

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Lee Brooker on 1 March 2022, following his release from HMP Norwich

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



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Summary

1. 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.
2. From 6 September 2021, the PPO is investigating post-release deaths that occur within 14 days of the prisoner's release.
3. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.
4. Mr Lee Brooker died from a drug overdose on 1 March 2022, following his release from HMP Norwich on 24 February. He was 40 years old. We offer our condolences to Mr Brooker's family and friends.
5. We found no issues of concern. We make no recommendations.

The Investigation Process

6. The PPO investigator obtained copies of relevant extracts from Mr Brooker's prison and probation records.
7. We informed HM Coroner for Hertfordshire of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
8. The PPO family liaison officer wrote to Mr Brooker's nominated next of kin, his mother, to explain the investigation. She said that she was concerned that when the family reported that they were unable to contact Mr Brooker, there were delays in checking on his welfare. We have addressed this in our report.
9. We shared our initial report with HM Prison and Probation Service (HMPPS). They notified us of some factual inaccuracies which have been amended in this report.
10. We sent a copy of our initial report to Mr Brooker's mother. She notified us of some factual inaccuracies which have been amended in this report.

Background Information

HMP Norwich

11. HMP Norwich serves the courts of Norfolk and Suffolk and holds a mix of up to 768 remanded and sentenced prisoners and young adults. The main site houses Category B and C prisoners. A local discharge unit (LDU) is on another site, housing Category C prisoners and an open resettlement facility, holding Category D prisoners. Virgin Care provides primary healthcare and substance misuse services. Norfolk and Suffolk Foundation Trust provides mental health services.

Probation Service

12. The Probation Service work with all individuals subject to custodial and community sentences. During a person's imprisonment, they oversee their sentence plan to assist in rehabilitation, as well as prepare reports to advise the Parole Board and have links with local partnerships to whom, where appropriate, they refer people for resettlement services. Post-release, the probation service supervise people throughout their licence period and post-sentence supervision.

Key Events

13. On 24 February 2022, Mr Lee Brooker was released on licence from HMP Norwich. He was required to comply with his licence conditions, which included living in a flat that probation staff had arranged for him.
14. Mr Brooker was released from prison on the morning of 24 February. He was unable to go to the probation office because he had to collect the keys for his new accommodation. Mr Brooker spoke to a probation practitioner on the telephone instead. Mr Brooker appeared to be in good spirits and said that he was grateful for his accommodation. The probation practitioner arranged a telephone appointment for Monday 28 February.
15. Mr Brooker did not keep his scheduled appointment on 28 February. Attempts were made to contact him on the mobile number provided but they were unsuccessful. Later that day, Mr Brooker's mother contacted his probation practitioner as she was concerned that she had not heard from him and he did not attend court. She also advised the probation practitioner that Mr Brooker had lost his phone.
16. That afternoon, the probation practitioner contacted a housing support officer and asked if someone could go to Mr Brooker's flat to do a welfare check.
17. On the morning of 1 March, a housing support officer went to Mr Brooker's flat and found him dead with drug paraphernalia nearby.

Post-mortem report

18. The post-mortem report concluded that Mr Brooker died from cardiorespiratory failure caused by multi-drug toxicity.

Findings

19. While Mr Brooker was in prison, he had regular meetings and support from drug recovery workers from Phoenix Futures. At times Mr Brooker told staff that he did not have any drug or alcohol issues, but as it was clear that he did have issues, staff continued to work with him and offered him ongoing support.
20. Before Mr Brooker was released from prison, his prison offender manager talked to him about how his drug tolerance level would be lower and the increased risks of overdose. She also discussed with him strategies to avoid drug use. We consider that Mr Brooker received appropriate support with his substance misuse issues and was warned about reduced tolerance.
21. We are satisfied that there was a legitimate reason why Mr Brooker did not attend the probation office on the day of his release and that it was reasonable to arrange an appointment for the Monday. When Mr Brooker failed to attend on the Monday and his family told his probation practitioner that they were unable to contact him, she asked for a welfare check to be carried out, which is when Mr Brooker was found dead. We are satisfied that there was nothing that prison or probation staff could have done to prevent Mr Brooker's death.
22. We make no recommendations.

Sue McAllister CB
Prisons and Probation Ombudsman

September 2022

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