone call on the evening of 14 September. We are satisfied that staff at the approved premises could not have been expected to predict or prevent his actions.

**Approved premises procedures on 14 September**

52. On the evening of 14 September, the man telephoned the approved premises, apparently in a state of intoxication and said goodbye. When he did so, he was not breaking his curfew. The staff had no concerns about risks to the public and no reason at that time to consider he was a risk to himself. Staff could take no enforcement action unless and until he had either breached his curfew or returned to the approved premises under the influence of alcohol.

53. The man had a new telephone number which was noted on the daily log, but his file and computer record had not yet been updated to reflect this. This meant that staff were unable to call him back immediately when he called. It seems unlikely in these circumstances that having the correct number available immediately would have made a difference, but it is important that approved premises keep up to date records of residents.

54. In light of what happened with the man, all staff at Brighton approved premises have been reminded that a change in significant information, such as a telephone number, must be noted in their records. We therefore make no further recommendation.

## RECOMMENDATION

The Chief Executive of Surrey and Sussex Probation Trust should ensure that offenders are supervised in line with their risk management plans and that plans are revised to reflect any changes.

ACTION PLAN

| No | Recommendation | Accepted/Not accepted | Response | Target date for completion | Progress (to be updated after 6 months) |
|---|---|---|---|---|---|
| 1 | The Chief Executive of Surrey and Sussex Probation Trust should ensure that offenders are supervised in line with their risk management plans and that plans are revised to reflect any changes | Accepted | All Offenders will be supervised in line with their risk management plans which will be revised to reflect any changes. | Ongoing | |