Investigation into the death of a man at an Approved Premises in the West Midlands Probation Area in April 2007

Report by the Prisons and Probation Ombudsman for England and Wales

May 2008

This report considers the circumstances surrounding the death of a man in April 2007 at an Approved Premises in the West Midlands Probation Area. The man was found hanging in his room during a routine room check. Despite attempts at resuscitation, staff and paramedics were unable to revive him. This was four days before an adoption hearing for his children. The man was 35 years old.

I extend my personal condolences to the man's family and to all those responsible for his care.

One of my investigators undertook the investigation with the assistance of another colleague. I would like to thank the Manager at the Approved Premises and her staff and the forensic psychiatric team at the Medium Secure Unit for their cooperation during this investigation. I am also grateful to the professional appointed by Birmingham and Solihull Mental Health Trust, who facilitated a clinical review of the mental health care that the man received.

The man was serving a two-year Community rehabilitation Order. He had a history of alcohol misuse, depression, personality disorder and self-harm. He had tried to take his life on several previous occasions. He attributed his self-harm and suicidal ideation to the distress of losing custody of his children. As the date for the adoption hearing grew nearer (19 April 2007), staff at the Approved Premises and the Medium Secure Unit, and his offender manager, maintained a heightened awareness of the man's risk to himself and others. In spite of this, the man did not present as being more of a suicide risk than at any other time. On the day that he died it was noted that he appeared to be happier than he had been in a while (although, paradoxically, this is a characteristic often noted amongst those who have determined to end their own lives). He left a suicide note that indicated he could not cope with the adoption of his children.

My report highlights the extent of the care and support that the man received for the duration of his Community Rehabilitation Order. I strongly support the two recommendations made by Birmingham and Solihull Mental Health Trust in the Serious and Untoward Incident Report.

During the course of the investigation, the management team at the Approved Premises addressed issues with regard to monitoring increased risk of self-harm and the storage of emergency response equipment. I have formally commended the management at the Approved Premises for their response to the lessons learned, in addition to the high level of support the staff there and elsewhere offered to the man. These lessons will also be of interest to NOMS nationally.

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Prisons and Probation Ombudsman **May 2008**

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SUMMARY

The man was sentenced to a Community Rehabilitation Order in September 2005. The order required him to maintain regular contact and attend all appointments with his offender manager for a period of two years.

The man led a transitory and chaotic lifestyle. He had a history of psychiatric care, both as an inpatient and in community based care. His depression, personality disorder, self-harm and suicidal ideation were worsened by alcohol dependency and loss of his children. (Social Services took his children into care in October 2004 and they were to be adopted.)

In March 2006, the man was arrested following an altercation with his brother-in-law. On arrest, he was found to have self-harmed. He was admitted to a local Mental Health Unit. On discharge, he was homeless. He found a place in a walk-in hostel for the homeless.

The man remained in the hostel for eight months. During this time he made several attempts on his life by taking overdoses of his prescribed medications (antidepressants and painkillers) and by cutting himself. The South East Home Treatment Team provided him with psychiatric support in the community, but his mental health remained erratic.

The man made frequent threats of violence towards his ex-wife, her partner and social workers. His behaviour worsened and his offender manager feared he posed a both a risk to himself and others. She worked closely with him, maintaining weekly contact with him and finding mental health support during periods of extreme crisis.

A combination of the threats, frequent self-harming and non-payment of rent led to notice of eviction from the walk-in hostel being served to him in November 2006. This caused further distress to him, adding to the building frustration he was experiencing over his children's adoption. He frequently said that he felt desperate and saw no point in living.

His offender manager succeeded in finding him a place at the Approved Premises for offenders with mental health disorders on 6 December 2006. Here he received a high level of support from staff and a forensic psychiatric team from a local clinic. Despite concerted multidisciplinary efforts to address his alcohol misuse, depression, frequent self-harm and suicidal ideation, he continued to feel desperate and deeply saddened at the prospect of losing custody of his children. The adoption hearing was to take place on 19 April 2007.

In mid April 2007, staff at the Approved Premises recall him being in the best mood they had seen in a long while. In the afternoon, a member of staff found him suspended from his bedroom window hanging by a length of cord which had been used as a ligature. He had left a suicide note. Despite attempts to revive him, he was pronounced dead at the local hospital.

THE INVESTIGATION PROCESS

1. The investigation was opened on 17 April 2007 by my lead investigator. She discussed the circumstances surrounding the man's death with the manager of the Approved Premises. The manager told my investigator that the man was on a Community Rehabilitation Order and that he moved to the hostel on 6 December 2006.

2. The investigator arranged to visit the hostel on 18 April to collect copies of all paperwork relating to the man's placement at the Approved Premises and his mental health care. Whilst at the hostel she was given the contact details of the man's probation officer. The investigator arranged for his probation case file to be sent to her office for consideration.

3. On 7 and 8 June, the investigator conducted interviews with staff at the Approved Premises, and with a resident, the man's probation officer, and the mental health specialists responsible for his care. The clinical reviewer from Birmingham and Solihull Mental Health Trust was present for all interviews relating to the man's mental health. The investigator returned to the hostel on 5 September 2007 to interview two members of staff who had been unavailable during her June visit.

4. The Birmingham and Solihull Mental Health Trust has reviewed the man's mental health care and produced a Serious and Untoward Incident Report. They have kindly allowed my investigator to use their findings and recommendations in support of her investigation.

5. One of my family liaison officers tried on numerous occasions to make contact with the man's family through his brother, but without success. The family will be given another opportunity to be involved with the investigation when attempts will be made to offer them this report to read.

The Approved Premises

6. The hostel is an Approved Premises run by the West Midlands Probation Area for male offenders with mental health disorders. It benefits from regular input from forensic psychiatric mental health professionals based at a Medium Secure Unit which is part of Birmingham and Solihull Mental Health Trust. There is no formal service level agreement or any direct funding links between the Probation Service and the Secure Unit. However, as a result of a Serious and Untoward Incident report produced by Birmingham and Solihull Mental Health Trust after the man's death, a service level agreement is now being considered.

7. The hostel has 20 single rooms, two lounges, a games room, kitchen, dining room and residents' laundry. A couple of the rooms are called 'safer rooms'. This means that the door hinges are on the outside of the door, creating fewer potential ligature points. The visitors' room has CCTV and can be used for maintaining constant watch on a resident if required.

8. As in all Approved Premises, the Manager is a Senior Probation Officer with a Probation Officer as Deputy Manager. There are waking night care staff, and day staff are experienced Probation Service Officers (PSOs).

9. The PSOs run the hostel on a day-to-day basis, checking on residents at set times during the day – 9:00am, 12:30pm and 5:00pm. Additional monitoring takes place as required. In addition to managing the residents within the premises, PSOs liaise with courts, prisons, external probation officers, the mental health team from the clinic and, where applicable, the resident's community mental health team. All staff at the hostel have access to mental health awareness training and are also trained in first aid.

10. When there is an event of significant self-harm this is recorded on a self-harm monitoring form, as well as in a resident's case file. This information is then made available to all parties responsible for a resident's care.

11. Each resident is assigned a key worker who is responsible for an average of five residents. The key worker helps a resident work through their licence conditions and prepares them for leaving the hostel – finding accommodation, employment, education and arranging benefits. In addition, the key worker will encourage the resident to address their offending behaviour and, where applicable, refer them to alcohol or drugs agencies. Key worker sessions with residents are held on a weekly basis. All contact is recorded and communicated with a resident's offender manager.

KEY FINDINGS

12. On 23 September 2005, the man was given a Community Rehabilitation Order by the Magistrates' Court as a penalty for racially aggravated harassment and using abusive and threatening language to a police officer. The Order stipulated that he had to maintain regular contact and attend all scheduled appointments with his offender manager for a period of two years.

13. Although he had seen psychiatrists in the past, he never provided any details of them when asked. It is recorded in his medical notes that he had been assessed by two community psychiatric nurses (CPNs) from the Homeless Team at the Hospital Accident and Emergency Unit in October 2005 following self-inflicted cuts to his arms. The man was subsequently referred for counselling via his GP.

14. In March 2006, the man was arrested for breach of the peace at his home following an altercation with his brother-in-law. When the police arrived they found him with cuts to his wrist that he had made himself with a razor. As a result of his self-harm he was admitted on an informal basis to a Mental Health Unit, for a period of assessment. He was also placed in contact with an alcohol advisory service. The man told staff that he was nervous in a crowd, did not trust people and sometimes thought people would harm him. He was diagnosed as being dependent upon alcohol.

15. During this period, Social Services considered allowing his children to be placed in the joint custody of their mother and grandmother. At that time, the man told his offender manager that he wanted to hurt his ex-wife and the social worker handling the custody of his children. The police were informed and, while searching his accommodation, found an axe. The social worker was told by her supervisor not to have any more contact with him due to his violent threats. This removed the only legitimate link left with his children. His offender manager noted that he was not made aware of this whilst he was at the Mental Health Unit for fear he might harm himself.

16. On 20 March, the man was visited at the Mental Health Unit by his offender manager. She noted that the man was not aware of the possibility that his children might be placed with their mother. She felt that his behaviour had been escalating rather than improving and, given his already vulnerable state, he would not take the news well. Later that day, he was discharged with prescribed medication and two weeks' support from a Home Treatment Team. This would provide him with care and support in the community setting rather than through another period in hospital. His offender manager informed his ex-wife of his discharge and his threats.

17. One week later the man took an overdose of 14 tramadol tablets (an analgesic) and went to an Accident and Emergency Unit (A&E). He reported hearing voices and having suicidal thoughts. The man said that the voices were telling him to harm himself. At this time, the man was homeless. He was required as part of his licence conditions to report to a homeless shelter so that his offender

manager could keep track of his whereabouts. The man took up residency at a walk-in self-referral hostel for the homeless. It is not an Approved Premises.

18. On 5 July, the man took another overdose. He was seen at the local hospital A&E and assessed by a psychiatric liaison worker. It was decided that no follow-on referral was required as his problems related to social problems, namely the lack of access to his children. Contacts for voluntary agencies were provided and he was discharged back to the hostel. A request for an urgent assessment was received by the community mental health surgery on 18 July.

19. Three days later the man was back at the hospital A&E accompanied by police officers, having cut himself. During assessment by South East Home Treatment Team, the man said that he felt depressed and wanted to die. Due to the increased risk of suicide it was agreed to admit him to the Psychiatric Hospital on an informal basis. He remained in hospital for two days before discharging himself and returning to the hostel. During this period, a second offender manager became responsible for the man, taking over from the initial offender manager.

20. The man continued to receive input from the Home Treatment Team until 11 September when he was referred to the Community Mental Health Team (CMHT) following a call from the Police Station. He was seen by a mental health nurse from the CMHT on 26 September. Two days later, he was admitted to hospital after taking an overdose of mirtazapine (an antidepressant) and tramadol, in addition to excessive blood loss after badly cutting his arms. He was given a blood transfusion. Once again he was assessed by the Home Treatment Team. The man said that his attempt at suicide was due to lack of access to his children, unemployment and feeling unsafe in his hostel accommodation. He said that he did not think he needed to be in hospital, but agreed to accept further support from the Home Treatment Team. Arrangements were made for the team to visit on alternate days and conduct a weekly medical review.

21. The Home Treatment Team continued to monitor the man's mental health and provide support with housing and benefit issues. During a review on 8 October, he reported that he had cut himself again but had not required medical attention. He also admitted to excessive drinking and smashing up his room at the hostel in frustration. The next day he made verbal threats to his ex-wife and her partner which were reported to the police. He also said that he wanted to end his own life as he "nothing to live for". When reviewed again on 16 October, he appeared to have settled. Despite calming down and reducing his alcohol consumption, he was served with 28 days notice of eviction as a result of unpaid rent. Alternative housing was organised and plans were made for a transfer of care from the Home Treatment Team to another GP with whom an appointment was made for 31 October.

22. On 21 October, the man took another overdose of mirtazapine (his antidepressant) and was admitted to hospital. The Home Treatment Team was informed. The man refused to see a psychiatrist and discharged himself against medical advice. The Home Treatment Team reviewed him on 23

October, at which time he appeared stable, denied any suicidal ideation, and had made no further attempt to self-harm. As the man seemed to have improved a mental health assessment the following week discharged him from the Home Treatment Team back to the care of another GP.

23. The man telephoned his new offender manager on 24 November and told her that he had been served with an eviction notice at the hostel the previous day. He had breached the house rules by drinking alcohol on the premises in addition to failing to pay service charges. The man said that he had been to the local authorities to find alternative accommodation and the local Housing Office would try and get him a flat as soon as possible. The man admitted to his offender manager that he had started drinking to excess again, triggered by the increasing distress of losing his children. He told her that the next family court hearing would take place in early December. The adoption process was causing great frustration and prompting violent thoughts and feelings towards his ex-wife and the social worker responsible for the case. The offender manager expressed concern about his unstable state and previous aggressive behaviours. She noted in his contact case file that she feared he "may react more violently should he feel he has completely lost the children, as at the moment he believes he may gain some form of contact with them, although [she had] tried to dispel this belief". She telephoned his mental health team at the local surgery and asked to speak to his psychiatrist. The psychiatrist said that she had an appointment scheduled with the man for 28 November but he had failed to attend the previous one.

24. On 28 November, the offender manager wrote a lengthy entry in the man's contact case file. She noted that over the previous few days she had received a number of telephone calls from him, and sounded distressed in many of them. He was finding his housing situation difficult. One of the housing associations he had contacted believed the eviction notice served was illegal and had said they would have to look into the matter. The hostel remained firm, maintaining they were within their remit to serve the notice as he had breached the tenancy agreement. However, they said he could remain there until the notice expired. The man was unhappy with this and wanted to leave straightaway, believing that he was being victimised by both the residents and manager. The housing associations were unable to find him emergency accommodation as the hostel was allowing him to stay until the notice expired. In addition, his community psychiatric nurse at the surgery was content with him residing at the hostel temporarily.

25. The man was deeply unhappy with his situation and continued to telephone his offender manager, whilst drunk, telling her that he could not face his children being taken away. The final court hearing regarding custody of the children was to take place the following week. He said that he had nothing to live for if they were taken away. The man failed to attend his psychiatric appointment. He said that he had other things to worry about – his housing situation.

26. On 30 November, his offender manager telephoned the deputy manager at the Approved Premises. They discussed his situation and the offender manager

agreed to fax his psychiatric reports and conviction records to the deputy manager for consideration.

27. On 1 December, tensions escalated at the hostel, resulting in the man taking another overdose of prescribed medication and alcohol. He was admitted to A&E, but once again discharged himself before receiving any treatment.

28. The deputy manager called the offender manager on 4 December to say that the Approved Premises would be able to offer the man a bed, but that he must adhere to strict conditions. He would be offered a single room and a high degree of support. The man was immediately informed and told that he would need to attend an interview at the Approved Premises the following morning.

29. The man was accepted into the Approved Premises on 6 December 2006. On arrival, he was assessed and inducted by the deputy manager. She noted from the Probation Service paperwork that he suffered from 'severe depression' and took prescribed medications – mirtazapine and tramadol. The man was given registration forms for the local GP practice so that he could be seen by a doctor and receive his medications. (All residents are registered with the GP within 24 hours of coming to the premises. Medications are dispensed and delivered by the local pharmacist. All medicines are held in a locked cabinet and dispensed by staff in accordance with the prescription and the GP or mental health team's instruction. Medications relating to mental health are reviewed for compliance on a weekly basis.)

30. As with all new residents, a management plan was drawn up by the deputy manager and the man. It aimed to encourage a sense of routine and stability in his daily life as well as putting support mechanisms in place. The deputy manager noted that the triggers for escalation in his behaviour were alcohol and lack of a supportive environment. They discussed how best to curb his drinking and the man requested that an hourly curfew be placed on him between 10:00am and 5:00pm. In addition, he agreed that he would only leave the Approved Premises between the hours of 10:00am-12:30pm, 2:00-5:00pm and from 5:30-6:30pm. He was assigned a key worker, one of the Probation Service Officers (PSOs).

31. The following day, the man was seen by a Community Psychiatric Nurse (CPN), from a NHS Medium Secure Unit. As well as providing acute in-patient and rehabilitation beds, the clinic has a community outreach service**.** This service is extended to residents at the Approved Premises.) During his assessment, the CPN noted that the man had made at least six attempts at suicide whilst he lived at the walk-in hostel. The man told the CPN that he was feeling very low in mood and suicidal. He said that he wanted to stop drinking alcohol so that he could sort his life out and get his children back. On registering with the GP, the man was placed on an alcohol detoxification programme, comprising chlordiazepoxide (commonly known as librium), thiamine (high dose of vitamin B) and diazepam (commonly known as valium).

32. On 14 December, the man saw a consultant psychiatrist (also from the medium secure unit), and the CPN. The man told them that he had been successful in

abstaining from drinking since arriving at the Approved Premises and restated that his personal goal was to regain access to his children. The man said that losing his children had prompted thoughts of suicide, but he felt better for being at the Approved Premises. He found it a safer environment than the hostel where he said he had been bullied and victimised. Despite not currently feeling suicidal, the man did say that he felt like self-harming. He asked to change his medication and also said that he did not think his antidepressant (mirtazapine) was working. It made him feel agitated. The consultant psychiatrist's plan of action was to reduce the librium over the next week and encourage him to talk to staff about his feelings, particularly when vulnerable to self-harm.

33. Five days later, during a review with the CPN, the man said that he had self-harmed during a difficult few days. He had cut his chest with a razor blade. The man said that he heard voices telling him to hang himself. The CPN asked him if he was still abstaining from drinking to which he replied that he was and found keeping busy helped. However, he had been feeling increasingly stressed as he had expected to receive some photographs of his children from their social worker. These had not arrived until that morning and the wait had distressed him.

34. Weekly multidisciplinary reviews are held at the Approved Premises with the clinical team from the Medium Secure Unit. On 21 December, a review was held with the consultant psychiatrist and the CPN present. During the review, they were told that the man had wanted to leave the Approved Premises the previous day as the voices were telling him to. He was low in mood and missing his children. The man had said that he was "gagging for a drink", but had resisted. He had stopped himself leaving on realising that he was in the best place to receive support. The man said that he had been experiencing suicidal thoughts on a daily basis and the only thing preventing him from hanging himself was his children. He told the psychiatrist and the CPN that he had cords and leads in his room that he could use as ligatures. The man said that he was desperately trying to ignore "everything else going on in his head" and that other residents were being supportive and telling him to not listen to the voices.

35. During the review, the man spoke about his positive relationship with his probation officer. He admitted that he had lost his temper with her on occasion, particularly when she tried to address topics that he was not comfortable discussing, namely his self-harm and drinking. The man asked for his hourly curfew to be reinstated as he was worried about starting to drink. In addition, he said that he was feeling increasingly anxious and having difficulty sleeping. He asked for his antidepressant to be changed and to be given sleeping tablets. He explained that his anxiety was increasing as he did not enjoy the Christmas period given it was around this time that he had married. He would find it difficult to remain sober. The team asked him if he would like to take up a hobby to help distract him from the temptation to drink. He agreed. The CPN told him that it would not be good time to change his antidepressant. The consultant psychiatrist wanted to try him on a different medication (venlafaxine), however this was incompatible with his analgesic (tramadol). As a result, an

alternative painkiller would have to be recommended by his GP before any changes could be introduced. The man's care plan was updated in the interim:

- he was encouraged to develop coping strategies for his poor sleeping pattern, i.e. reduce his caffeine levels
- to remain on his current prescribed medications (mirtazapine and tramadol)
- to focus on positive thoughts to prevent deterioration in his mood
- the team would chase up his psychiatric notes from the Home Treatment Team
- another multidisciplinary team meeting would be held after the Christmas period.

43. On 4 January 2007, during her review with the man, the consultant psychiatrist had sight of the Home Treatment Team's notes, including the psychiatrist's discharge summary. The man told the consultant psychiatrist that he had self-harmed the previous day and this had made him feel better. Despite the relief, he was still experiencing violent and disturbing dreams about his ex-wife. He restated that he did not think his antidepressant was working. Although his sleeping had improved, he still heard voices telling him to hurt himself and others. The doctor's assessment was that, although he was hearing voices, there was no evidence of psychosis. She updated his care plan to include consideration of changing his antidepressant once the team had the opportunity to fully review the Home Treatment Team's notes. The man was once again advised to talk to staff at the Approved Premises if he felt like self-harming or had suicidal thoughts.

44. The man relapsed on 10 January and drank alcohol. The following day he had a multidisciplinary review in which his drinking was raised. The man said that alcohol did not agree with him and made him feel nauseous. He asked again for his antidepressant to be changed and this was agreed. His thoughts of self-harm had increased and he was starting to feel uncomfortable at the Approved Premises. His offender manager (who was present at the review) told him that she thought it would be better for him to stay until his Community Rehabilitation Order expired in September 2007. It was agreed that his antidepressant would be changed from mirtazapine to venlafaxine. After considering his presentation since arriving at the Approved Premises and his past notes, it was concluded that he suffered from depression and a likely borderline personality disorder. Given the diagnosis it was decided that he was appropriately placed at the hostel, but consideration would have to be given for his future care.

45. An appointment had been made for him to see the psychiatrist at the local surgery (Home Treatment Team) on 12 January, but he did not attend as he was unaware of it. Three days later, he had a supervision session with his offender manager. He told her that he was having some problems settling, but continued to comply with the curfews, hostel rules and his medications. The man maintained that he still wanted to leave the Approved Premises as he was finding it difficult to change. His offender manager persuaded him to persist, telling him "this was the most structured intervention [he had] received to date".

46. On 16 January, the man was seen by a trainee forensic psychologist. She told my investigator that the man was initially reluctant to engage with her and he had said she was wasting her time. However, he became less reticent during the session. They talked about his self-harm and history of suicide attempts. The man said that he had started to self-harm from the age of 14, but had not "cut up" for two weeks. The man told her that he had recently stopped thinking about suicide saying, "What's the point, I'd end up in hospital and it would get back to the Social Services?" He said that the voices he heard made him feel guilty about his children being in care, and that he harmed himself to relieve these feelings. The man went on to tell her how he had thought about hanging himself and that he had a noose in his room. He also said that he thought about taking his children away and harming his ex-wife, but had not done this yet as he had no money. He felt that he would have to do this before April when the children were due to be adopted. The psychologist encouraged him to think about more positive goals, and agreed that over the next few weeks they would develop some coping strategies to help with his anxiety.

47. On 18 January, in one of his weekly multidisciplinary care plan meetings, the man said that he had been to see his GP. He said the GP was reluctant to change his analgesic (tramadol), "as nothing else helps with [his] pain". Given this decision, he would not be able to change his antidepressant. It was explained to him that other forms of antidepressants (serotonin-norepinephrine reuptake inhibitors or selective serotonin reuptake inhibitors) were incompatible with his painkiller. The man said that he understood and was fine with remaining on the mirtazapine. At this time, he was still taking a low dose of librium as part of his alcohol detoxification, to be reviewed with a view to reducing it further in a fortnight.

48. The following morning, the man had a supervision session with his offender manager in which they again discussed his desire to leave the Approved Premises. The man said that when he came to the hostel he had narrowly missed being allocated council accommodation of his own. He would need to re-register for housing as he had moved area to come to this hostel. As a compromise, it was decided that his curfew hours should be relaxed to give him some more freedom and responsibility.

49. On 23 January 2007, during a meeting with his Community Psychiatric Nurse (CPN) the man said that he was feeling paranoid and had an increased desire to drink. He also claimed that he had assaulted the foster parent to his children when he bumped into them near the Approved Premises the previous week. (This was not true, but the CPN properly informed his offender manager.) Over the next week, the man became increasingly preoccupied with thoughts of wanting to take his children and run away.

50. His next mental health review took place on 1 February with two doctors. During this meeting, the man said that he was coping with his withdrawal from diazepam but still needed the tramadol for the pains in his back, knees and shoulder (the result of a previous industrial injury). However, he would consider stopping the tramadol if if it was necessary so that he could change his antidepressant. He said that he wanted to self-harm as the voices were telling

him to. He was unable to do so as staff at the Approved Premises had taken away his craft knives. The man said that he felt safe without the knives and was scared to be alone. The voices had been silent for some time, but he had started hearing them again the previous week. They asked him "if he was going to do it?" He denied thoughts of suicide, but said that if something happened to him "he wouldn't care". One of the doctors noted that his appearance was dishevelled and anxious. He had cuts on his arms. He appeared more spontaneous than on previous occasions and the voices might suggest psychotic symptoms. The care plan was to monitor his behaviour to determine whether he was experiencing psychotic symptoms. A further appointment would be scheduled with the trainee psychologist to discuss his self-harm issues and the voices. It was noted that he would stop taking the librium at the weekend.

51. The trainee psychologist met the man on 13 February. He was very defensive and said that he wanted to be left alone. He could not see the point in talking to anyone and did not want any help. The man denied any self-harm since they last met, although the psychologist noted that his contact case file indicated the contrary. She asked him whether the reason for not wanting to talk about his self-harm was that he was frightened of stopping. The man refused to answer and asked to leave. She said that she would schedule a further appointment with him.

52. Over the next few weeks, the man became increasingly paranoid. He self-harmed and drank alcohol. He was seen by various members of the Medium Secure Unit team, all of whom noted his escalation in paranoia and hearing voices. The voices were telling him to harm his ex-wife and "kick off" at the court during the adoption hearing. Staff at the Approved Premises were advised that the man had a high risk of self-harm, and he was encouraged to use distraction methods and to talk to staff when he felt like hurting himself. Further consideration was given to changing his medications. Replacing the tramadol was proving problematic as the GP said he would have to identify a similar analgesic that would not aggravate his asthma. A low dose of antipsychotic medication was also considered.

53. On 27 February, the man had his next session with the trainee psychologist. He engaged more during this session and spoke about his desire to self-harm. The man told her that he had been speaking to staff or played computer games when he felt like hurting himself. This had helped and staff had removed all sharp objects from his room. He said that the voices had worsened during the last week. He described one as being his dead brother; another as a female voice. They told him to harm himself and other people. The trainee psychologist talked through some more coping techniques with the man and encouraged him to write down his feelings when he felt like hurting himself. She said that during their next session they would look at what triggered these feelings.

54. Later in the day, the man had a supervision session with his offender manager. She noted from his key worker's notes that he had been displaying anger towards other residents and had self-harmed. The man maintained that he

wanted to move out of the Approved Premises. During the evening of 1 March, he had an argument with one of the other residents. He called him a 'Paki' and this resulted in the man being pushed. The man was upset by the incident and reported it to the police. The other resident was arrested but later released. On 2 March, his offender manager spoke to him about the argument. She asked him if there was another way to resolve the matter. The man said discussing it was the most appropriate way as what he had really wanted to do was resort to violence.

55. The following week continued to be disruptive. On 5 March, the man brought a stick insect as a pet into the Approved Premises. He received a warning and was reminded of that the house rules stipulated no pets. The man was very unhappy with this and was abusive towards the Manager. He said that she was only interested in the 'Black and Asian residents' and threatened to pack his bags and leave the hostel. He was told to take the insect back to the pet shop, but it died overnight. The next day the man apologised to the manager for his behaviour. He was given a verbal warning regarding his recent actions and reminded that, if he did not comply with the conditions of living at the hostel, he would be asked to leave. Whilst he modified his behaviour towards staff, tension continued between him and some residents. On occasions, he used his strong personality to 'wind residents up' and cause arguments.

56. On 13 March, the trainee psychologist had another session with the man. They discussed his recent behaviour and some cuts to his forearms. The man said that he had thought about jumping out of windows or hanging himself. On being asked about his recent cuts, the man said that he did not remember causing them. He said that he continued to feel angry and guilty about the situation with his children. She asked him to complete the worksheets she gave him whenever he self-harmed. He said that he was unsure about completing them, but acknowledged that there might be value in developing some new coping strategies.

57. A consultant psychiatrist from the Personality Disorder Service (a specialist service, based in Birmingham, for people with enduring and complex emotional, interpersonal and behavioural problems), wrote to the consultant psychiatrist (Medium Secure Unit) acknowledging the letter which referred the man. The consultant psychiatrist from the Personality Disorder Service said that, once a referral application had been submitted, it would be "considered at the next available opportunity in [their] regular clinical meeting". Following this they would contact the consultant psychiatrist from the Medium Secure Unit.

58. In the meantime, the man continued to self-harm and consume alcohol on an occasional basis. During a session with the consultant psychiatrist on 15 March, the man said that he thought about self-harm and suicide most of the time, although he could not say why it was linked to the approaching adoption hearing. He said that he was experiencing violent nightmares, and was disappointed when he woke up and they were not real. In addition, he said that his desire to harm himself or others was becoming harder to resist. The consultant psychiatrist noted that the man appeared low in mood (but not tearful) and he was not displaying any signs of psychosis. The psychiatrist's

care plan after this session was to consider introducing venlafaxine (antidepressant) once he stopped taking the tramadol. A low dose of an antipsychotic medication could also be considered once the change had been made. The consultant psychiatrist would also chase up the referral to the Personality Disorder Service.

59. When the consultant psychiatrist next saw the man on 22 March she was again unable to change his antidepressant medication. The tramadol had not yet been reduced. However, she did note that the tramadol was to be stopped the following week. Later that day, the man scribbled on his medication card. He was called into the manager's office and given a further warning. She told him that his behaviour was unacceptable and that she would contact his offender manager to ask her to find alternative accommodation for him.

60. On 23 March, the manager telephoned West Midlands Probation at to say that she was withdrawing the man's bed due to his unreasonable behaviour. His offender manager was on leave at this time, so the manager reported her intentions to another offender manager. She cited the incidents of racist abuse and added that he had also scribbled over his medication card. The manager also referred to the previous altercation with a resident on 1 March. She said that she wanted the man out of the Approved Premises immediately. The other offender manager agreed to call back once options had been investigated. He spoke to the manager at another Approved Premises, but there were no vacancies and in any case they would be reluctant to accept the man on the grounds that the current Approved Premises wanted to evict him. Other options were explored, but given the man's case history there was no accommodation with the support that he would need. The other offender manager spoke with the manager and explained the situation. She agreed that they would be prepared to keep the man over the weekend, but would prefer him to leave as soon as possible. In addition to his recent behaviour, the man was exercising a negative influence over a resident who had begun to self-harm. The other offender manager noted in the contact case file that the manager felt the man was not technically mentally ill and that he suffered a personality disorder. In light of this, it was felt his bed should be given to an individual who was mentally ill.

61. The other offender manager contacted a hostel, part of Birmingham's specialist personality disorder service alongside the Personality Disorder Service. Unfortunately, that hostel was unable to offer a bed at this time but agreed to send out a referral pack. The offender manager was put in contact with the Personality Disorder Service. They were similarly unable to offer a bed immediately, but would also send out a referral pack.

62. Efforts continued to try and secure alternative accommodation for the man. The other offender manager carried on dealing with the situation in the man's offender manager's absence on annual leave. The manager and the deputy manager acknowledged the limitations in finding the man somewhere else to live. An application for the hostel in Birmingham had been partially completed, but there was a query over revised admission criteria. The form also required the man's input and, as his behaviour had improved over the previous few days

(confirmed by the deputy manager), it was decided to leave the application until his offender manager returned on 4 April.

63. On 29 March, his consultant psychiatrist discussed the referral to the Personality Disorder Service. A referral pack would be looked at over the next week. The man seemed positive about the referral and was willing to engage. Despite this, little had changed in his mental state. He continued to be paranoid and have violent dreams about harming his ex-wife and her partner. However, he denied any recent self-harm or excessive alcohol use. The doctor again noted that he was not displaying any obvious psychotic symptoms. The man's painkiller (tramadol) was stopped on this day and it was planned that he would change antidepressant the following week.

64. On 30 March, the man was issued with a formal warning letter regarding his poor behaviour. This letter followed the verbal warning given on 22 March. After receiving the letter his behaviour improved. He returned to using distraction techniques to cope with his frustrations, and began building a model of the Eiffel Tower out of matchsticks. The man stopped being antagonistic towards other residents and made friends with the resident whom he had reported to the police.

65. On 2 April, the deputy manager informed the man's probation service that the man had self-harmed. The deputy manager said he would be asked to leave his current hostel at lunchtime on 5 April, but would be notified some time on 3 or 4 April. The man's offender manager was on leave so the deputy manager spoke to a different offender manager. This person told the deputy manager that the man's offender manager would be back at work on 4 April and he would now be on leave until that date. The deputy manager said she would notify the mental health team at the medium secure unit of events to make sure that sufficient support would be available over the weekend.

66. The man had an appointment scheduled with the trainee psychologist for 3 April. He missed it as he was not at the hostel when she arrived. He came back later in the day and asked to speak to her. He told her that he had consumed four alcoholic drinks. She noted that he did not appear intoxicated. The man went on to explain that he had spoken with his solicitor who had said that he did not need to appear in court for the adoption hearing. He was also told that he would not be given his final access visit with the children. After being told this the man had cut his arms badly and required medical attention. He was disappointed with himself for self-harming but stated that "he could not cope" and his "life was over" as he had lost his children. It was not until he received the telephone call from his solicitor that the reality of losing his children had properly sank in. He said that until this point he had believed there was a chance that it would not happen. The man told the trainee forensic psychologist that he did not "have any fight left in him and [did not] care what happened any more". He was scared to be on his own as he did not know what he might do. However, he then went on to say that "he would just have to get on with things". The trainee psychologist noted that he left their session in a better frame of mind. Despite this improvement, she raised a heightened risk of

self-harm with the staff at the Approved Premises so they could keep a close eye on him.

67. The referral application pack for the Personality Disorder Service was also completed and submitted on that day (3 April 2007). The man refused to answer any questions about his children on the application. The reasons he gave for wanting to be referred were to address his self-harm issues, depression and low self-esteem. He said that he wanted to feel better about life and have a clearer head.

68. The man's offender manager returned to work on 4 April. She spoke to the deputy manager for an update on recent events. The deputy manager told her that they had decided that the man could remain at the Approved Premises for the time being. A multidisciplinary meeting would be held the following day and the offender manager was invited to attend.

69. On 5 April, the man met with his CPN and the man's psychiatrist for his weekly mental health review. The man told them that he was feeling "ok" but it had been a hard week. He had self-harmed on the Monday (2 April) and had been drinking six to seven pints a day. The man said that the painkillers and mirtazapine were not working and he saw no point in taking the latter. It was noted that his painkiller dose was to be increased by the GP the following week. The man asked to start his new antidepressant (venlafaxine) immediately, but the doctor explained that it would be detrimental to change abruptly and they would consider introducing it.

70. The trainee psychologist saw the man at their fortnightly session on 10 April. He appeared very low during the session, although he acknowledged that it was understandable given the adoption hearing would take place on 19 April. Despite feeling low, the man said that he had not cut himself during the previous week even though he had wanted to. He had been using some of the coping strategies to stop himself – listening to music, going for walks in the park and punching his pillows. The man still said that he felt that there was no point in living without his children, but a resident had helped him put things into perspective by asking him what his children would think if they saw him hurt himself. This appeared to have stopped him. On discussing the adoption hearing, he told the trainee psychologist of his intention to attend regardless of not being required to do so. He quickly changed his mind and then talked about making plans for that day to distract him and help him get through it safely. He thought about either staying in his room or going to the pub. After the session, the psychologist made staff aware of the man's thoughts about attending the court.

71. The man's offender manager spoke with him during the morning on 12 April. He appeared generally quite calm, but became agitated when they spoke about the impending court hearing. He was extremely upset about being denied final contact with his children. The man said that he wanted to go to the court and began reeling off threats against his ex-wife and the social workers. His offender manager explained that his threats were concerning and that, whilst

she understood his frustration, he would need to try and cope with the situation in a different way.

72. After speaking with the man, his offender manager attended the scheduled wider multidisciplinary team meeting to discuss how to manage him over the coming week. In addition to the medium secure unit team and the man's offender manager, an officer attended to represent the Multi Agency Public Protection Arrangements (MAPPA) interests. (MAPPA ensures that a risk management plan is drawn up for the most serious offenders to protect the public from possible risk. The man was considered to be a Level Two risk. The highest level is Three.)

73. The purpose of a larger scale meeting was to consider how to handle the situation should the man try and attend court, given his expressed thoughts of harming his ex-wife and partner (who would be present). The MAPPA representative informed the mental health team that they were awaiting feedback from the MAPPA coordinator on his referral. A meeting had been provisionally scheduled for 17 April. The man's medications had now been changed and he had started the new antidepressant. In addition, his referral application had been submitted to the Personality Disorder Service. A further plan was in place to engage the Home Treatment Team to assess the man if a crisis situation arose and he needed to be admitted to a psychiatric hospital. The immediate care plan outlined was:

- to monitor his drinking and contact his probation officer if it became excessive
- The officer representing MAPPA would liaise with MAPPA regarding (if necessary) preventing the man from attending court
- to heighten awareness of risk of self-harm and possible harm to others during this period.

74. The following day, it was noted in the hostel log book that at 4:25pm the man had returned to the hostel obviously drunk. The man said that he had "knocked out" a man at the Midlands Art Centre. This story was unfounded and was regarded by staff as another of his exaggerated stories of bravado (apparently a common occurrence).

75. The next evening the man asked a member of staff for a razor so he could shave. The she asked him if he was genuine about his intention and he said that he was. Five minutes later the man returned with the razor and blood on his sweatshirt and arms. The member of staff asked him what he had done and asked if he needed medical attention. The man said that he did not want any. He returned a little later and let her tend to his cuts. The member of staff told him that she was disappointed and would never give him a razor again as he could not be trusted. She checked the razor that he handed back. Two of the blades were missing (she had given him a razor with three blades in the head) so she searched his room. As she could not find them and he did not admit to taking them out, she wrote in the hostel book, "I guess he has more blades in his room. I would suggest giving him no more razors for now."

76. On 15 April, two probation service officers (PSOs) were on shift. The male PSO saw the man several times during the course of the day. He spoke to him during the late morning before the man left the hostel to have a beer. On his return, the PSO sat outside in the garden chatting with him. He did not seem drunk. The man told him about his plans after the court hearing had taken place and about how he wanted to go to Ireland. During the afternoon the man left the hostel again and went to the park opposite. At 4:00pm, the man came to the staff office to say that he was going to help the other residents in the garden. Both PSOs noted that the man seemed to be in a good mood, in fact the male PSO said during interview that the man "seemed in the best mood [he had] seen him in ages". During an interview with my investigator, one of the residents and a friend said that the man had given some of his belongings (music compact discs) away that afternoon. The man also went to the living room and said 'good bye' in Italian to the resident interviewed. He said that no one, including himself, had considered this to be an indication of suicidal ideation at that time, particularly as he appeared to be in a very good mood.

77. At 5:00pm, the male PSO performed the routine afternoon staff checks on each resident's room. The procedure for checking rooms is for staff to knock before they enter. Even if there is no answer, staff open the door to check that the resident is okay. The PSO checked a few rooms before reaching the man's room. He knocked on the door and entered. He saw him hanging from what looked like a length of cord from the window. The PSO dropped what he had in his hands and ran over to him and checked his wrist for a pulse. There was blood coming from his nose. The PSO used his mobile phone to call the emergency services. The PSO then left the room, shut the door and ran downstairs to get help. He saw female PSO in the kitchen with some of the residents. The male PSO was still on the phone so he moved away from the kitchen to carry on explaining the situation to the emergency services. He did not want residents to overhear and panic.

78. The male PSO quickly got the female PSO's attention. They moved the residents into the kitchen and she accompanied him upstairs. The female PSO was unable to enter the room and the male PSO sent her back downstairs to retrieve a pair of scissors so they could cut the man down. The female PSO passed the scissors to him through the door. He told her to go to the office and telephone the deputy manager who was the on-call manager for the day. The male PSO cut the man down and placed the man on the floor while he remained on the phone to the emergency services. He heard the man give a 'death rattle' (an expression known for last air being expelled from a deceased persons' lungs). The PSO placed the phone on the floor whilst still connected and began chest compressions. However, there was no sign of life at all making any cardio pulmonary resuscitation (CPR) attempts futile.

79. The PSO did not attempt mouth-to-mouth contact as there was blood coming from the man's nose. He explained to my investigator that he had been trained to avoid any contact with fluids. He did not have a resuscitation aid (protective mouthpiece) to hand (they are kept in the first aid box in the office, but he did not take it with him to the room). After three rounds of chest compressions with no response, he placed the man in the recovery position as he felt there was

nothing else he could do. Approximately two minutes later, the paramedics entered the room and also attempted resuscitation before taking the man to hospital.

80. At 5:55pm, the police arrived at the hostel. On searching his room they found a suicide note. The contents clearly indicated that he had intended to take his life.

81. At 6:30pm, the staff nurse at the local hospital A&E telephoned and asked for the man's next of kin details as they would need to be informed of his death. The only contact telephone number on his file was that of the Regional Offender Manager. It was Social Services who succeeded in contacting his family.

82. The man's funeral took place on Monday 21 May. Some members of staff from the hostel and his offender manager attended.

ISSUES

Clinical issues

83. A Serious Untoward Incident review and action plan has been completed by Birmingham and Solihull Mental Health Trust.

84. I summarise the findings of the review panel here:

85. During his time at the Approved Premises, the man was monitored through weekly multidisciplinary meetings and reviewed by the consultant psychiatrist, several other psychiatric professionals, and a forensic community psychiatric nurse (CPN). The man also had weekly sessions with the trainee forensic psychologist.

86. On 2 April, following four previous incidents of self-harm at the Approved Premises, the man cut his arm deeply and had to attend hospital. After discussions between the consultant psychiatrist, and the psychiatrist from the Mental Health Day Centre, the deputy manager of the Approved Premises, a referral was made to South East Home Treatment Team. The referral was accepted and contact details were provided to the hostel in case of future incidents of crisis behaviour. A referral was also made on 3 April to the Personality Disorder Service in Birmingham. The man was reviewed by a Forensic Psychiatrist from the Medium Secure Unit, and the CPN, on 5 April. The man was last seen by the trainee forensic psychologist on 10 April. At this time, despite continuing to consume excessive amounts of alcohol on a daily basis, there was little change in his mental state.

87. The multidisciplinary meeting held at the Approved Premises on 12 April identified that there might be an increased risk to the man's ex-wife and partner as the court date for the adoption got closer. The man was continuing to make violent threats and wanted to attend the court hearing. A full risk assessment and plan was documented at this time including a warning issued to court staff and arrangements for an escort if the man was to attend the hearing.

88. In the opinion of clinical staff the episodes of self-harm exhibited by the man were the result of stress. The ongoing issues with his ex-wife and the adoption of his children were central to the increase in risk of both self-harm and harm to others.

89. The Serious Untoward Incident review noted that the hostel is an Approved Premises dealing specifically with mentally disordered offenders and run by the Probation Service. The Approved Premises was originally set up with the medium secure unit, but there are no formal links with either the Mental Health Trust or the Secure Unit. Although there is no legal requirement to hold a care programme approach (CPA) responsibility for residents at an Approved Premises, around 60 per cent of residents are already known to various community teams who retain CPA responsibility. The CPA is something that all mental health service users should receive. The purpose of the CPA is to ensure that there is a care co-ordinator for the service user, therefore enabling

an auditable continuity of care. In the man's case, the absence of a CPA managed by a community mental health team whilst he was at the hostel was overcome by care provided by the secure unit team. Prior to coming to the hostel, the community mental health surgery assumed CPA responsibility. This was relinquished once the man was discharged from their care after failing to attend several appointments.

90. The review said there were different understandings of the relationship between the hostel and the medium secure unit. The hostel staff and the Probation Service believe there to be a Service Level Agreement in place, but the review confirmed that this is not the case. There is an unwritten understanding that the secure unit will provide cover in emergencies but only if there is no assigned Resident Medical Officer (RMO) from the community. For residents with an RMO, contact should be made with the relevant team. Given this situation, communication between all involved parties is paramount.

91. The review concluded there were difficulties surrounding the management of service users with personality disorders in an environment such as the Approved Premises, especially as staff are not specifically trained in mental health. Residents have a tenancy and are able to keep their belongings, but there is no facility for Level 2 (5 minute) observations. However, in the case of the man, when a possible need for inpatient admission was identified, appropriate referrals were made from the multidisciplinary team at the hostel. The review recommends (and I concur):

Senior managers from Birmingham and Solihull Mental Health Trust and the Probation Service should discuss the development and implementation of a formal Service Level Agreement between the medium secure unit and the Approved Premises.

92. The man was registered with the Community Mental Health Team (CMHT) and, even though attempts had been made to refer him to the Consultant Psychiatrist's Team at the Mental Health Day Centre, a transfer had not taken place. Care Programme Approach (CPA) responsibility therefore continued to reside with the CMHT surgery. Although the man was transferred to the CMHT surgery from South East Home Treatment Team, he did not attend any of the four scheduled appointments and was therefore not reviewed by the psychiatrist. The review recommends:

Birmingham and Solihull Mental Health Trust and the Probation Service should maintain better communication with Community Mental Health Teams (CMHTs) to ensure continuity of care through:

- **informing each other of an offender's movements**
- **emphasising CMHT's role in maintaining responsibility for care until a formal handover to another care provider has been completed.**

93. The review concluded that mental health care whilst the man was at the Approved Premises was thorough. He benefited from close and consistent

contact with psychiatric and psychological support from the Medium Secure Unit.

Other issues

Issuing warnings

94. During March 2007, the man received warnings for his behaviour and was asked to leave the Approved Premises. My investigator spoke to the manager at length on the subject of issuing warnings. She explained that the man's behaviour had become increasingly unacceptable (racist abuse, altercations, bringing a pet into the hostel), and there was an added concern that he was having a negative affect on a fellow resident. Since becoming friends with the man, the resident had begun self-harming and staff attributed this to the man's influence. The manager said that the man had a strong personality which often created tension amongst the residents. He was prone to fabricating stories and provoking arguments, particularly when he had been drinking.

95. On 30 March, the manager issued a formal warning letter to the man. He was asked to move out. She explained that at the hostel they usually try to resolve behavioural issues informally, but his poor behaviour had been escalating and a firm hand needed to be taken. My investigator asked whether issuing a formal warning at this time (19 days before the adoption hearing) would create further problems for him. The manager assured my investigator that, once the warning had been issued, his behaviour improved. My investigator asked whether he had attributed his behaviour to the frustration and distress over the adoption hearing. She said that, although he rarely discussed his self-harming or his children with her, she was aware of these issues. Careful consideration was taken over issuing the warnings. It would not have been reasonable or fair to staff or the other residents not to issue a warning to him as he was disrupting the household and breaching conditions.

Managing increased risk of self-harm or suicide

96. My investigator explored the management of increased risk of self-harm or suicide with both the manager and deputy manager of the Approved Premises. It was explained to her that, if it is brought to staff attention that a resident is at risk of hurting themselves, their room is searched and any sharp or dangerous objects (such as razor blades or knives) are removed. The resident is asked to hand over these implements. If he does not, he is told that his bed might be withdrawn.

97. Before the man's death, the manager had issued a form to be completed whenever a resident self-harmed and detailing the incident. These forms are used to monitor self-harming behaviour and to identify any increased propensity to self-harm. She felt that this monitoring process was successful, but explained that since the man's death they have been reviewing all procedures (at a regional level) relating to self-harm and suicide. At the time of his residency, there was no additional process in place for managing an increased risk of self-harm at a multidisciplinary level such as the Assessment, Care in Custody and Teamwork (ACCT) document used by the Prison Service. (The ACCT form helps all those responsible for a person's care better manage the increased risk by clearly documenting interactions, observations and

assessments, in addition to detailing care plans. The document is accessible to all involved, both discipline and clinical staff, making care transparent with shared responsibility. An 'open' ACCT form cannot be closed without a joint decision to do so, including the agreement of the person concerned.)

98. The ACCT form works well in a closed setting such as a prison as there is better scope for close observation and, where necessary, constant supervision. The model cannot be directly transposed to an Approved Premises setting as a hostel is not practically equipped or staffed to provide the same level of observations. However, some Probation Service areas have adapted the process and have been using a version of ACCT in Approved Premises. During the course of this investigation the management team at the Approved Premises have begun a consultation process to adopt a version of the ACCT themselves. They will wish to consult with NOMS centrally, as there are important lessons to be learned from experience elsewhere. Nevertheless, I welcome their pro-active approach and look forward to seeing a system for improved self-harm monitoring introduced in the near future.

Anti-ligature knives

99. Although Approved Premises are not required to provide staff with anti-ligature knives for use in emergency, the hostel did keep one in the staff office. However, the knife was not actually used when the man was found hanging. This was partly due to staff not being clear where the knife was stored, but predominantly because staff were presented with an unfamiliar situation of finding a resident hanging and locating the knife was not the first thing that came to mind. Self-evidently, there was some delay while the second officer used the telephone to call for emergency assistance (I mean no criticism of him in this regard). Indeed, he reacted quickly to discovering the man and used the closest tool to hand to cut him down (a standard pair of scissors) before attempting cardio pulmonary resuscitation. Again, I would be reluctant to criticise the male PSO for not using the anti-ligature knife as it would have taken longer to find the knife than grab a pair of scissors. However, I would stress that, if management are going to provide emergency response equipment for staff, it is self-evident that it must be clear to all where it is kept and when to use it.

100. Since the man's death, the management team at the hostel have issued a memorandum to staff reminding them of where equipment is kept. They have gone one step further in providing all staff with anti-ligature knifes to wear on their belts next to their personal alarms. Again, I commend this pro-active response to lesson learning. NOMS may wish to consider if this is practice that should be commended across the Probation Service.

Conclusion

101. The man's self-harming was impulsive and seemingly triggered by the anger, stress and frustration he experienced, predominantly in response to the adoption hearing. On occasion, he objected to his medications and did not always properly engage with his mental health care. But on the whole he understood and appreciated what the medium secure unit and the Approved Premises were trying to do for him. Sadly, he never stopped self-harming and often said that he wanted to take his life.

102. I judge that staff did all that they could to manage his self-harm when the man was in periods of crisis. They would search his room more frequently and remove any items considered dangerous. During times when he demonstrated an increased risk to himself he would be closely monitored and the mental health team were immediately informed.

103. In sum, the man was appropriately cared for by both probation staff and the clinical team, receiving close and consistent contact with psychiatric and psychological support from the medium secure unit. It is tragic that he felt the only way to escape his chronic distress was suicide. I understand that the man remains greatly missed by staff at the Approved Premises.

RECOMMENDATIONS AND COMMENDATIONS

Senior managers from Birmingham and Solihull Mental Health Trust and the Probation Service should discuss the development and implementation of a formal Service Level Agreement between the medium secure unit and the Approved Premises.

Birmingham and Solihull Mental Health Trust and the Probation Service should maintain better communication with Community Mental Health Teams (CMHTs) to ensure continuity of care through:

- **informing each other of an offender's movements**
- **emphasising CMHT's role in maintaining responsibility for care until a formal handover to another care provider has been completed.**

Commendations

I would like to commend staff at the Approved Premises and the Medium Secure Unit, and the man's offender manager for offering him a high level of care and support. I would be grateful if this report could be shared with those concerned.

I commend the management at the Approved Premises for taking a pro-active and positive response to lessons learned as a result of this tragic incident, as demonstrated in the review of monitoring incidence of self-harm and provision of anti-ligature knives for all staff. NOMS centrally will wish to take an interest in these developments.