Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Aaron Bridges, a resident of Albion Street Approved Premises, on 17 January 2022

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

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.

On 18 January 2022, Mr Aaron Bridges, a resident of Albion Street Approved Premises (AP), died of multiple injuries having been hit by a train. He was 33 years old. I offer my condolences to Mr Bridges' family and friends.

Mr Bridges had a history of offending and aggressive behaviour that was linked to alcohol misuse. There was nothing in Mr Bridges' behaviour while he was at the AP that gave any indication he would take his life.

Kimberley Bingham
Acting Prisons and Probation Ombudsman **October 2023**

Contents

Summary

Events

1. In November 2020, Mr Aaron Bridges was sentenced to 26 months in prison. On 2 December 2021, he was released on licence to an Approved Premises (AP). Mr Bridges intended to live with his mother when he left the AP.

2. Mr Bridges had a history of violence against his ex-partner which was linked to alcohol misuse. Staff assessed his risk of suicide and self-harm as low during his induction at the AP. Mr Bridges had taken a drug overdose once, in October 2020, when he was homeless. He did not disclose any thoughts of suicide or self-harm during his time at the AP.

3. On 17 January 2021, staff suspected that Mr Bridges was under the influence of alcohol, and he left the AP after his curfew time. Staff reported Mr Bridges' behaviour to the out of hours manager who decided that he had breached his licence conditions and should be recalled to prison. Staff reported him to the police as unlawfully at large.

4. Mr Bridges contacted his ex-partner and friend and told them that he was going to die. At around 10.15pm, a train driver saw Mr Bridges walking on the train line. Mr Bridges was hit by a train shortly after. Paramedics attended the incident and at 10.48pm, they confirmed that Mr Bridges had died.

5. The post-mortem examination confirmed that Mr Bridges died from multiple injuries.

Findings

6. We are satisfied that staff at the AP appropriately assessed Mr Bridges' risk of suicide and self-harm.

7. We are concerned that a member of AP staff refused to be interviewed. This made it more difficult for us to fully assess the circumstances of Mr Bridges' death.

Recommendation

The Regional Security Manager for Sodexo Government and the area manager for the North East region of the Probation Service should ensure that staff fully comply with in line with the Probation Service Approved Premises Instruction.

The Investigation Process

8. The investigator issued notices to staff and prisoners at Albion Street Approved Premises informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

9. The investigator obtained copies of relevant extracts from Mr Bridges' prison and medical records. She interviewed two members of staff on 1 and 3 February.

10. The investigation was delayed awaiting the outcome of the police investigation into Mr Bridges' death.

11. We informed HM Coroner for West Yorkshire (Western District) of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

12. We wrote to Mr Bridges' family to explain the investigation. We did not receive a response.

13. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Background Information

Albion Street Approved Premises

14. Approved Premises (formerly known as probation or bail hostels) accommodate people 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.

HM Inspector of Probation

15. The most recent inspection of the North East Division of the Probation Service was in June 2019. Inspectors reported that leaders in the North East division had a clear strategy and vision to deliver a quality service and this had been communicated well to staff and many key stakeholders.

16. Inspectors found that reports on self-inflicted deaths had led to a self-harm reduction strategy across all APs.

Previous deaths at Albion Street Approved Premises

17. Mr Bridges was the second resident to die at Albion Street AP since January 2019. The first death was due to natural causes. There were no similarities between the previous investigation and Mr Bridges' death.

Key Events

18. On 12 November 2020, Mr Aaron Bridges was sentenced to 26 months in prison for breach of a restraining order. He was sent to HMP Moorland. On 2 December 2021, he was released on licence to reside at Albion Street Approved Premises (AP) for one month. Mr Bridges' licence expiry date was 1 January 2023.

2021

19. Mr Bridges told prison staff that he was keen to leave prison and intended to live with his mother when he left the AP on 21 January 2022. He had lived in an AP before.

20. Mr Bridges reported to Albion Street AP at midday on 2 December 2021. He could come and go freely during the day but had to be in the AP between 7.00pm and 7.00am, in line with his curfew. His licence stated that he must not contact his ex-partner, the subject of the restraining order.

21. During Mr Bridges' induction to the AP, staff noted that he had a history of alcohol issues in the community. Mr Bridges' offending behaviour was linked to his alcohol use and his binge drinking often resulted in aggression towards his ex-partner. Staff completed a self-harm risk assessment with Mr Bridges during his induction. Mr Bridges said he had taken an overdose when he was released from a previous prison sentence in October 2020, because he was homeless at the time and felt that he had no support. He denied any feelings of low mood and staff noted he appeared positive and motivated. Mr Bridges was prescribed antidepressant medication (30mg of mirtazapine) in prison which he decided to stop taking when he was released because he felt he no longer needed it. Staff encouraged him to seek support from his GP and he agreed to start taking his prescribed medication again. Staff assessed him as being at low risk of suicide and self-harm. They recorded that he should be subject to random alcohol tests.

22. Mr Bridges saw his GP and was prescribed 30mg of mirtazapine.

23. Mr Bridges appeared to settle well at the AP and complied with his licence conditions. Staff did not record any concerns during routine welfare checks. Mr Bridges was approved to stay with his mother on 25 and 26 December. He returned to the AP on 27 December and told staff that he had enjoyed spending time with his family.

2022

24. On 11 January 2022, Mr Bridges had an argument with another resident. The AP manager told us that Mr Bridges was suspected of being under the influence of alcohol. They issued him with a final manager's warning and an improvement plan. This said that Mr Bridges should remain alcohol free and not display any aggressive or threatening behaviour. The AP manager said that Mr Bridges was issued with a final warning because of the severity of the incident and that this would be reviewed on 17 January. Mr Bridges was very apologetic about his behaviour and thankful that he would be allowed to remain at the AP if he complied with his improvement plan.

25. The AP manager told us that alcohol testing was suspended during the COVID-19 pandemic and testing did not take place while Mr Bridges was resident at the AP. Staff informed Mr Bridges' offender manager that he was suspected of being under the influence of alcohol and the negative impact this had on his behaviour. Mr Bridges' licence conditions did not specify that he should not consume alcohol.

26. On 12 January, Mr Bridges told AP staff he had taken cocaine before he had argued with the other resident. The AP manager said that drug tests were also suspended due to the COVID-19 pandemic but could be authorised if there was a risk to staff and residents. Mr Bridges had a drug test the same day. (The results were received on 21 January, after Mr Bridges' death, and did not detect any illicit substances.)

27. The AP manager said that since drug testing resumed in APs, two residents undergo random drug tests each week.

Events of 17 and 18 January

28. At 11.00am on 17 January, staff completed a welfare check on Mr Bridges and did not note any concerns. At 1.00pm, Mr Bridges met his offender manager and a residential support worker. Mr Bridges agreed that substances had a negative impact on his behaviour and he told them that he had not taken drugs or consumed alcohol since 11 January. His offender manager confirmed that he would leave the AP on 21 January to live with his mother and that she would continue to support him.

29. Staff completed welfare checks at 4.00pm and 7.00pm. Mr Bridges was in his room on both occasions and did not express any concerns. In a statement, a night resident support worker, said that at around 9.00pm, he heard Mr Bridges arguing on his mobile telephone. He suspected that Mr Bridges was under the influence of alcohol. Mr Bridges demanded that the AP staff give him his prescribed medication, but they refused his request because of his presentation.

30. The member of staff refused to be interviewed by the investigator.

31. At around 9.10pm, Mr Bridges left the AP, contrary to the terms of his curfew, and a night resident support worker, contacted the out of hours manager, who advised the support worker to let her know if Mr Bridges had not returned by 10.00pm. At 9.40pm, the night support worker contacted the out of hours and said Mr Bridges had returned to the AP.

32. The night support worker told the investigator that she heard Mr Bridges arguing on the telephone with a man. She recalled that the night resident support worker spoke to Mr Bridges' friend on the telephone but could not say what they discussed. Mr Bridges was under the influence of alcohol, was slurring his words and was unsteady on his feet. The night support worker passed this information to the duty manager. The night support worker offered Mr Bridges support and encouraged him to remain at the AP. Mr Bridges left the AP again at 10.00pm.

33. At around 10.10pm, Mr Bridges telephoned the AP and said that he was on his way back. The night support worker telephoned the duty manager at 10.38pm and said Mr Bridges had not returned. The duty manager advised AP staff that if Mr Bridges had not returned to the AP by 11.00pm, they should call her back to start the out of

hours recall process, which would include informing the police. Mr Bridges did not return to the AP. At 11.27pm, staff contacted the police to report Mr Bridges as unlawfully at large. Staff gave the police details of Mr Bridges' ex-partner to ensure welfare checks took place. The night support worker told the investigator that the AP was locked at 11.00pm and staff would usually give residents the opportunity to return by this time before they were reported as unlawfully at large. She did not consider that Mr Bridges was at risk of suicide and self-harm.

34. At around 11.45pm, the police telephoned the AP and said that a man, who was identified as Mr Bridges, had fallen in front of a train and died. The police could not say if Mr Bridges' fall was intentional. At 1.55am on 18 January, the police attended the AP and spoke to staff. No suicide note was found in Mr Bridges' room.

Information received following the police investigation

35. The police investigation found that on 17 January, Mr Bridges made numerous telephone calls to his ex-partner. Mr Bridges told her that he needed money to buy alcohol. At 8.00pm, Mr Bridges called his ex-partner but did not express any suicidal thoughts. Between 9.56pm and 10.09pm, Mr Bridges sent three text messages to his ex-partner which said, "Gonna die", "On tracks train coming" and "Gone". Mr Bridges telephoned his ex-partner on two further occasions at 10.10pm, but she was unable to answer. Mr Bridges did not answer his telephone when his ex-partner returned his calls.

36. Mr Bridges also spoke to his friend on several occasions on 17 January. During a telephone call at 8.55pm, Mr Bridges sounded intoxicated and asked for money to buy alcohol. Mr Bridges' friend refused and told him to return to the AP. Mr Bridges did not express any suicidal thoughts. At 9.58pm, he sent his friend a text message which said, "Going to die". Mr Bridges' friend did not see the message until the following morning.

37. The police investigation noted that at approximately 10.15pm, a train driver observed Mr Bridges walking on the train lines. He appeared intoxicated and did not make any attempt to move from the path of the approaching train. Mr Bridges was hit by the train shortly after.

38. Paramedics attended the train station where Mr Bridges was found and at 10.48pm, they confirmed that he had died.

Contact with Mr Bridges' family

39. On 17 January, the police informed Mr Bridges' family of his death once his body had been identified. On 18 January, a senior probation service manager, telephoned Mr Bridges' next of kin, his mother, to offer her condolences and discuss next steps.

40. Albion Street AP maintained contact with Mr Bridges' family and, in line with national instructions, offered to contribute to the costs of the funeral.

Support for prisoners and staff

41. The AP manager spoke to staff and residents who had had interactions with Mr Bridges and provided contact details for support organisations if they wanted further support.

Post-mortem report

42. A post-mortem examination established that Mr Bridges died from multiple injuries. Toxicology tests indicated that Mr Bridges had used cocaine and ethanol (alcohol) in the hours before his death.

Inquest

43. An inquest concluded on 11 March 2024. The inquest concluded a narrative verdict.

Findings

Assessment of Mr Bridges' risk

44. During Mr Bridges' induction, staff completed a self-harm risk assessment. The purpose is to identify and manage residents who might be at risk of self-harm, in conjunction with Equip (Managing Risk of Intentional Injury and Risk to Self, Community Process) and PI 32/2014, Approved Premises Manual, and the Approved Premises Reducing Self-Inflicted Deaths Action Plan.

45. The assessment asks about any previous incidents of attempted suicide or self-harm. Mr Bridges had a history of substance misuse and was prescribed antidepressant medication. He told staff about the incident in October 2020 where he had taken an overdose, however he did not disclose any current thoughts of suicide or self-harm. Staff assessed Mr Bridges' as at low risk of suicide and self-harm.

46. Mr Bridges had a history of violence against his ex-partner and staff identified that his aggression was linked to alcohol misuse, which affected his emotional well-being. On the day of his death, staff heard Mr Bridges arguing on his mobile telephone and suspected that he was under the influence of alcohol.

47. At the time of Mr Bridges' residency at the AP, drug and alcohol testing was suspended due to the COVID-19 pandemic. When Mr Bridges told staff that he had taken cocaine, the AP manager authorised a drug test. While Mr Bridges' licence conditions did not state that he should not consume alcohol, it was clear that his behaviour significantly deteriorated when he was under the influence. On the night of his death, AP staff informed the out of hours manager who decided that Mr Bridges should be recalled to prison. When Mr Bridges left the AP outside of his curfew and in breach of his licence conditions, staff took appropriate action and reported him to the police as unlawfully at large.

48. Information received after his death revealed that Mr Bridges had repeatedly contacted his ex-partner, had bought alcohol and was threatening to take his life.

49. The out of hours manager, told us that she was aware that Mr Bridges was under the influence of alcohol when he left the AP outside of his curfew. As Mr Bridges was assessed as a low risk of suicide and self-harm and staff did not have any concerns that his risk had increased, she decided that he should be given a chance to return to the AP by 11.00pm. The manager said that she considered the risk to Mr Bridges' ex-partner if he did not return to the AP. When Mr Bridges did not return, she concluded that his risk could no longer be managed in the community and advised the night resident staff to inform the police that he was unlawfully at large.

50. We are satisfied that AP staff considered Mr Bridges' risk of suicide and self-harm and there was no reason for them to think that he might harm himself on the night of 17 January. We are also satisfied that they took appropriate action when he failed to return to the AP.

Compliance with our investigations

51. The Probation Service Approved Premises Instruction sets out the actions staff must follow when a resident dies, including that they must assist with any investigation, create a file, facilitate Police/PPO visits and that they must "be available for interview if required".

52. The investigator asked to interview a member of staff on three occasions. The Regional Security Manager for Sodexo Government told us the member of staff refused to be interviewed because he had already provided a statement.

53. The member of staff's statement provided some helpful details about the events of 18 January. However, the night support worker also told us that the member of staff had spoken to Mr Bridges' friend on the telephone, which was not included in their statement. The staff members refusal to co-operate with our investigation meant we were unable to fully explore how Mr Bridges was behaving on the night of his death and what support was offered to him when his behaviour deteriorated. We make the following recommendation:

The Regional Security Manager for Sodexo Government and the area manager for the North East region of the Probation Service should ensure that staff fully comply with our investigations, in line with the Probation Service Approved Premises Instruction.

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