Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ryan Burke, a resident at Cuthbert House Approved Premises, on 20 June 2021

A report by the Prisons and Probation Ombudsman

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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*

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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.

Our 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 Ryan Burke died after jumping from the Tyne Bridge on 20 June 2021, while a resident at Cuthbert House Approved Premises. He was 19 years old. I offer my condolences to Mr Burke's family and friends.

Mr Burke arrived at Cuthbert House on 8 June 2021. He gave staff no indication that he was at risk of suicide or self-harm and I consider that staff at Cuthbert House could not have foreseen or prevented Mr Burke's actions.

However, I consider it would have been good practice for staff to have spoken to Mr Burke after his court appearance on 18 June to assess his wellbeing.

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

Sue McAllister CB
Prisons and Probation Ombudsman **January 2022**

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Summary

Events

1. On 3 March 2021, Mr Ryan Burke was sentenced to 28 weeks in prison for criminal damage, having a bladed article and harassment. He was sent to HMP Durham.

2. Mr Burke had a long history of offending and of solvent and alcohol misuse. He was thought to have mental health issues but refused to engage with mental health services or substance misuse services.

3. Before he went to prison Mr Burke had posted comments on social media saying he was sexually attracted to children. This had attracted attention and potentially put him at risk from local 'vigilantes' groups.

4. On 8 June, Mr Burke was released on licence to Cuthbert House Approved Premises (AP) in Gateshead. He told staff that he had no thoughts of suicide or self-harm. He was polite but staff found it very difficult to engage with him.

5. On Friday 18 June, Mr Burke attended court as police had applied for a Sexual Harm Prevention Order against him. Mr Burke did not discuss the outcome of this hearing with staff at Cuthbert House.

6. On the morning of Sunday 20 June, Mr Burke left Cuthbert House. He had not returned by 7.00pm, his curfew time. At 8.35pm, staff began licence recall procedures. Police visited Cuthbert House later that night to tell staff that a man had died after jumping from the Tyne Bridge. They suspected it was Mr Burke but were awaiting formal identification. The next day, they confirmed that it was Mr Burke.

Findings

7. We do not know why Mr Burke jumped off the bridge on 20 June or even whether he intended to kill himself.

8. Mr Burke was only at Cuthbert House for 12 days before he died. We do not consider that AP staff could reasonably have been expected to have foreseen or prevented Mr Burke's actions on 20 June.

9. However, we note that, for understandable reasons, the emphasis by staff was on the risk Mr Burke might pose to others and that very little consideration was given to whether Mr Burke might be at risk of suicide or self-harm.

10. We are also concerned that staff seem to have assessed Mr Burke's risk to himself solely on the basis of what he said and his denials of suicidal thoughts, and dd not appear to have considered his many risk factors for suicide and self-harm.

11. We also consider it would have been good practice for staff to have spoken to Mr Burke after his court appearance.

Recommendations

- The National Approved Premises Team should remind staff that they need to consider an individual's risk factors when considering their risk of suicide or self-harm and should not rely solely on what the individual says or how he/she presents.
- The Manager of Cuthbert House should ensure that someone speaks to an AP resident after a court appearance to assess their wellbeing.

The Investigation Process

12. The investigator issued notices to staff and residents at Cuthbert House Approved Premises (AP) informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

13. The investigator obtained copies of relevant extracts from Mr Burke's prison and probation record.

14. The investigator interviewed four members of staff on 26 July. The interviews were completed by video due to the restrictions imposed by the COVID-19 pandemic.

15. We informed HM Coroner for Tyne and Wear Gateshead and South Tyneside. We have sent the coroner a copy of this report.

16. The Ombudsman's family liaison officer contacted Mr Burke's family to explain the investigation and ask if they wanted to raise any issues. They raised no issues but asked for a copy of the report.

17. The initial report was shared with the Probation Service. There were no factual inaccuracies.

18. Mr Burke's next of kin received a copy of the initial report. They did not raise any further issues or comment on the factual accuracy of the report.

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Background Information

Cuthbert House Approved Premises (AP)

19. Approved premises (formerly known as probation and bail hostels) provide an enhanced level of residential supervision in the community. Most residents are required to stay as a condition of a court order or prison licence.

20. Cuthbert House Approved Premises in Gateshead is managed by the National Probation Service (North East Area). It accommodates up to 24 men over the age of 18. Residents are required to sign in and out of the building and follow agreed curfews. During induction, staff tell residents about the premises' rules and allocate them a key worker who is their primary contact and who holds one-to-one sessions about the issues in the resident's sentence plan. Residents are responsible for their own health and are required to register at a local doctor's surgery. As part of the conditions of residence, staff hold all prescribed medicines and issue them as prescribed.

Previous deaths at Cuthbert House

21. We have investigated two previous deaths at Cuthbert House (in 2010 and 2015). There were no issues relevant to the circumstances of Mr Burke's death.

Key Events

HMP Durham

22. On 3 March 2021, Mr Ryan Burke was sentenced to 28 weeks in prison for criminal damage, having a bladed article in a public place, and harassment. (The harassment offence involved sexually inappropriate communications with his then probation officer.) He was sent to HMP Durham.

23. Mr Burke had a long history of offending and had spent periods in a Secure Children's Home as well as in prison. He abused solvents and alcohol and had a history of violence and sexually inappropriate behaviour. Although he usually attended probation appointments, he did not engage in any meaningful way and did not accept that he posed a risk to others.

24. There were significant concerns about his mental health, but he refused to engage in mental health assessments. He had a provisional diagnosis of emerging borderline personality disorder and also showed signs of possible paranoia and psychosis. He was assessed as having poor emotional control and was prone to impulsive behaviour, especially when under the influence of solvents or alcohol.

25. Before he was sent to prison, Mr Burke had posted a video on social media saying that he was sexually attracted to children, and his comments had attracted a lot of attention from local 'paedophile vigilante' groups. As a result, he was located in the Vulnerable Prisoners (VP) unit.

26. While in prison, Mr Burke expressed what were described as 'bizarre' ideas about a prisoner and about the COVID-19 pandemic, as well as voicing sexual fantasies about children. It was considered that his views made him vulnerable and he was allocated a single cell on the advice of the mental health team.

27. Mr Burke said he used up to four cans of solvents a day before he was sent to prison. He had not been working with any agencies to reduce this and his behaviour worsened when he used them. Mr Burke did not engage with Durham's substance misuse or mental health teams.

28. Mr Burke had no next of kin or visitors listed while he was in prison, although he said he had a good group of friends. He said his father was dead, that he was not in contact with his mother and that he did not have his brother's contact details.

29. Mr Burke was not considered to be at risk of suicide or self-harm while in prison.

30. Details of Mr Burke's previous offences and whereabouts before he was sent to Durham had already been posted on the internet following his social media post. Prison and probation staff considered that if Mr Burke's move to an Approved Premises (AP) became public knowledge, it could put both him and AP staff at risk. However, there was no alternative accommodation available, so it was agreed Mr Burke would move to Cuthbert House AP in Gateshead. He would receive support from Northumberland County Council's Leaving Care Team and

Adult Social Care. Mr Burke knew he would be attending court in June, where he was likely to be issued with a Sexual Harm Prevention Order (SHPO).

Cuthbert House AP

31. On 8 June, Mr Burke was released on licence to Cuthbert House AP. His licence was due to expire on 14 September. He was to be managed by Multi-Agency Public Protection Arrangements (MAPPA) level 2. This meant the police, probation and prisons would be involved in assessing and managing Mr Burke's risk of violence and sexual offences.

32. When Mr Burke arrived at Cuthbert House AP, he met an AP residential worker. She explained the AP rules and routines. They worked through a Support and Safety Plan (SaSP, a guided welfare assessment).

33. The AP residential worker asked Mr Burke whether he had any thoughts of suicide or self-harm. He said he did not. He mentioned he felt a bit anxious about the video he had posted on social media. He said he was not a sex offender but had been drunk and posted it for a laugh. Mr Burke gave his mood a score of 7 out of 10 and said he would speak to AP staff if he felt suicidal or wanted to harm himself. He said he had never intentionally harmed himself and could not think of a reason why he would do so.

34. The AP residential worker told the investigator that Mr Burke seemed distracted throughout their meeting and it was impossible to have a proper conversation with him. For example, when she asked him where he was born, he just kept saying, "I don't really know where I am from, I'm not really from anywhere, I'm from everywhere." She said he found it difficult to focus and his conversation went round in circles and he would ask her to repeat what she had said. She did not get the impression that he was under the influence of anything.

35. The AP residential worker said that was the most 'normal' she saw Mr Burke. Her only contacts with him afterwards were brief interactions around the AP (including helping him set up an email address to claim benefits) or when she went to his room to do welfare checks, but she considered that he had deteriorated and become more distracted. She would find him in his room, with his mask on, not watching TV but just sitting in the dark, although he would always say he was fine when she asked. The residential worker also said that although Mr Burke had told her he had friends to support him, she never saw him using his mobile phone.

36. On 9 June, a residential worker met Mr Burke for an induction interview. He asked Mr Burke whether he felt stressed or depressed. He said he did not.

37. Later that day, Mr Burke met with the residential worker and his offender manager (probation officer), by video. The probation officer told us that on 27 May she had volunteered to move to another probation office and take on 48 cases from a colleague who was on sick leave. She had no handover and had to go through all the cases and pick them up from scratch. She knew Mr Burke was being released from prison on 8 June, but she had no previous knowledge of him apart from hearsay information about him having harassed a previous female

probation officer. As a result, it was agreed that she should not see him on her own.

38. At the meeting on 9 June, the probation officer and with the residential worker discussed what was expected of Mr Burke while he was on licence, and his future plans. Mr Burke was unhappy that one of his licence conditions was not to contact his siblings or have any unsupervised contact with children under 18 years old. Mr Burke seemed angry and uncooperative during this meeting because of this.

39. On 11 June, Mr Burke met with a substance misuse worker. He said he had not used solvents since he had been sent to prison and did not need any help. During their conversation, Mr Burke said he needed to stop posting stupid things on social media.

40. At 7.00pm on 15 June, police arrived at the AP to give Mr Burke court paperwork. This was for the court appearance, scheduled for 18 June, when police would request a Sexual Harm Prevention Order (SHPO). Mr Burke seemed bemused, although he had previously been told about this, and said he was not a sex offender. Police advised him to speak to his solicitor.

41. On 16 June, Mr Burke, the probation officer and an AP residential worker who was Mr Burke's key worker, took part in a three-way video meeting. Mr Burke lacked concentration but did say he had settled into the AP and had started to get his benefits sorted, which had worried him. Mr Burke said his main behavioural risk was his solvent misuse, but he said he was not using solvents anymore.

42. The probation officer asked Mr Burke about his visit from the police the day before. Mr Burke said he did not really understand what was going on and was going to contact his solicitor, but he thought the order might be a result of things he had posted on social media. She agreed and asked about comments he had made while in prison about being sexually attracted to children. Mr Burke said this was not true. She told us that Mr Burke did not seem particularly concerned about his court appearance.

43. Later that day, the AP manager telephoned his probation officer to discuss Mr Burke's presentation as he seemed vacant, emotionless and preoccupied. They agreed to explore possible mental health support for Mr Burke and to meet to discuss what work or intervention would best help him.

44. On 17 June, Mr Burke met with an AP residential worker and a Leaving Care Support Worker. They discussed what work they could do together and how Mr Burke could prevent future solvent use. The AP residential worker said Mr Burke did not engage much.

45. On Friday 18 June, Mr Burke attended Newcastle Magistrates Court. There is no record that anyone from the AP discussed this with Mr Burke on his return, although staff noticed he seemed brighter than usual. No issues were noted in Mr Burke's records that night or the next day.

46. On Sunday 20 June, Mr Burke left the AP at approximately 11.45am. He failed to return by his curfew time, 7.00pm, and at 8.35pm, staff started the licence recall process.

47. At 10.20pm that night, police arrived at the AP to check Mr Burke's room. They told staff a man had jumped from the Tyne Bridge. They suspected it might be Mr Burke, but he would not be formally identified until the next day.

48. At 11.00am on 21 June, police confirmed the dead man was Mr Burke. He had not left any notes, texts or telephone messages before he died.

Contact with Mr Burke's family

49. The police notified Mr Burke's family of his death.

50. The Probation Service contributed to the cost of Mr Burke's funeral, in line with national guidelines.

Support for residents and staff

51. After Mr Burke's death the AP manager debriefed the staff involved to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

52. The AP posted notices informing other residents of Mr Burke's death and offering support.

Post-mortem report

53. The post-mortem report was unavailable at the time of issuing this report. However, the coroner's officer told the investigator that the cause of Mr Burke's death was neck, chest and pelvic injuries.

54. Mr Burke had a blood alcohol level of 235mg/100ml (around three times the drink drive limit in England and Wales) at the time of his death. Blood alcohol levels of 200-300 mg/100 ml are associated with confusion, dizziness, exaggerated emotional states, disturbances of vision, perception of colour, form, motion, dimensions, and increased pain threshold, poor muscular coordination, staggering gait, slurred speech, apathy and lethargy.

55. The fact that there were similar levels of alcohol in both Mr Burke's blood and urine suggests he had been drinking very shortly before he died.

Findings

Management of Mr Burke's risk of suicide and self-harm

56. Mr Burke left no notes or messages to explain his death. It is possible that his death was simply a drunken accident and we cannot be sure that he intended to kill himself.

57. Mr Burke had no history of attempted suicide or self-harm and had not been subject to any suicide monitoring procedures while in prison. Probation concerns prior to his death had been about the risk he posed to others, about the risk others might pose to him because of his social media post, or about the risk to him of accidental injury or death as a result of substance misuse. He was not assessed as being at risk of suicide or self-harm.

58. When Mr Burke arrived at Cuthbert House, AP staff went through a welfare support plan with Mr Burke, which specifically asked about any thoughts or history of self-harm. Mr Burke said he did not have any.

59. Although we do not consider that AP staff could reasonably have been expected to have foreseen Mr Burke's actions on 20 June, we are concerned that staff seem to have assessed Mr Burke's risk to himself solely on the basis of what he said and his denials of suicidal thoughts. As we have said repeatedly in our reports, this is not a reliable indicator of risk by itself. Staff should also consider an individual's risk factors for suicide and self-harm. Mr Burke had several risk factors, including his age, his previous substance abuse, his lack of family contact, his impulsivity, his possible mental health issues, and the fact that he was facing homelessness and unemployment when he left the AP.

60. It is also possible that the implications of the social media post were beginning to dawn on Mr Burke during his time at the AP, particularly after his court appearance.

61. Mr Burke expressed unhappiness that his licence conditions prohibited him from seeing certain family members, but did not pursue this issue. He told staff he was concerned about the video and said he had posted it for a laugh when he was drunk. Mr Burke was aware that he had a court date pending, which he assumed was something to do with the video. He seemed upset when police served court paperwork for an application for a SHPO though, and he said he was not a sex offender. However, when the probation officer and an AP residential worker discussed this with him the next day, they said he seemed unconcerned.

62. Mr Burke's key worker was not on duty when he returned from court on Friday 18 June, and there is no record that any of the other AP staff discussed the court hearing with him on his return. The only note in Mr Burke's record was that he seemed "brighter" than he had previously. We were told that it was likely that staff, particularly his key worker or probation officer, would have spoken to Mr Burke when they returned to work on Monday morning.

63. If Mr Burke did intend to kill himself, we do not know why. It could have been a response to his court appearance, but it could have been for other reasons which

staff were not aware of. However, although there is no requirement for staff to check on an AP resident following a court appearance, we consider it would have been good practice for somebody to have spoken to Mr Burke on his return from court to assess his mood and, if necessary provide some support. This is especially the case given that Mr Burke was only 19 years old.

64. We recognise that, Mr Burke did not engage or talk about his emotions with people he saw as authority figures and that even if staff had made a point of speaking to him after his court appearance, it does not mean his actions would have been different. Nevertheless, we recommend:

The National Approved Premises Team should remind staff that they need to consider an individual's risk factors when considering their risk of suicide or self-harm and should not rely solely on what the individual says or how he/she presents.

The Manager of Cuthbert House should ensure that someone speaks to an AP resident after a court appearance to assess their wellbeing.

65. We are also concerned that the probation officer and the AP staff who had dealings with Mr Burke seemed to know very little about him. Although this was understandable in the probation officer's case as she had only very recently taken over a colleague's caseload, we are surprised that the residential worker seemed to know more about Mr Burke than the key worker.

66. Having said that, we accept that Mr Burke was only at Cuthbert House for 12 days and that he was a difficult person to engage with.

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