

**Circumstances surrounding the death of a resident at a Probation Service
Approved Premises in April 2005**

Report by the Prisons and Probation Ombudsman for England and Wales

November 2005

This is the report of an investigation into the death of an Approved Premises resident in April 2005. The man died having apparently having taken his own life by hanging. He had been resident at the Approved Premises as a condition of his bail.

The purpose of my investigation was to discover whether the level of care provided for the man at the Approved Premises was sufficient, and whether there are any lessons that can be learned to help prevent a similar death in the future.

The death of a loved one is a devastating experience, and I offer my sincere condolences to the man's family and friends. Although he had not lived with either of his parents for some time, the death of their son was no less difficult for them to bear. I am especially grateful to them for agreeing to meet with the investigator and for sharing with her their memories of their son. The information provided by the man's parents was most helpful to the investigation. After seeing my report in draft form, the man's father commented in a letter that was shared with the Coroner.

The man's former partner was also contacted by one of my family liaison officers but she did not wish to be involved in the investigation.

A senior investigator from this office carried out the investigation with the co-operation of the Probation Area. I am grateful for the assistance that the investigator received from the manager and staff at the Approved Premises who made facilities available and participated fully in the inquiry. I also acknowledge the assistance of the local Police.

The investigator conducted formal interviews with the hostel manager, a district team manager, hostel staff and hostel residents. The investigator also examined documents provided by the hostel. The report is organised as follows. Part 1 provides some personal details about the man together with information about the Approved Premises. Part 2 considers the circumstances surrounding the man's death. My conclusions and recommendations are presented in Part 3.

This report presents a favourable view of the Approved Premises, and the care and support that staff provide to residents. I am satisfied that the premises are operated in accordance with Approved Premises guidelines, and I have found no evidence to indicate that the man's actions could have been easily predicted or prevented. However, I make five recommendations in areas where the possibilities of improvement have been identified, particularly in respect of the sharing of information between the Prison and Probation Services.

**EMMA BRADLEY
DEPUTY OMBUDSMAN**

NOVEMBER 2005

CONTENTS	Page No.
SUMMARY	4
PART ONE:	
Section 1 –The Deceased Man	5
Section 2 –The Approved Premises	7
PART TWO:	
The man’s residence at the premises	8
Events leading up to the man’s death	11
PART THREE:	
Consideration and conclusions	14
Recommendations	16

Summary

The man who died was known to his parents and family as a hard working man who had been dogged by a number of failed relationships in his life. He had three children from previous relationships and another by his former partner but each of his relationships came to an end in violence and he was estranged from his children. Nevertheless, he was described as a kind, caring man who at times could not cope with the demands of life and resorted to alcohol that affected his behaviour.

The man was on remand awaiting court proceedings in respect of a charge of assaulting his former partner. He was released on bail from Magistrates' Court on 27 September 2004 with a condition to reside at the Approved Premises. It was known that he had made previous attempts to take his life but there was no indication that he felt depressed or suicidal at that time. He became well known to staff as someone who worked hard and presented no management problems, apart from concerns about the level of his alcohol consumption.

The man talked to staff and fellow residents about his concerns for his former partner and child and his fears that the partner would be unable to cope without him. He left the hostel in December 2004 and apparently effected a reconciliation with the former partner, with whom he lived, although this was in breach of bail conditions.

On 13 March 2005, the man was arrested following an altercation at the partner's home and he was subsequently remanded on bail, again with a condition of residence at the Approved Premises for a second time. Again, he talked to staff and other residents about his concerns for the woman and their child, regretting the lack of contact. During this time he did not work and his use of alcohol was noticeably less. He was required to attend the local Police Station early in April to face the possibility of further charges against him and he was worried about this prospect.

In the early hours of the following morning, the man was found hanged on the door of his room in the Approved Premises. He left notes to indicate an intention to take his own life. It was clear to the investigator that man who died had been liked by his fellow residents and members of staff who were both shocked and saddened by his death.

PART ONE:

The man who died

1. He was born in Worcestershire where he remained until he was aged six, when his parents decided to relocate. Subsequently, his parents divorced and both remarried. He remained close to them and to his half sisters and brother. When he left school he tried various jobs until he became a skilled artisan. His father runs a business with his other son and told the investigator that it was his dead son who gave him the encouragement and enthusiasm to change careers when he (the father) became disillusioned with his previous profession.
2. The dead man's relationships with his former partners are well documented in the police report and there is no need to rehearse them here. Suffice it to say that all of the man's offending behaviour was linked to his relationships and his use of alcohol. He served two short terms of imprisonment in 1995 and 2002 for offences connected to relationships that existed at those times.
3. His father said that the man found it difficult to commit himself completely to a relationship. Nevertheless, he worked hard to support his families while he remained with them. A pattern was described of him working very long hours then becoming tired and stressed. He would often turn to alcohol for relaxation, but instead he became aggressive and, at times, violent. His father said that each time things became too much for him, his son would just walk away. However the man had many friends and could be loyal and caring, and ready to help others. This was demonstrated when he served a short period of imprisonment on the Isle of Wight where he supported younger, more vulnerable prisoners.
4. In 2003, when the man was working, he met his partner and quickly established a relationship. The man's parents said that the relationship was intense. It was clearly volatile, and on a number of occasions the woman made allegations that the man had been violent towards her although subsequently she retracted many of those allegations. Towards the end of 2003, the woman became pregnant and, in May 2004, the couple jointly purchased a house where they lived together and on which the man paid the mortgage. His partner gave birth to a son in August 2004.
5. In July 2004, the man was arrested and charged with assaulting his partner. In August, he was bailed with a condition of residence at an Approved Premises but, approximately one month later, he breached a condition of his bail that he should not contact his partner and was remanded into custody. On 27 September, bail was again granted and he went to stay at the Approved Premises where he later died.
6. During October 2004, the man telephoned his mother telling her that he had been working but living in a van for some time. He told his mother that his partner had said the child was not his. He said he felt he had nothing more to live for and he was going to kill himself. His mother was anxious for her son's safety and contacted his father. The

father told the investigator that he too was worried about his son as, unusually, the man had left a message on his father's answer phone. He made various enquiries to locate his son. On 18 October, he was so concerned at the content of the message that he contacted the police as the man was not responding to calls to his mobile phone. The father was informed that his son was resident at an Approved Premises where he seemed fine. The police arranged for a member of staff from the premises to telephone him. He was assured that his son was well, and had gone to work as usual.

7. The father told the investigator that, subsequently, he tried for days to contact his son on his mobile phone but there was no answer. He said this was not unusual as his son could be very difficult when he had decided that he did not want to talk and experience had taught his family to be patient. The father also said his son had threatened suicide in the past and he believed this was sometimes a cry for help, sometimes in order to manipulate a situation.

The Approved Premises

8. Approved Premises were formerly known as Probation and Bail Hostels and are approved by the Secretary of State within Section 9 of the Criminal Justice and Court Services Act 2000. Their purpose is to provide accommodation for persons granted bail in criminal proceedings, and in connection with the supervision and rehabilitation of persons convicted of offences. Approved Premises can provide a supportive, structured environment in the community for high risk and difficult to manage offenders. The management of offenders accommodated in Approved Premises is governed by the National Standards for the Supervision of Offenders and the guidance contained in the National Approved Premises Handbook.
9. The Approved Premises can accommodate 18 residents, 15 men and three women, in separate areas. Residents share kitchen and bathroom facilities. The Approved Premises accepts offenders on bail and subject to either community penalties or prison licences. Residents must be over the age of 18, but any type of offender will be considered, depending upon the level of assessed risk and the dynamics of the resident group at any particular point in time.
10. Until about a decade ago, Approved Premises offered accommodation for offenders who had nowhere else to go, but in recent years the resident profile has changed. Nowadays, Approved Premises cater largely for dangerous or serious offenders who are assessed as posing a high risk of re-offending or harm to the public. The purpose of the house is to provide an enhanced level of supervision for some of the most difficult and high-risk offenders in the community. Each resident is subject to curfew restrictions, usually from 11:00pm to 7:00am for those not working, although other curfew hours may be enforced if either court orders or licences stipulate.
11. The house is staffed by a Manager assisted by a Deputy Manager and six assistant wardens, four of whom work full time and two part-time. There is also a pool of relief staff who are called upon when the need arises. They must be familiar with the requirements of the premises before undertaking any duties. Two members of staff are on duty each night, one who remains awake and one who sleeps in, to be on call if necessary. There is also an administrative services officer. Each assistant warden acts as a key worker for a number of residents, and their work is overseen by the Deputy Manager. Key workers are responsible for monitoring the behaviour of their residents and for providing advice and encouragement. They are expected to work with case managers, usually supervising probation officers based in local offices, to address offending behaviour. The Deputy Manager acts as case manager for residents on bail like the man who died, who do not have case managers in the field.

PART TWO:

The man's residence at the Approved Premises

12. The man was referred to the Approved Premises, on 22 September 2004, by a probation officer working in the prison where he was remanded. The referral form indicated the existence of Form 2052SH, a form used by the Prison Service to denote that an individual is at risk of self-harm. The man was assessed as being at risk following an attempt to hang himself in a police station earlier in September. The referral form stated:

'... was on 2052SH register. Said he was feeling really low when in police cells but did not intend to kill himself.'

No further information was provided and no dialogue took place to enable a risk management plan to be formulated.

13. There had been no further attempts at self harm and the Manager of the Approved Premises confirmed to the investigator that a copy of the Form 2052SH was not obtained. The experience of the house is that there is a considerable variation from prison to prison on the sharing of information and in particular in respect of F2052SH forms. On this occasion, the information was not shared with the Approved Premises and it was not asked for. An OASys (Offender Assessment System) form was completed that gave details of three previous suicide attempts disclosed by the man, one in response to the recent allegations against him. However, although the section on risks to the individual in the full analysis identified current concerns about suicide and self harm, the relevant boxes on the final, summary, page of the document had not been ticked. Anyone looking only at the summary to identify the level of risk would not have been aware of the possible suicide risk.

I recommend that the Probation Area issues a reminder to staff about the correct procedures for completing OASys assessments.

14. On 27 September, the man was granted bail with a condition to live and sleep each night at the Approved Premises. Further conditions were that he should not go to the town where his partner lived, save to attend court or keep appointments with his solicitor, and that he should not contact his partner. He completed the induction procedure where the rules were explained to him and he appeared to settle well. The man was allocated a Key Worker and, on 7 October, at a meeting with the Key Worker and another member of staff, he talked at length about the allegations against him and his relationship with his partner. He understood all his bail conditions and did not express dismay at any of them.
15. The premises log records that, two days later on 9 October, a woman claiming to be the man's sister-in-law called at the Approved Premises asking to see the man. He met her outside the premises and it was noted that the woman was rather agitated. The man went inside, directly to his room, but the woman returned and asked to speak with him again. The man refused to see her and told members of staff that she was his partner.

He also said that he had received many text messages from her on his mobile phone and that he was not aware that she knew of his address. Over the next day or so, he told members of staff that he believed his partner was not managing well without him and that she had sent him a text saying that she felt suicidal. He did not mention feeling depressed or suicidal himself and did not appear to be so.

16. Records indicate that the man did not spend much time in the premises as he was working long hours during the day and went to a public house several evenings each week. There are notes to indicate that he returned to the premises under the influence of alcohol on various occasions, but there was nothing in his bail conditions to prevent him drinking alcohol, and he did not breach the house rules. Members of staff spoke to him about his level of alcohol consumption, and expressed concern, but it was noted that he:

‘... wasn’t any problem to staff or any residents at the hostel.’

17. In November, the man moved into a single room in a flat on the premises and it was reported that he was happy with the move. On 12 November he again told his Key Worker that he was worried about his partner who, he claimed, continued to text him threatening to harm herself. He expressed concern about her state of mind, and the difficult position he was in when she continued to contact him. He told the key worker that one evening she had been at the public house where he was drinking and this could threaten his bail conditions. Although the man’s expressed concerns for his partner are recorded on several occasions, there is no indication in the records that he was depressed or coping badly himself.
18. On 6 December, the man was found to have taken a woman back to his room, in breach of the Approved Premises’ rules and it was clear that both were heavily under the influence of alcohol. The man was issued with a warning letter and he appeared to be disgruntled by this. His Key Worker discussed his use of alcohol with him and stressed the dangers of drink driving. The man was adamant that his level of alcohol consumption was not problematic and he would not risk losing his driving licence as he needed his vehicle to transport his tools to and from work. The man expressed his intention of finding accommodation that would be suitable to the court as an alternative bail address.
19. The solicitor who was acting for the man at that time told the investigator that she was contacted by him on 13 December, asking if it would be possible for him to move out of the hostel if he could provide a suitable alternative address. On 17 December, the man was granted a variation of bail with a condition to reside at a private address close to the Approved Premises. He left the house on 20 December 2004. His solicitor heard nothing further from the man until, on 13 March 2005, he was arrested after an altercation at his home address. He was bailed to return to the police station on 1 April 2005, possibly to face further charges. However, as the man had been staying at his home address with his former partner, in breach of his bail, he was kept in custody overnight.
20. The man told the solicitor that he had met his former partner at a county court hearing on 21 December. He said they had a long conversation in which, in his view, they had

sorted out their difficulties and he had moved back into their home. He was aware that this placed him in breach of his bail. On 14 March 2005, the man appeared at Magistrates' Court where, with his agreement, he was readmitted to bail with a condition to reside back at the Approved Premises.

Events leading to the man's death

21. The Approved Premises agreed to accommodate the man on the basis of what was known about him from his previous stay, and neither a new referral form nor a fresh OASys assessment was requested. Although new residents are allocated shared rooms whenever possible, the man was not viewed as a new resident as he was well known and had been away only some twelve weeks. The investigator was told that, because the man had been at the house so recently, a fresh risk assessment was not undertaken.
22. Each resident of the premises is required to meet formally with their Key Worker on a weekly basis. What takes place at those sessions depends upon the status of the resident, as it is not possible to focus on offending behaviour with residents who are unconvicted and resident as a condition of their bail. The man had informal contact with his Key Worker when she was on duty and formal sessions took place on 22 March and 29 March. Although he worked regularly during his first period of residence, during his second stay the man did not work. He told his Key Worker that he did not intend to look for work until the court proceedings were over as it would not be fair to an employer if he 'left them high and dry' if he received a custodial sentence.
23. Members of staff and some other residents who knew the man were aware that he was unhappy about the situation with his former partner. The investigator was told that the man would often speak of her and their son, and it was thought that he was particularly unhappy about his lack of contact with the child. The Key Worker was also concerned about the level of the man's alcohol consumption although this was known to be less than during his previous period of residence. Despite these concerns, the man appeared settled at the premises and did not display any overt signs of depression. There seemed nothing to indicate that his worries were anything more than would be expected of someone in his position, facing charges of violence and expecting further charges to be brought.
24. On 29 March, the man told his Key Worker of his concerns about returning to the police station on 1 April where he might face further assault charges. He talked about the altercation that had taken place on 13 March, at his former partner's home, with members of her family and friends. He portrayed himself as the injured party, saying he had been assaulted. On 1 April, the Key Worker consulted the man about sharing his room with a new resident who was expected to arrive later that day. He said he was happy to share and moved some of his belongings to leave more space. The Key Worker commented that, although the man had never presented as a particularly happy man, neither was he miserable. On that day, there was no indication of any mental turmoil. The man left the premises during the afternoon, between 4:00 and 5:00pm, to report to the police station.
25. The night care supervisor who saw the man return to the hostel around 10.50 pm told the investigator that he had known the man during his earlier period of residence. He said the man would often return in the evening, visibly the worse for drink and at these times he could be quite argumentative. However, since returning for the second period of residence, the man had looked so much better that, at first, the supervisor had not

recognised him. He was not aware of any occasion, during the current stay, when the man had returned the worse for drink. On the night of 1 April, the night care supervisor perceived the man to be sober when he obtained his keys and went to his room. At around 11:00pm, the night care supervisor and his colleague checked the premises as they were required to do. The supervisor spoke to the man in the shared kitchen of his flat, where he was talking with another resident. The supervisor commented that the man appeared quite relaxed and wished the workers good night without seeming at all strained.

26. The night care supervisor was aware that the new resident who was to share a room with the man had failed to return to the premises in time for curfew, and the duty manager had been informed. The duty manager arrived at the house around 11.45pm to start recall proceedings for the new resident. At around 1:00am, the police contacted the premises saying that the new resident had been arrested but could not be kept in custody without charge. As he was on licence, nothing could be done until a recall notice was issued. The duty manager agreed that this man could return to the house overnight, pending recall procedures.
27. Shortly after 1.15am, the new resident was brought back to the house by a police officer and escorted to his room by that officer and the night care supervisor. The night care supervisor said that as they approached the door of room 3A, he saw the end of a belt hanging down from the top of the door. Despite this, he said he did not think of anything being wrong. However, when he unlocked the door and turned the key, the door would not open. The night care supervisor said he pushed the door and opened it a little, causing the belt to fall. As he pushed harder the door opened enough for him to see the dead man slumped to the floor with a belt around his neck. The police officer was first to reach the man and the night care supervisor saw him shake his head, as if to indicate that he had died.
28. The night care supervisor said that, as he knew the duty manager was on the premises, dealing with a breach, he ran downstairs, leaving the police officer to deal with the man on the floor. He told the duty manager that there was a problem with a resident and she should call the emergency services. The duty manager immediately telephoned for an ambulance. The night care supervisor then ran back upstairs to the flat, banging on the door of his sleeping colleague's room as he did so. When he reached room 3A, the police officer had loosened the belt and was kneeling next to the man, feeling for a pulse. He believed that the officer shook his head in a manner to indicate that the man could not be helped. The new resident was taken to another room. An ambulance arrived quickly and paramedics attended to the man around 1:35am. Their equipment showed no heart activity, and they confirmed that he had died. Two notes of a farewell nature were subsequently found in his room and it was established that he had written them.
29. The man's father particularly wanted to know why the night care supervisor had made no attempt to resuscitate his son when he was found. The investigator was told that all members of staff (apart from those employed by the Probation Area on a casual basis) have been trained in first aid and resuscitation techniques, and are encouraged to use

them when necessary. The final decision whether to attempt resuscitation is for individual staff members to make as quickly as possible if an emergency occurs. In the man's case, the night care supervisor believed the police officer had indicated that he was beyond help. The police officer took charge when the man was found and the night care supervisor believed it was appropriate for him to do so.

30. The investigator found evidence to suggest that, in the past, some of the man's actions were prompted by the need for attention when he was in distress rather than by a desire to end his life. On this occasion, he expected to share his room and it may be reasonable to speculate about whether he expected to be found. However, the hour of curfew had passed, his new room-mate had not arrived and the man knew that anyone failing to return in time for curfew would be breached. Taken together with the fact that he left notes and the post mortem found a high level of pain killer in his system, the indications appear to be that he had decided to take his own life.

PART THREE:

Consideration and Conclusions

31. It was my role to consider if the risk of self harm had been properly assessed and managed, and whether the level of care provided for the deceased man was adequate. In doing so, I also considered whether the hostel procedures were clear to staff and commensurate with the requirements for all such hostels as defined in the Approved Premises Handbook. It was clear that the premises provided a supportive environment for staff and residents alike. The members of staff interviewed were familiar with procedures and appeared dedicated to their work. Residents spoke highly of the quality of care provided for them.
32. From the referral form and the OASys assessment, the man was known to have attempted to take his life in the past. It was also known that a form 2052SH had been raised by the Prison Service but no attempt was made to obtain this form. The Approved Premises case record completed on the man's first admission gives details of a suicide attempt, '7 years ago when he took 56 tablets'. This appears to have been information provided by him that was not confirmed or cross referenced with any other information. Consequently, the nature and extent of his suicidal feelings were not explored as fully as they might have been when he first arrived at the Approved Premises. However, during the three months he spent at the house between September and December 2004, neither his behaviour nor his demeanour gave staff any reason to suppose that he was at risk.
33. As a consequence, in March 2005, when a place was again requested for the man, no new referral form or OASys assessment was requested or prepared as it was felt that the premises had sufficient information on which to decide whether to offer him a place. Nevertheless, he had been away for several weeks and the Approved Premises' staff had scant knowledge of what had happened to him within that time. The Manager of the house informed the investigator that various things, such as telephone conversations between the man and his ex-partner, came to light after his death that would have been useful for staff to have known about in advance. It is the view of staff at the house that, if the man had revealed suicidal feelings to his key worker or to any other member of staff, they would have been communicated to the deputy manager for action. It is not possible to know whether the man would have disclosed any pertinent information during a full referral inquiry, and there is no evidence to suggest that his death could have been prevented. Nevertheless, without a full up to date assessment of risk, it was not possible to devise a strategy for harm prevention, if one was necessary.

I recommend that the Probation Area requires a rigorous assessment procedure to be undertaken for each Approved Premises placement referral regardless of whether the offender has been previously known to the Area.

34. The Manager of the Approved Premises told the investigator that, following the man's death, it has been agreed that if the existence of a Prison Service Form 2052SH (or equivalent) is noted, then every effort will be made to obtain the necessary information

from the prison. I applaud this decision but I believe it does not go far enough. It is crucial that information is shared freely between the Prison and Probation Services. I understand that there may be some difficulties in respect of unconvicted people like the deceased man I do not believe that such difficulties apply where the duty of care is concerned.

I recommend that the National Probation Directorate and the Prison Service should produce a protocol for sharing information pertaining to risk on those who are released from prison subject to Probation Service supervision.

35. A Probation Circular (40/2004) issued by the National Probation Directorate requires all Probation Areas to devise a strategic plan to reduce incidents of sudden death in Approved Premises. The Assistant Chief Officer (ACO) with responsibility for Approved Premises in the Probation Area confirmed that there is a strategy in place, although not in the form of a written plan. He was confident that all staff are familiar with Annex C of the circular, providing instructions on what to do in the event of a death or an incident of significant self harm. The ACO has indicated his intention to undertake further work with his local Area Manager to improve the existing strategy and I applaud this action.

I recommend that the Probation Area publishes a written suicide and self harm prevention strategy that should be made known to all staff and a copy kept in each Approved Premises.

36. Following investigations into previous deaths in Approved Premises, I have recommended that mechanisms should be put in place to enable members of staff to summon assistance quickly in emergency situations. The National Probation Directorate responded speedily to my recommendations and to those of the NPD's security survey, by providing pin point monitor alarms that incorporate a direct call button to the Approved Premises' alarm system and to the police. Such a system will, no doubt, prove invaluable in various emergency situations but it does not prevent crucial time being lost when staff members must return to the office to summon other emergency services.
37. No time was lost in summoning an ambulance and paramedics arrived speedily to attend to the man. Sadly, it seems that he was already beyond their help when they were summoned but a delay, however brief, could mean the difference between life and death for others. The National Probation Directorate has said that it is not in a position to supply mobile phones to all staff in Approved Premises although individual Probation Areas may choose to do so.

I recommend that the Probation Area provides a mobile telephone for each Approved Premises, to be carried by night supervisors when making checks of the premises.

RECOMMENDATIONS:

National Recommendations:

- **I recommend that the National Probation Directorate and the Prison Service should produce a protocol for sharing information pertaining to risk on those who are released from prison subject to Probation Service supervision.**

The National Probation Directorate has accepted this recommendation and work is in hand to develop guidance in support of the Prison Service's new suicide and self harm management framework that is about to be implemented.

Area recommendations:

- **I recommend that the Probation Area issues a reminder to staff about the correct procedures for completing OASys assessments.**
- **I recommend that the Probation Area requires a more rigorous assessment procedure to be undertaken for each Approved Premises placement referral regardless of whether the offender has been previously known to the Area.**
- **I recommend that the Probation Area publishes a written suicide and self harm prevention strategy that should be made known to all staff and a copy kept in each Approved Premises.**
- **I recommend that the Probation Area provides a mobile telephone for each Approved Premises, to be carried by night supervisors when making checks of the premises.**

All Area recommendations have been accepted.

Staff at the Approved Premises have been reminded about the correct procedures for completing OASys assessments. Following a recent Effective Supervision inspection by Her Majesty's Inspector of Probation, the Probation Area has developed a Risk Management Improvement Plan. The plan includes a series of workshops in which the Manager of the Approved Premises will participate.

Approved Premises staff have been instructed to complete a fresh OASys assessment, or undertake a review of existing OASys assessments on each occasion an offender resides at an Approved Premises.

The Approved Premises Manager is collaborating in the drafting of the suicide and self harm strategy. The Area has said it will ensure that the strategy is in place without delay.