

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

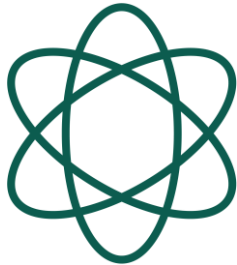
# **Independent investigation into the death of Mr Scott Brightmore on 1 December 2022, following his release from HMP Moorland**

**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 detained people in immigration centres.
2. Since 6 September 2021, the PPO has been investigating post-release deaths that occur within 14 days of a person's release from prison.
3. If my office is to best assist HMPPS in ensuring the standard of care received by those within service remit is appropriate then our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.
4. Mr Scott Brightmore was found dead in his accommodation on 1 December 2022, following his release from HMP Moorland on 18 November. He died from combined drug toxicity. Mr Brightmore was 42 years old. We offer our condolences to his family and friends.
5. Mr Brightmore had a long history of substance misuse and was released from Moorland with a prescription for methadone (a heroin substitute) to last him until 21 November. From then, he was expected to collect his methadone daily from a community substance misuse service. He collected it on 21, 22 and 23 November but did not attend after that. The last known sighting of Mr Brightmore was when he returned to his accommodation on 24 November. His body was found after he failed to attend his probation appointment on 29 November and his community offender manager (COM) contacted his housing support officer. Heroin, along with methadone and other prescription drugs, were found in Mr Brightmore's body after his death.
6. The community substance misuse service was not expected to tell Mr Brightmore's COM that he had stopped collecting his methadone, so the COM was unaware. It is possible that Mr Brightmore would have been found sooner had the COM been told. We make no recommendation, but the Probation Service may want to consider whether it would be desirable for community substance misuse services to advise them of someone failing to collect their methadone.

## The Investigation Process

7. HM Prison and Probation Service (HMPPS) notified us of Mr Brightmore's death on 12 December 2022.
8. The PPO investigator obtained copies of relevant extracts from Mr Brightmore's prison and probation records.
9. We informed HM Coroner for West Yorkshire of the investigation. He gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
10. The Ombudsman's family liaison officer contacted Mr Brightmore's next of kin, his mother, to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond.
11. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS found no factual inaccuracies.

## **Background Information**

### **HMP Moorland**

12. HMP Moorland is a category C resettlement prison which holds up to 1,000 men. Practice Plus Group provides healthcare services at the prison, including primary care, mental health, and substance misuse services. There is healthcare cover from 7.30am until 7.30pm. Outside of these hours, cover is available by telephone consultation with an emergency care practitioner or one of the local prisons' heads of healthcare on a rota system.

### **HM Inspectorate of Prisons**

13. The most recent inspection of HMP Moorland was in February 2019. Inspectors said that resettlement staff were stretched by the high number of releases each month (about 100 prisoners), but they managed to review prisoners' resettlement needs before release. This support was often compromised by prisoners arriving with less than 12 weeks to serve. However, inspectors noted that a pre-release check provided a useful safety net just before release.

### **Probation Service**

14. 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. They 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

15. Mr Scott Brightmore had a long history of offending, which was mainly linked to substance misuse. Mr Brightmore said that he first took heroin when he was 15 years old and crack cocaine aged 25. Mr Brightmore also misused prescription medications. He had gone to hospital on previous occasions as a result of drug overdoses.
16. Following a burglary, on 26 August 2022, Mr Brightmore received a four-month suspended prison sentence. Then, after a shoplifting offence, on 5 September, Mr Brightmore was sentenced to one month in prison, and his suspended sentence was activated, making a total of five months imprisonment. He was sent to HMP Leeds.
17. Prior to his imprisonment, Mr Brightmore was prescribed methadone (a heroin substitute) in the community. He also said that he was using crack cocaine and had a problem with alcohol. His methadone treatment programme continued at Leeds and Mr Brightmore said that he was keen to engage with the substance misuse service (SMS) there.
18. On 30 September, Mr Brightmore was moved to HMP Moorland. He had a settled time in prison and his SMS engagement continued.

## Pre-release planning

19. On 28 October, Mr Brightmore's new community offender manager (COM) contacted him to introduce herself and discuss arrangements for his release.
20. On 2 November, Mr Brightmore's SMS worker at Moorland met with him and discussed release arrangements, including community methadone prescriptions and engagement with a community SMS. He told Mr Brightmore that a harm reduction and overdose awareness session would take place before his release.
21. On 15 November, Mr Brightmore's SMS worker carried out the harm reduction session, including the use of naloxone (used in emergency situations to reverse the effects of an opioid overdose). Before he left prison, the SMS team gave Mr Brightmore the information from the session in writing and also details of the appointment they had arranged for him on 21 November with the community SMS, Turning Point.
22. Before his imprisonment, Mr Brightmore had supported housing with My Space Housing. The support included telephone contact, third party contact with other agencies and face to face contact with the assigned housing support worker on a weekly basis. Mr Brightmore's accommodation remained open to him, and on 15 November, his COM contacted My Space to check that arrangements were in place for his return. This was timely as My Space was expecting a later release date of 22 November. Mr Brightmore's COM contacted his prison offender manager (POM) before his release to ask him to let Mr Brightmore know that the keys for his accommodation could be picked up from the probation office when he attended on the day of his release.

## **Post-release events**

23. On Friday 18 November, Mr Brightmore was released from prison, with naloxone and a bridging prescription for his medications, including methadone, for the period before his SMS appointment on Monday 21 November. On the day of his release, he attended the probation office. Although he had been given written information about his Turning Point appointment, Mr Brightmore said that he was not sure of the details (he had memory problems which previously he said were as a result of head injuries and drug use). His COM phoned Turning Point and although she was unable to get through to confirm the arrangements, Mr Brightmore subsequently attended Turning Point and received his prescription. Mr Brightmore's COM arranged his next probation appointment for 29 November.
24. On 21 November, Mr Brightmore attended his SMS appointment, and picked up his methadone prescription. He did so again on 22 November, and for the last time on 23 November.
25. On 23 November, Mr Brightmore reported to the police that his mobile phone and some money had been stolen from him. As a result, he was no longer able to communicate with his COM directly.
26. On 23 November, Mr Brightmore also had a meeting with his My Space housing support officer. My Space told the PPO's investigator that the meetings were scheduled for once a week to help Mr Brightmore independently sustain his tenancy.
27. On 29 November, Mr Brightmore did not attend his probation appointment. His COM contacted his housing support officer at My Space Housing and asked her to make contact with Mr Brightmore and let him know of a new appointment on 6 December.

## **Circumstances of Mr Brightmore's death**

28. On 1 December, staff at My Space Housing were concerned that Mr Brightmore had not attended his weekly meeting, and they contacted his COM to see whether she had had any contact. That day, they entered Mr Brightmore's flat with an ambulance crew, where they found him dead. Police reported that drug paraphernalia and used needles were found in the flat. CCTV footage showed Mr Brightmore returning to his flat on 24 November, which was the last time he was seen alive.

## **Post-mortem report**

29. The post-mortem report concluded that Mr Brightmore had a fatal concentration of morphine in his blood, and that it was likely that he had died shortly after taking heroin. He also had pregabalin and methadone (both of which he was prescribed) as well as zopiclone (which he was not prescribed) in his blood. Although these were not at levels that alone would have caused death their use may have enhanced the sedative and respiratory depressant effects of the heroin, increasing the risk of death. The pathologist gave the cause of death as the combined effects of morphine, pregabalin, methadone and zopiclone.

## Findings

30. Mr Brightmore had a short period in prison which can be challenging for agencies to provide support on release. In particular, a lack of suitable accommodation is associated with poorer outcomes for people released from prison. However, there was sufficient release planning for Mr Brightmore and he was fortunate in having his supported accommodation kept available for him while he was in prison. Mr Brightmore's flat was in a block with four other residents, but he had access to his own entrance door at the back of the building and did not share any communal areas with other residents. Therefore, no one immediately noticed his absence.
31. Mr Brightmore needed regular engagement with the SMS in order to obtain his methadone. He picked up his last prescription from them on 23 November. The fact that he stopped attending after that was not reported by the SMS to Mr Brightmore's COM. There are no formal arrangements for information sharing in circumstances like this although a notification that Mr Brightmore had stopped picking up his methadone may have resulted in an earlier check on him. In other cases, it could also have a bearing on the risk management of offenders.
32. We make no recommendation, but the Probation Service may want to consider whether it would be desirable for community substance misuse services to advise them of someone failing to collect their methadone.

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

**August 2023**

### **Inquest**

33. The inquest, heard on 13 February 2023, concluded that Mr Brightmore died from the effects of drugs.

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