

**Investigation into the circumstances surrounding the  
death of a man whilst a resident at Ozanam House  
Approved Premises in Northumbria Probation Trust in  
December 2009**

**Report by the Prisons and Probation Ombudsman  
for England and Wales**

**August 2010**

This is the report of an investigation into the death of a man. He was found hanging in woods in County Durham, in December 2009. At the time of his death he had been reported missing from Ozanam House Approved Premises in Newcastle, having broken the conditions of his licence, and procedures to recall him to prison had been put in place. The man had been released from prison just five days before his death. He was 45 years of age.

I extend my condolences and those of my colleagues to the man's family. I hope that my report goes some way to answering their questions.

The investigation was carried out on behalf of the Ombudsman by one of her investigators. I would also like to take this opportunity to thank all of the staff at Ozanam House and in particular the manager for their cooperation during the investigation. This is the first apparently self inflicted death of an Ozanam House resident since the Ombudsman started investigating such deaths in April 2004.

A clinical review was conducted by the clinical reviewer on behalf of the local Primary Care Trust (PCT). The PCT is not obliged to carry out a clinical review following deaths at approved premises and I am most grateful to him, whose review is annexed to this report.

It is evident from the investigation that the man was a quiet man, who was affected greatly by the loss of contact with his family. I have given much thought to his frame of mind whilst he was in prison. He was supported by many members of staff and, although he spoke of harming himself, I am satisfied that there was no need for suicide monitoring to have been implemented. He suffered from depression throughout his prison sentence he was remorseful about his offences and the way that they had affected his family. My report concludes that staff who had contact with him could not have reasonably foreseen his actions.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and residents involved in my investigation.

**Jane Webb**  
**Acting Prison and Probation Ombudsman**

**August 2010**

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## SUMMARY

The man was remanded into custody at HMP Durham on 23 January 2009. Whilst at the prison he was assessed by healthcare staff. He presented as low in mood and emotional and was referred to the prison's mental health in reach team. A prison doctor prescribed mild antidepressants.

On 11 February 2009, the man was transferred to HMP Acklington. During his induction at the prison, staff noted that although he appeared to be coping with prison life, reference to his offending made him become emotional and upset. On 13 March, he was given a full mental health screening by one of the prison's community psychiatric nurses (CPN). The nurse observed that he was visibly tearful about the loss of contact with his parents but concluded that no further mental health input was required at that time.

Over the following months the man became more settled at Acklington. He denied any thoughts of self harm but continued to feel depressed about the loss of contact with his family. In August, he was seen by one of the prison's doctors again after saying that he was feeling much lower in mood. He had received a letter from his parents advising him that they wanted no further contact with him.

On 1 September, a CPN completed a further mental health assessment on the man. She suggested to him that he should take part in some cognitive behavioural therapy, but he declined to participate. She continued to meet with him in a supportive and monitoring role. During these meetings he expressed ongoing worries about family matters.

As the man's release date approached, arrangements were made for him to reside at Ozanam House, an approved premises in Newcastle. He met with his offender manager who would be monitoring him on his release from prison.

The man met the CPN for the last time on 27 November, when she provided him with a letter for his GP which summarised his care. She noted that overall his anxieties had reduced, that he was aware of coping strategies and knew how to access help outside of prison. He was released on licence from Acklington to Ozanam House on 7 December.

On arrival at Ozanam House, the man was given an induction. Over the following days he met with his key worker, offender manager and other members of staff whose job it was to monitor and provide support to him. On 8 December, he spent the day with his girlfriend. The next day he registered with the local job centre and local GP.

Later that day, at a meeting with his key worker, the man became upset about the hurt he had caused to his victims and family. He remained low in mood but the key worker noted that he expressed no intention of harming himself. Later that afternoon he met his offender manager. In addition to discussing future targets and possible employment, the offender manager had a brief discussion with him about his parents' request that he have no contact with them for the time being.

On the morning of 11 December, the man told staff that he had felt unwell during the night and had not slept well, asking if he could spend the day in bed. He left the approved premises later that afternoon and he never returned.

When the man failed to return, breaking the requirements of his curfew, staff initiated the process which would lead to his recall to prison custody. However, the following day staff at the approved premises learned that he had been found, having apparently taken his own life, in woods in County Durham.

## THE INVESTIGATION PROCESS

1. The investigation following the man's death was carried out by one of the Ombudsman's investigators.
2. Notices announcing the investigation and its terms of reference were issued to both staff and residents at Ozanam House. The notices were displayed around the approved premises and invited staff and residents to contact the investigator should they wish to do so. Although none of the residents came forward to speak with the investigator, the approved premises manager did speak with them shortly after the man's death. I understand that other residents were surprised and saddened by his apparent actions.
3. The investigator obtained documentation relating to the man's time at Ozanam House and visited the premises to conduct interviews with staff. During the course of the investigation he provided verbal and written feedback to the manager.
4. One of the Ombudsman's family liaison officers contacted the man's family to discuss the purpose and scope of the investigation and to give them the opportunity to raise any questions or concerns they had about his death. His family asked whether he had settled in prison, what his attitude was like and whether he showed any remorse for the things that he had done. I hope that this report helps them to better understand what happened to him in the time leading to his death.
5. The investigator spoke with a Detective Sergeant from Northumbria Police and has been in contact with the coroner's office. A copy of this report will be sent to Her Majesty's Coroner for Durham and Darlington, to assist him with his enquiries. A copy will also be sent to the National Offender Management Service, the organisation that oversees the Probation Service.

## OZANAM HOUSE

6. Ozanam House is an approved premises, formerly known as a probation and bail hostel. The purpose of an approved premises is to provide an enhanced level of residential supervision in the community, in a supportive and structured living environment.
7. Ozanam House is located near the centre of Newcastle-upon-Tyne. It is managed by a senior probation officer, who has overall responsibility for its running. He is assisted by a deputy manager who is responsible for the day-to-day management of residents. The frontline team is made up of three key workers, one of whom works part time. There are ten support workers covering evening and weekend shifts between them, as well as three night care workers.
8. The admissions policy at Ozanam House is based on an assessment of risk. The residents profile is continually changing and the approved premises provide resettlement to prolific lower risk offenders in addition to those who have committed more serious or violent and dangerous offences. The majority of residents are required to stay as a condition of a court order or prison licence.
9. Each resident is allocated a key worker. This member of staff acts as their primary point of contact during their stay and assists them in sorting out practical issues. Regular key work sessions also give residents the opportunity to discuss their difficulties in depth. Although the sessions are not governed by a set agenda, issues such as benefits, health and future accommodation are routinely discussed. Residents at Ozanam House are all asked to register with a local general practitioner (GP). Approved premises do not provide healthcare and a resident's medical treatment is a confidential matter between them and their doctor.
10. Whilst at Ozanam House residents are required to pay rent and abide by the rules and regulations which includes observing an overnight curfew. During the day residents are free to go out unaccompanied, they are not required to tell staff where they are going. Breakfast and dinner is provided to all residents.
11. Ozanam House has an established routine for inducting all new residents. The induction is carried out by the member of staff who is on duty at the time a new resident arrives. During the process residents are told about the local house rules and their expected behaviour. Ozanam has a strict policy on alcohol and drug use, the possession of which is strictly forbidden.
12. The man's death was the first apparently self-inflicted death at Ozanam House since the Ombudsman took on the responsibility for the investigation of deaths in custody in April 2004. There have been two other deaths at the approved premises since then, one due to apparent natural causes and the other to a suspected overdose. There are no obvious similarities between those two deaths and that of the man.

## KEY FINDINGS

13. The man was 45 years old at the time of his death. He had a history of minor offences, including a conviction in 2008 for damage to property and disorderly behaviour, and in 2004 a caution for battery. His last sentence was for a sexual offence committed against a child. Appearing at Crown Court on 23 January 2009, he was sentenced to one year nine months imprisonment.
14. The man was received into prison custody at HMP Durham. During the reception process a healthcare assessment was completed by healthcare staff. It was noted that he had no previous history of suicide or of harming himself. However, given the nature of his offence, that it was his first time in prison custody and that he presented in an emotional state, a non urgent referral was made for him to be reviewed by a member of the mental health in reach Team (MHIRT) at the prison.
15. He was introduced to his personal officer at Durham on 5 February. The officer explained prison life and the wing's rules and regimes. He became tearful and emotional as he explained to his personal officer that his parents were not talking to him due to the nature of his offence. He said that he had not told them anything about the charge or about his appearance at court, but that his girlfriend had informed them. He said that people had made false allegations against him.
16. One of the prison doctors at Durham saw the man after he complained of feeling depressed. The doctor noted that he had been seeing his own GP due to concerns surrounding his case and presented as being low in mood and depressed. The doctor prescribed 15 mg of Mirtazapine, a mild antidepressant which is used to improve the mood of people who are feeling low or depressed.
17. On 11 February, the man was transferred to HMP Acklington. At the time of his transfer he had not been seen by members of the MHIRT at Durham. Staff at Durham notified their colleagues at Acklington of the situation, requesting that a new appointment be made for him. During his induction at Acklington staff noted that although he appeared to be coping with prison life, reference to his offence made him become emotional and upset. He was advised of the support systems in place at the prison including the chaplain, Listeners and access to the Samaritans. (Listeners are prisoners who have volunteered and have been trained by the Samaritans to support prisoners who are in distress or crisis and need to talk in confidence.)
18. On 16 February, the man was seen by another one of the prison's doctors. The doctor recorded in the medical record:

“Sleep pattern poor. Lying awake all night. Been in prison three weeks on 21 month sentence. First time in prison. Struggling. Family no longer want anything to do with him. Worried about dog which has recently been his only companion. Fleeting thoughts of self harm but no current plans. On snri [Serotonin reuptake inhibitor – Mirtazapine, an antidepressant type medication]. MHT [mental health team] review.”

Later that day the man was registered with a member of the MHIRT.

19. The man was given a full mental health screening on 13 March, by a community psychiatric nurse (CPN), from the MHIRT at Acklington. The nurse observed that he was visibly tearful about his loss of parental contact and issues related to his offence. He told the nurse that he was, "beating himself up" over negative feelings and that these were having an effect upon his mood. She recorded that he expressed no thoughts of self harm, but did have fleeting thoughts at times. The nurse recorded that thinking about his family and dog prevented him from carrying out such actions. She concluded that no further mental health input was required at that time. He was again made aware of support services available should he find himself struggling to cope or require them.
20. During the man's first month at Acklington, staff at the prison wrote in his prison records that he remained anxious and worried about his parents and dog. He was especially concerned that his parents had not contacted him, despite him writing to them. The prison chaplain reassured him that they probably needed time to come to terms with the situation.
21. Over the summer months the man worked in the market gardens at Acklington. He appeared to settle and was noted by staff as being a quiet prisoner who complied with staff requests and wing routines. He received frequent visits from his girlfriend. During this time he continued to tell staff that he was feeling down because his parents were still not communicating with him. However, he hoped to 'turn things around' when he was released four months later.
22. In August the man reported to healthcare that he was having problems. He was struggling to cope and continued to suffer from depression. He denied any thoughts of harming himself but again expressed concerns about his dog and the fact that, despite writing to his parents, he had had no reply. On 18 August, he was seen again by the second prison doctor. He noted that the man was feeling much lower in mood, having recently received a letter from his parents stating that they wanted no further contact with him. He felt he had nothing further to live for and expressed thoughts of worthlessness, but said he had no plans of suicide or of harming himself at that time. The doctor prescribed Sertraline Hydrochloride, another anti-depressant medication used to treat the symptoms of depression and anxiety, instead of the Mirtazapine that had previously been prescribed. A further appointment was made for him to be seen by the MHIRT at the prison.
23. A CPN, another member of the prison's MHIRT, attempted to see the man on 26 August, but was unable to do so as he was receiving a visit. However, wing staff reported that they had no concerns with regard to his presentation or behaviour at that time. The CPN made a further attempt to speak with him on 28 August, but was again unable to do so as he was at work.
24. On 1 September, the CPN carried out a further mental health review with the man. He told the nurse that he was due to be released in December, and that since his arrival at Acklington had gradually begun to feel worse. He explained

that he had had no contact with his family since they learnt of his situation, and worried about never seeing them again. During the assessment he denied harming himself or having suicidal thoughts. However, he said that when worrying he found himself repeating sentences in his head. The CPN planned a further assessment and suggested that participation in some cognitive behavioural therapy might be of benefit. She also arranged for some self help information to be forwarded to him on the wing.

25. The second prison doctor saw the man on 3 September. He noted in the medical record that he felt that his medication was making things worse. The doctor advised him to continue with the medication for a further two weeks in order to give it an opportunity to start working. On 8 September, the man was seen again by the CPN. She noted that he was still depressed and there appeared to be no change in his presentation. During the session he revealed a little more of his family history and expressed that he might never get out of prison. He said that he was experiencing feelings of guilt, blame and failure which in turn prompted feelings of sadness, fear and worry.
26. On 23 September, the man's personal officer wrote a report for a public protection unit meeting held to prepare and plan for his release to an approved premises in the community. He wrote that the man was a quiet prisoner who was somewhat nervous and timid about his surroundings and had struggled to cope on a few occasions. The personal officer added that he was always polite and co-operative with staff and received regular visits from his girlfriend and friends. However, since coming into custody, he had had no contact with his family. The personal officer noted that when not working in the prison gardens the man spent much of his time reading fishing magazines, which he said was his main hobby outside prison.
27. At the public protection meeting on 24 September, preliminary preparations were made for the man's eventual release to an approved premises outside the Sunderland area.
28. The CPN met with him again on 28 September. During their meeting he had good eye contact and appeared more relaxed than before. Although the CPN noted that he had decided not to participate in any cognitive behavioural therapy at the time, she advised him that she would continue to see him in a supportive and monitoring role.
29. On 12 October, the CPN met the man for a further review. During their meeting he revealed his fear that his parents might have got rid of his dog and talked about being punished by them for being in prison. Although he was tearful at times, she reported that he denied any thoughts of harming himself. He told her that he did not think the Sertraline Hydrochloride, which he had started five weeks previously, was working and could not remember why he had been taken off the Mirtazapine. She subsequently discussed his medication with the second prison doctor and they decided that Mirtazapine would be re-prescribed as it seemed to have helped him before.

30. The offender manager met the man on 20 October to introduce himself as his probation offender manager who would monitor him in the community on his release from prison. He told the investigator that during the meeting the man became tearful when talking about his offence. He said that he had been having difficulty in coping with his time in prison, but was happy to talk openly about aspects of his life. He said that the man was looking forward to his release and hoped to continue further studies in horticulture or estate management and overall appeared to be optimistic about the future.
31. On 22 October, the man was accepted by Ozanam House, pending a bed becoming available, upon his release from prison.
32. The man saw the CPN again on 13 November. He told her that he had felt an overall improvement since their last meeting and that he was to be released in three weeks time to an approved premises. She discussed an onward referral to the community mental health team on his release, but he stated that he was happy to see his own general practitioner. She agreed that she would write a summary letter to his GP and see him once again prior to his release.
33. The offender manager received telephone confirmation from Ozanam House on 17 November that a bed would be available for the man on 7 December.
34. In an e-mail of 19 November, from the Probation Victim Liaison Unit, the offender manager was advised that the man's parents had made it clear that they did not wish to have any contact with him after his release from prison. They hoped that he would respect their wishes, adding that they were happy to return his dog should he wish it. (This information was not relayed to him at this time.)
35. The man saw the CPN for the last time on 27 November. She noted that he was bright and was looking forward to getting out of prison. He expressed some anxiety with regard to his family's reaction, but said he had support from his girlfriend and friends. She handed him a letter summarising his care, which he was to pass on to hostel staff or his GP. She wrote that overall his anxiety had reduced. He was aware of coping strategies and how to access help outside prison. He denied any thoughts of harming himself and said there were no adverse side effects from his medication. He was discharged from the MHIRT's care.
36. On 7 December, the man was released from Acklington. His licence said that he must reside at Ozanam House and report as and when required to the offender manager, his offender manager. On his release from Acklington he made his way directly to register with his local probation office, arriving around mid-afternoon. From there he proceeded to Ozanam House.
37. Before his arrival at Ozanam House, the man's key worker completed a Risk Management Strategy. (The strategy highlights any concerns with regard to a resident's risk to staff, other residents, and themselves. Each week a meeting is held at which risk factors are discussed further.) It was noted that, although there were no mental or physical health concerns, he was at a medium risk of

harming himself, due to his release and the possibility of feeling low in his new environment. The key worker noted on the assessment that checks should be increased if staff became concerned about the man's wellbeing.

38. At 5.45pm he was given an induction to the approved premises by a project support worker. The rules and regime were explained to him and he was shown to his room and issued with his medication. The project support worker noted that the man appeared a little nervous but appeared to settle in well. A Resident Information Form was also completed in which he provided his medication and GP details and information about his next of kin, his mother. He left the premises at around 7.00pm with a number of other residents, returning not long after. In interview the project support worker told the investigator that the man appeared quite shy and timid during the induction, but took an interest and asked various questions. He said his initial reserve was understandable for someone who had just been released from prison. When he interviewed him, the project support worker said he had no concern with regard to his well being.
39. In the early hours of 8 December, one of the night care workers checked the man in his room, reporting that there were no issues. The following morning he left the approved premises early, returning at approximately 8.30pm.
40. The man's offender manager visited him at Ozanam House at around 3.30pm for a previously arranged appointment, but he was not there. The offender manager was told by staff that the man had been informed about the appointment. He rang the man leaving a message for him to contact him immediately. He called the offender manager back shortly afterwards, informing him that he had spent the day with his girlfriend and had not realised he had had an appointment, saying that he had not been told by staff. The offender manager accepted the confusion over the missed appointment but advised him that he would be given a warning should the same thing happen again. During their conversation the man said that that he was pleased to be out of prison and was looking forward to continuing his education/training, possibly in estate/countryside management. The offender manager arranged a further appointment for 18 December at Ozanam House.
41. The man arrived back at the approved premises at 8.30pm. The project support worker noted in his record that he spent most of the remainder of the evening in his room and that no further issues were raised.
42. On 9 December, the man again left the approved premises, returning at around 9.15pm. Another project support worker observed that he had his supper and took his medication at 9.25pm. She also noted that earlier in the day he had registered with the local community GP and job centre. She told my investigator that he was a quiet, well mannered resident who kept himself to himself. She said that during her contact with him he gave no cause for concern and exhibited no signs of harming himself or any suicidal ideation.
43. During his registration with the community GP, earlier in the day, the man was seen by a GP. He recorded that the man had suffered from depression since going into prison and been prescribed Mirtazapine. It was noted that he suffered

from poor sleep and appetite and was very tearful and remorseful. However, the GP thought that he was not suicidal. In his clinical review the clinical reviewer says that there was no further contact with the man and a healthcare professional and that there was no evidence to suggest that the CPN's letter was ever seen by the GP or a member of the community GP's medical practice. The GP made plans for him to be reviewed in early January 2010.

44. On the morning of 10 December, the man met again with his key worker. He completed a self assessment form highlighting problems that he might face in the community and addressing the likelihood or re-offending in the future. During the meeting he confirmed that he had signed on at the local benefits office. His key worker reminded him of the need to attend probation appointments regularly.
45. During the session the man became upset about the hurt he had caused to his victims and their families. He said that he was feeling a little down due to losing contact with his own family, but had found his own girlfriend to be supportive. His key worker explained to him that if he felt depressed he could, and should, approach a member of staff, no matter what time it was. He noted that, when tactfully prompted, the man had expressed no intention of harming himself. He organised an education training and employment referral to be made in order to give him access to Newcastle Futures, an employment and career advice charity in the city.
46. The key worker told the investigator that the man was emotional during their meeting. He was not clear whether he was upset about his own position, that of his victims, or his family, saying that it was difficult to tell. He was satisfied that, given his presentation, the man's risk of harming himself had not increased since his earlier completion of the risk assessment which had put him at medium risk. The key worker said that the man wanted to engage in employment and was looking to the future.
47. At around 4.30pm the offender manager, who in addition to being the man's offender manager also worked at the approved premises as a support worker, met with him again. The man said that he had settled into Ozanam House, but wanted to move to his girlfriend's home as soon as possible. They discussed his offence focussed work and possible programmes to be completed to assist him to reach his targets. He again expressed his wish to continue with possible employment in estate management or game keeping. During their meeting the offender manager also had a brief discussion with him about his parents' request that he should not contact them for the time being. He noted that the man appeared to accept this and did not appear distressed or tearful. During the meeting he showed no indication that he might harm himself. However, he told the offender manager that he was disgusted at what he had done and ashamed at the disgrace he had brought on his parents by his offending.
48. The man briefly left the approved premises with another resident, then returned and spent most of the evening in the lounge watching television. At 10.10pm he was issued with his medication.

49. At 7.40am on 11 December, the night care worker carried out a routine room check on the man. He told her that he had been up all night feeling sick and had not slept well. He asked if he could stay in bed. She told him that he could stay in bed all day if he wished, but suggested that he should come down to the kitchen for a drink and some toast. He declined the suggestion. At 1.02pm he left the approved premises and he never returned.
50. A relief support worker said she received a call from a friend of the man at about 8.10pm asking whether or not he had returned to the approved premises. She said his friend called again about half an hour later. When he failed to return before his curfew time she notified the police, thus initiating the process that would lead to his recall to prison custody.
51. At 4.10pm on 12 December, staff at the approved premises learned from the police that a body, thought to be that of the man, had been found in woods in County Durham. At 1.10am the following morning staff were informed that his body had been formally identified and that his parents had been notified of his death.
52. The approved premises manager contacted the man's family the following day inviting them to visit Ozanam House, but they declined.

## ISSUES CONSIDERED

53. In his report the clinical reviewer says that:

“It was clearly recognised from an early stage in the man’s custodial sentence that he was not coping mentally with the circumstances that led to his conviction or thereafter with the socio-domestic circumstances that were compounded by his conviction. It is commendable that health care professionals interacting with him in the custodial setting were able to recognise such. It is also commendable that he felt able to trust the healthcare professionals he was interacting with to be able to share with them, not only the circumstances surrounding his conviction, but his family circumstances which seemed to be a significant stressor causing him some considerable mental pain.”

54. He goes on to say that the man would seem to have, “... focused hope on his dog, his two children and his own parents as the light to aim for at what he saw as a very dark tunnel”. He adds that it would seem that he was very remorseful as to the circumstances that led to his conviction. He says that:

“Whilst the man seemed to accept that his liberty had been deprived for good reason, this clearly did not prevent health care professionals at HMP Acklington behaving in an appropriate, professional and commendable manner, specifically the professionalism of the CPN who extended her duty of care by preparing him for release and providing a letter which he could use to bridge his care from the custodial to the community setting.”

He says that although there was no clear evidence that the GP saw the CPN’s referral letter, it was clear from his consultation with the man that his depression was recognised and that he had lost contact with his family due to his conviction. The GP recognised other symptoms and but judged that he was not suicidal when seen during the consultation.

55. In his report the clinical reviewer says that the man’s death would seem to be an unfortunate event which was not as a result of lack of healthcare professionalism. He says that it is unlikely that any other course of action would have changed the eventual outcome. He highlights that the:

“... good practice of the CPN in attempting to bridge the gap between custodial and community health care professional services went a long way in attempting to prevent what would seem to have been the unpreventable.”

56. He concludes that, “The standard of clinical care afforded to the man at the relevant time would seem to equate, if not exceed that afforded to a man of similar age and circumstances in the community setting.” I concur with the clinical reviewer’s opinions and I am satisfied that the man was managed appropriately by staff. I make no recommendations.

## **CONCLUSION**

57. After the man was sent to prison he received continual support from healthcare staff, initially at Durham, and then upon his transfer to Acklington. As the clinical reviewer notes it was commendable that he was able to trust staff at the prisons, sharing deep and personal information with them in order that they could assist.
58. The prison mental health nurse prepared a handover letter which she gave to the man. There being no evidence to suggest the contrary, he appears to have not handed over, either to his GP or to staff, the letter which provided a summary of his care. It might be that the outcome would have been different had he done so. However, given the remorse and guilt that he had obviously experienced it is difficult to say whether or not his death could have been prevented even if he had handed the letter over. I conclude that staff who had contact with him, both at Acklington and Ozanam House, could not have reasonably foreseen his eventual actions and untimely death.