Investigation into the circumstances surrounding the death of a resident of an Approved Premises in the Cumbria Probation Area in September 2006

Report by the Prisons and Probation Ombudsman for England and Wales

June 2007

The man who is the subject of this report died in a park toilet in September 2006, having injected himself with heroin and consumed a large quantity of alcohol. He was a resident at an Approved Premises in Carlisle. He was 38 years old.

The loss of any family member is distressing, but especially so in the circumstances described in this report. The man had a long history of mental illness, and was suffering with increasingly bad headaches. He left a note in one of his pockets telling police officers who he was and where he was from. He had also written a final letter to his mother, and one to staff at the hostel. My colleagues and I offer our sincere condolences to the man's family and friends.

The man who died had been in prison custody on remand but was bailed by Carlisle Crown Court to the Approved Premises. On 28 April 2006, he was sentenced by the same court and given a community order of two years supervision, mental health treatment, and six months continued residence at the hostel. For most of his stay, the man was also monitored under the Cumbria Probation Area's procedures for residents assessed to be at risk of suicide.

Because of the extent of the man's mental health history, I asked for a clinical review of the care and treatment he received. Carlisle Primary Care Trust commissioned the review and it was undertaken by a doctor. The doctor's assessment of the man's healthcare is that he was well treated whilst in prison custody and when he was at the Approved Premises. The report concludes that the treatment was equivalent to that available in the wider community.

Two of my investigators carried out the investigation on my behalf. I also wish to thank the manager of the Approved Premises for making the necessary facilities and information available to my investigators.

My report makes two recommendations for Cumbria Probation Area, and identifies four areas of good practice. I have been pleased to learn that the report and findings have been accepted by Cumbria Probation Area and actions undertaken to implement the changes.

Stephen Shaw CBE
Prisons and Probation Ombudsman **June 2007**

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SUMMARY

On 31 May 2005, the man who later died was remanded into custody and taken to HMP Durham. He told reception staff that he had a history of mental health problems and a daily drug habit made up of methadone, benzodiazepines, and cannabis. He also said that he had a history of self harm. He had made previous attempts to take his life by hanging, drug overdose and gassing.

The man remained at Durham for ten months until 13 March 2006 when he was granted bail by Carlisle Crown Court subject to his residence at the Approved Premises. Two days after his arrival, he told staff that he felt anxious and suicidal, and was placed on suicide and self harm monitoring.

On 28 April, the returned to Carlisle Crown Court for sentencing. He was given a community order comprising two years supervision, mental health treatment, and six months continued residence at the Approved Premises. Despite the order to continue mental health treatment, he began to refuse his medication. He said it was making him ill. The treatment was changed on a number of occasions, but the man still maintained that it did not suit him.

On 9 July 2006, after expressing suicidal thoughts, the man was assessed by Carlisle NHS Mental Health crisis team and was admitted to the Carleton Clinic the following day. He remained there until 23 August when he returned to the hostel.

Just over two weeks later, the man left the Approved Premises and went to a toilet in a local park. He injected himself with heroin and at the same time drank a large quantity of alcohol. A member of public found him collapsed in the toilet and called the emergency services, but sadly he had already died. Police officers found a note in one of his pockets which told them who he was and where he was from. Later, they found two more notes in his room, one to his mother and the other addressed to staff at the hostel.

THE INVESTIGATION PROCESS

1. When my office was notified of the man's death, the investigation was allocated to two of my investigators. One was the lead investigator and he contacted the senior probation officer at the Approved Premises to arrange a visit to the hostel and familiarise himself with the circumstances of the man's death.

2. On 22 September 2006, the lead investigator met the senior probation officer and the Assistant Chief Officer for Interventions at the hostel. The senior probation officer gave an overview of events, and my investigator explained the investigation procedure. He also viewed the Approved Premises, including the man's room, and spoke to a resident who had known the man who died.

3. It is not routine practice to request clinical reviews of the care of residents who die in Approved Premises. However, because of the man's long history of mental illness, I decided to make an exception. The assist investigator asked the doctor responsible for residents at the hostel for the man's medical record. Initially, the doctor and Cumbria Primary Care Trust were reluctant to participate in my investigation. They subsequently reviewed their decision and the PCT commissioned South Tyneside Primary Care Trust to carry out the clinical review.

4. As with all of my investigations, I invite members of the family to contribute towards my report and to raise any concerns or questions they might like me to consider. On 3 October, one of my Family Liaison Officers telephoned the man's mother and explained my role in investigating the death of any resident in Approved Premises. She told my Family Liaison Officer that the staff at the hostel looked after her son. She described her son as deeply depressed and confirmed that he telephoned her every day and, for a number of weeks, had threatened to take his own life. The man did not tell his mother why he wanted to end his life, and it is not clear whether she told the staff. The man's mother told my Family Liaison Officer that she had asked the staff whether they were aware how depressed he was, and they told her that the man was seeing a doctor. The man's mother believes that the staff did their best for her son. Finally, she told my Family Liaison Officer that staff from the hostel attended the man's funeral, and that she had no questions or concerns for me to consider.

5. On 19 October, the assist investigator visited the hostel and examined the probation records. He identified those members of staff who he considered appropriate to interview. The following month, both investigators returned to Carlisle and interviewed a number of the staff employed at the Approved Premises. All staff co-operated fully with my investigation.

THE APPROVED PREMISES

6. Approved Premises, formally known as Probation and Bail Hostels, are approved by the Secretary of State within Section 9 of the Criminal Justice and Court Services Act 2000. Their purpose is to provide an enhanced level of residential supervision in the community, as well as a supportive and structured environment.

7. The Approved Premises where the man lived is a 24 bed building, located in Carlisle. Internally, the premises have comprehensive closed circuit camera observation and recording facilities, providing an accurate timeline of movement in and out of the building, and covering strategic points within the building.

8. The hostel is managed by a senior probation officer with overall responsibility for its running, assisted by a deputy manager who is responsible for the day-to-day management of residents and for making decisions about enforcement. The frontline team is made up of seven permanent members of staff, four of whom are assistant wardens and three who are Approved Premises workers. A pool of approximately 20 relief workers cover staff absences related to annual leave, training commitments or sickness.

9. The admissions policy is based on assessment of risk. In recent years, the residents' profile has changed significantly, with prolific lower risk offenders superseded by those convicted of more serious violent or dangerous offences. The hostel now takes fewer people coming straight from court, and the majority of residents are required to stay as a condition of a court order or prison licence.

10. Each resident is allocated a keyworker soon after their arrival, and this member of staff acts as their primary point of contact for sorting out practical issues. Regular keywork sessions 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.

11. The Approved Premises has close links with local health services, and all residents are registered with a General Practitioner. Residents with significant mental health or emotional problems have access to specialist treatment and support provided by North Cumbria Mental Health and Learning Disabilities NHS Trust. As part of this service, the Trust funds a psychiatric crisis team which assesses individuals with severe symptoms of mental ill-health.

12. Residents are required to pay rent and abide by the hostel's rules and regulations, including observing a strict overnight curfew between 11.00pm and 7.00am. During the day, they are free to go out unaccompanied and are not required to tell staff where they are going.

13. When residents are subject to statutory supervision, relevant information is regularly shared with field probation officers who are responsible for decisions about the management of offenders. The man's case manager was a trainee probation officer at the time she supervised him.

Risk of Self Harm, Suicide and Sudden Death Policy

14. The National Probation Service circular 40/2004, "Strategy for Preventing Sudden Deaths in Approved Premises", requires all Approved Premises to have their own policy for preventing deaths. The policy for the hostel has one aim which is:

    "The Approved Premises has a duty of care for all residents, to identify and monitor those residents who are at risk of self harm or sudden death, thereby avoiding or reducing the risk of harm or death".

    The policy expresses the importance that management and staff place on the prevention of self harm, suicide and sudden death. It provides guidance to staff on the procedures and actions to be followed when residents present a risk of self harm or suicide. The policy is managed directly by the Approved Premises manager, and is broken down into nine sections: Overall Aim, Referrals, Pre-admission, Admission and Induction, Duration of Period of Residence, Case Management, Departure, Management Issues, and Staff Training and Awareness.

15. When a resident is identified as at risk of suicide or self harm, form BGH27 is opened by any member of staff. The form requires the staff member to identify the level of risk and record on the front cover the action which is required. There are nine action points, to be used as appropriate, and the rest of the form is for daily monitoring, including observations and contact with the resident.

Community Orders

16. In April 2005, new legislation came into force in England and Wales which brought together existing community-based disposals under the umbrella of a generic community order. This allows the courts to impose a community order and specify the activities which the offender is to take part in. Amongst the options are drug treatment, mental health treatment, residence at a particular place, supervision by the Probation Service, curfew between certain hours of the day and unpaid work. From 28 April 2006, the man who died was subject to a community order with three requirements: two years of supervision, mental health treatment, and six months residence at the hostel.

17. The supervision element of the man's order required him to report to his supervising officer in accordance with National Standards. (National Standards 2005 specify that offenders must report at least once a week for the first 12 weeks, fortnightly for the next 12 weeks and four weekly thereafter, until the supervisory period ends. During supervision sessions,

offenders are expected to analyse their criminal and anti-social behaviour in a structured manner, and develop skills to avoid re-offending.)

18. Offenders who fail to keep scheduled appointments, or who commit new offences, can be breached and returned to court. The first stage of the breach process is that the offender is issued with a Warning Notification, giving seven days to provide evidence that they had a legitimate reason to be absent. If no evidence is provided, the warning stays on file and two unacceptable absences in a year mean that they are returned to court. The court has the power to re-sentence the offender or add new conditions to the order.

19. The treatment element of the man's order required him to co-operate with the package of care put in place by North Cumbria Mental Health and Learning Disabilities NHS Trust. He was expected to take medication prescribed by his doctor or psychiatrist.

Multi-Agency Public Protection Arrangements (MAPPA)

20. MAPPA is a formal partnership between police, probation, prisons and other statutory and non-statutory agencies which assesses and manages offenders in order to minimise the risk of serious harm they pose to the public. There are four core functions:

    - Identification of offenders with the potential to commit serious violent and sexual offences
    - sharing information to assess risks posed by identified offenders
    - assessing risk of serious harm
    - managing risk.

21. Offenders who fall within the MAPPA remit are classified according to the nature of their risk and its management. The higher the risk, the higher the level at which they are managed:

    - Level One offenders are managed by one agency, usually the police or Probation Service
    - Level Two offenders are managed jointly by the MAPPA agencies
    - Level Three offenders are managed by the Multi-Agency Public Protection Panel (MAPPP) which is made up of senior managers from the MAPPA agencies.

Drug Rehabilitation Requirement (DRR)

22. Anyone assessed as suitable for DRR has to participate in regular drug testing and drug treatment.

KEY FINDINGS

23. The deputy manager at the Approved Premises is responsible for assessing new referrals. He does this by carrying out a risk assessment and judging their suitability. Whilst the man who later died was at HMP Durham, an application was submitted for him to be offered a placement at the hostel from 13 March 2006. The purpose of the placement was initially for two weeks, to allow assessment for a community order with a drug rehabilitation requirement (DRR) and a continued period of residence.

24. The Approved Premises application form is a seven page document, divided into two sections. It includes detailed information about the offender, offence analysis and risk assessment information. In section one, the applicant wrote that the man had been a heroin user but, as he had been on remand since May 2005, he was currently not using drugs. The document identifies him as subject to MAPPA at Level One.

25. Section two gives a detailed offender assessment. It noted the man's history of heroin use, alcohol related offending, aggressive behaviour and impulsive actions. The document shows that he was currently co-operative. It continued that, although he had acted in an anti-social way and been involved with mental health services, at the time he was well. Under the heading of significant events was recorded that the man had committed a serious offence whilst not complying with medication. Additionally, it noted a risk to the public when using alcohol or drugs and that he could display aggressive behaviour. Finally, the document noted concerns about his past mental stability.

26. The deputy manager and the manager considered the application and, although the man who died was not assessed as high risk and so did not fit the normal resident profile, they agreed to offer a place. At interview, the deputy manager told the investigators that he was conscious of the man's needs and thought that they could be met at the hostel. The regular links with mental health services, including access to the crisis team and a mental health social worker, would all provide the type of support he needed.

27. On 13 March 2006, the man was bailed by Carlisle Crown Court to the Approved Premises. The judge recognised his special needs and the length of time that he had been on remand. Another condition of his bail was that he should be assessed for a DRR. (He was found to be unsuitable, as he had not been using drugs for some time.)

28. Following the man's arrival at the hostel, he was given a full induction and his case management record was begun. (The case management record notes details of significant contacts and events, as well as the supervisor's thoughts about the current situation and future actions.) The man signed the record to show that he understood the rules of the hostel and the conditions of his bail. The deputy manager delivered part of the induction session, and described the man as needing continual reassurance. He said that, during

the first few days, the man would constantly speak to staff and ask if he was doing what was required.

29. The man who is the subject of this report was allocated a key worker, who had not met him previously. He described him as nervous, but no more than any other resident new to the premises. He added that the man was happy to be at the hostel, and had told him that he did not want to return to prison.

30. The key worker made the first entry into the case management record. He wrote that the man was cooperative throughout the induction session and adamant that he was going to change his lifestyle and behaviour. He noted that, due to his mental health problems, an appointment was made for him to see a doctor and obtain medication for the night.

31. The next day, 14 March, the Drug Intervention Programme Team Care Co-ordinator wrote to the man and told him that an assessment was arranged for 20 March.

32. One of the relief assistant wardens told my investigators that she had known the man for a number of years as she once lived in the same area. She described him as quiet and likeable. On 15 March, the man told her that he was feeling anxious and suicidal. She opened a risk of self harm or suicide form and immediately began to monitor him.

33. She relief assistant warden was concerned about the man and contacted the local General Practitioner (GP) at his surgery. She wrote in the self harm record that the doctor did not think the man was going to harm himself, but at interview she could not recall how he reached this assessment. She thought that the doctor either saw the man at the hostel, or that he had been to the surgery. She also noted that the doctor prescribed medication to help the man sleep.

34. When the relief assistant warden opened the self harm form, she did not complete the front page action plan correctly. She wrote the man's name, date of birth, nature of concern, her own name, and the time and date that the form was opened. The nine further sections were not complete, including the level of monitoring, referral to the doctor, notification to other staff and the duty manager.

35. The self harm monitoring form remained open. On 22 March, the man's key worker recorded that the man was struggling with his medication. He wrote that he felt suicidal, and was aware that this was due to his medication, and he did not see it as a current threat. The man saw another doctor who increased the dosage of his sleeping tablets and prescribed an anti-depressant. The key worker also recorded that the man was worried about a court appearance the following day.

36. The following day, the man who later died was again bailed to the Approved Premises for a further four week assessment. His key worker recorded that the assessment would include random breathalyser tests. He added that the

man appeared extremely motivated to address any issues in order to change his lifestyle, addictions and offending behaviour. On 24 March, the man's solicitor wrote to him and explained the terms of his release on bail.

37. On 2 April, the key worker noted in the case management record that he had spent a lot of time with the man who later died, whom he said needed lots of reassurance. Another entry was made four days later when the man was referred to the crisis team because of concerns about his threats to commit suicide. He was assessed by two staff. They did not consider that he was at risk, but thought he was stressed by his forthcoming court appearance.

38. On 28 April, the man appeared at Carlisle Crown Court and was sentenced. The woman who would later become his supervising officer was the duty probation officer at court that day. She had not previously had any contact with the man. She told my investigator that she remembered speaking to him at court after he was sentenced. She said that he understood the community order imposed on him and was positive about his future. He was pleased not to be returning to prison and talked to her about wanting to be allowed to return to his home area one day.

39. The same day, and in response to the man's application to the Foundation Construction Award Brickwork Course at Carlisle College, the admissions officer wrote to invite him to a meeting at 4.00pm on 12 June.

40. The man who is the subject of this report received two letters on 3 May. The first was from Eden Housing Association who wrote to tell him that he was eligible for assistance as a homeless person. However, he did not meet their criteria whilst at the hostel, where he was expected to remain for six months. The second letter was from North Cumbria Mental Health and Learning Disabilities NHS Trust who told him that his doctor had asked the Trust to make him a routine appointment. He was asked to telephone to agree a time.

41. On 5 May, the man got a letter from Jobcentre Plus inviting him for interview to look at improving his chance of finding employment and ensure he was receiving the correct benefits. He also received a second letter from North Cumbria Mental Health and Learning Disabilities NHS Trust telling him that a member of the Adult Mental Health Team would be in touch with him at 11.00am on 9 May.

42. He also attended an appointment with his GP, who issued a note for social security and statutory sick pay purposes with a diagnosis of depression.

43. On 24 May, the man did not attend his scheduled appointment with his probation officer, who said that this was unusual as he normally attended promptly. He was issued with a Warning Notification, and given seven days to provide an acceptable reason. The warning was later withdrawn when it was realised that the man had actually been attending an appointment with the basic skills worker, inadvertently booked for the same time.

44. At interview, the supervising probation officer told the investigators that her impression of the man at the time was of someone who was positive about the future. She said he wanted to attend college, and eventually move closer to his mother's home. She was aware of reports that he might not comply with his medication, and this might cause him to swing between the high and low end of the condition. The supervising officer knew that he was diagnosed as bipolar, and said that she had discussed it with the man. She said that he understood the diagnosis, but did not agree with it or understand how the doctors had arrived at it.

45. Two days later, the key worker had a conversation with the man who admitted that he had not swallowed his medication for four days. The key worker noted this in the handover records for the attention of the staff, and also made a point of speaking to the man after he was given his medication to make sure that he had swallowed it.

46. On 8 June, the man's supervising officer referred him to the Cumbria MAPPA. Her report, which was subsequently agreed by her line manager, said that the man's offending history meant he potentially posed a risk of harm to members of the public. The supervising officer's line manager considered that the man should be registered a Level One risk, which would mean that day-to-day management would be the responsibility of Cumbria Probation Area and other agencies would be informed of changes in his behaviour and circumstances. The line manager tacitly acknowledged that the risk could increase if the man stopped taking his medication, his behaviour deteriorated or his compliance with supervision waned, and stated that the supervising officer should make another referral if there were further concerns.

47. Three weeks later, on 29 June, the risk of self harm or suicide document, first opened on 15 March, was closed. Hostel staff had noticed a marked improvement in the man's outlook on life and thought that he appeared much more positive. However, the man's supervising officer also interviewed him that day, and her opinion differed as he spoke to her about suicidal thoughts. She told my investigator that the man who later died looked unkempt, was reluctant to speak to her and his body language was different (she described it as hunched up). She thought that this was significant as he had previously taken a pride in his appearance and was normally talkative. She added that the man was worried about moving on. The supervising officer said that she did not think that the man was stable, but rather that he was at the low end of his bi-polar symptoms.

48. After the interview, the supervising officer became aware of the earlier decision to close the self harm document, and so immediately telephoned the deputy manager to tell him about her conversation with the man. It was evident to my investigators that there is a close working relationship between the supervising officer and the Approved Premises, such that she felt sufficiently confident to say that she disagreed with the decision. As a result, the form was re-opened and monitoring resumed.

5 July – 10 July

49. Between 5 July and 10 July, there are a number of entries in the case management record about further deterioration with the man's compliance with his medication and his overall wellbeing. He told staff that he felt suicidal and was worried about the effect his medication was having. Due to their level of concern, the crisis team was contacted on 6 July and they visited the man at the Approved Premises later in the day. The doctor changed his medication.

50. After 6 July, there are further records that the man was complaining to staff about headaches and lack of sleep. He was increasingly angry and referred to reading the Bible. He continued to refuse to take his medication from time to time. A couple of days later, it was recorded that he continued to express suicidal thoughts and he was actively thinking about overdosing on heroin. He told a relief member of staff that he was anxious about being returned to prison because he was not taking his medication. These concerns were not transferred to the self harm and suicide monitoring document, but the crisis team was contacted.

51. The relief worker said that he had known the man since his arrival at the hostel, when he said that the man had told him that he was manic depressive. He described the man who later died as someone willing to talk about his feelings, and sometimes happy and sometimes sad. He explained that, when the man was happy, he would be cheeky and talkative and when he was sad he would be quiet and not interact with staff.

52. Later that day (8 July), another relief member of staff recorded in the self harm document that the man had not been taking his medication. She had taken a telephone call from someone believed to be another resident who had told her that the man had not been taking his medication as it made him feel ill. The telephone caller said that the man had expressed suicidal thoughts and was anxious and depressed. She relief worker noted the man's appointment with the crisis team, and informed the duty manager of the call.

53. The man who is the subject of this report saw a psychiatrist at the Carleton Clinic the next day, and when he returned to the Approved Premises he was unhappy that his medication had not been changed. The following day (10 July), he was crying, angry and agitated about the way he was dealt with by the crisis team, and again told hostel staff that he would overdose on heroin. As a result, another call was made to the crisis team who arranged to see the man at 1.30pm and admitted him to the Carleton Clinic. The man's mood was described as low and he had suicidal thoughts.

54. On 11 July, Cumbria Action for Social Support wrote to tell the man that they were in contact with a housing association about his request to move into independent accommodation after his tenancy at the hostel ended.

55. Four days after the man was admitted to the Carleton Clinic, the deputy manager and the man's supervising officer went to visit him as they wanted to keep in touch and check that the hostel remained the appropriate accommodation. The supervising officer visited again on 20 July, and the deputy manager made another visit before the man was discharged in late August. This is an example of good practice and clearly demonstrates the supportive environment at the hostel.

56. At interview, the deputy manager said he saw a marked deterioration in the man who later died, and told the clinic staff that he did not want him to return to the hostel whilst in his current medical condition. He said he asked for the man to be placed in accommodation which was better suited to his needs.

57. After a fortnight in the clinic, the man was transferred on 25 July to the West Cumbrian Hospital where Electroconvulsive Therapy (ECT) could be administered. (ECT is used to treat depressive illness, schizophrenia, catatonia and mania. The National Institute for Clinical Excellence guidelines recommend that ECT should be used to gain fast and short term improvement of severe symptoms after all other treatment options have failed, or when the situation is thought to be life threatening.) The first treatment was given three days later, and it stopped on 15 August as it was making the man high and disinhibited. He returned to the Carleton Clinic the same day.

58. On 22 August, after some improvement to the man's symptoms, a discharge meeting was held at the clinic which considered whether it was appropriate for him to return to the Approved Premises. The deputy manager was on leave and unable to attend the meeting, so the supervising officer attended instead. She told the investigators that she thought that the man's mood was down, and the clinic staff told her they thought he did not want to leave. However, no alternative accommodation was available for the man, and so the supervising officer requested that, in the event of his return to the hostel, there should be a full care package in place to avoid a further crisis situation. She was assured that the man would have crisis team support in the event of any immediate concerns. The meeting decided to allow the man to return to the Approved Premises the following day (23 August).

23 August – 8 September

59. The self harm monitoring resumed when the man returned to the hostel, and the entry on 23 August described him as cheerful at first, but less so later in the day. No self harm concerns were noted. A hostel worker told my investigators that she noticed that the man had changed. She described him as obsessive about his medication and wanting to change it.

60. At the beginning of September, about a week before the man died, the key worker overheard a conversation between the man and an unknown visitor. The visitor offered cocaine to the man who died, who said he did not have any money. The key worker watched the man and the visitor on the closed circuit television camera situated just outside the front entrance of the

building. He saw that the man who later died did not take anything from the visitor.

61. On 7 September, the key worker and the deputy manager met the man to discuss his failure to take his prescribed medication. The man was reminded about the condition to take his medication, and reluctantly appeared to accept that he would have to comply. A further review was planned for 11 September to ensure he was complying with the condition of his licence.

62. The key worker told the investigators that he normally had weekly meetings with his designated residents, but saw the man who later died more frequently. The man worried about his mother, and would telephone daily and occasionally up to three times a day. The key worker worked with the man to allow him to regain access to North Cumbrian Addictive Behaviour Services, from which he had previously been banned.

63. The man's supervising officer met with him on 7 September when she said that he was quiet, and complaining of headaches. Although he said that he was fed up of taking medication, the supervising officer was not concerned about any heightened risk of self harm.

64. The self harm monitoring record shows that, with the exception of a few entries, the man was more settled and would join in with activities. He continued to complain about his medication, saying that it made him tired. On 8 September, he said that he had a bad headache every day and that his tablets made him anxious.

65. At 5.00pm on 8 September, a female relief worker started her shift. She first met the man when he returned from the Carleton Clinic. She described him as a quiet resident. She said that he would not readily engage with people, but that she always knew when he wanted to talk. She said that he complained to her of being tired and having headaches, which she discussed with other staff.

66. The female relief worker remembered the man collecting his medication that evening, and again he said that he was tired and had a headache. He said that he thought the headache was caused by his medication, but he had to take the tablets as "he had been told off" previously. The man asked the female relief worker to arrange a wake up call the following morning, as he did not want to get into trouble for missing his medication. She did not see him again that evening, but saw him the next morning.

9 September

67. The female relief worker saw the man in the television room in the morning. At interview, she remembered that they talked about a television programme which he laughed about. She left the building at 10.30am and went off duty.

68. The first image of the man recorded on the CCTV footage was at 9.01am, when he left his room to enter the bathroom. There are further images of him inside the building, and one of him leaving the hostel by the rear entrance at 11.28am and returning almost immediately. The final image of the man was at 11.45am, when he left the building through the front entrance. An assistant warden who had taken over from the female relief worker remembered seeing him leave the building and waved to him as he left. The assistant warden was speaking to another resident at the time, and so did not speak to the man who later died.

69. At 1.19pm, a member of the public entered a toilet in Bitts Park in Carlisle and found the man collapsed in a toilet cubicle. The emergency services were called, but sadly the man was found to be dead. I have been told by the police that a note was found in one of his pockets which said who he was and gave his address. A syringe and an empty bottle of vodka were found in the cubicle.

70. At 2.15pm, the assistant warden was telephoned by a police officer and told that a man's body had been found in Bitts Park, and that the police were trying to confirm the identity. The officer told the assistant warden that a note had been found with a name and address, and from the description, the assistant warden was satisfied that it was the man who is the subject of this report. The police took responsibility for informing the man's mother of his death.

71. After the man's room was searched, a wallet containing a large amount of cash was found along with two notes. The first note was to his mother and apologised for what he was about to do and asked for her forgiveness. The man said that his head was sore and the doctor could not help deal with the pain. The second note asked hostel staff to make sure that his wallet was given to his mother, and thanked them for trying to help him.

72. After reporting the death to Cumbria Probation Area, the assistant warden gathered all the residents together to inform them of the man's death. One of the residents told my investigator that he saw the man arrive at the park at about 11.45am on 9 September. The resident said that he stopped to ask him where he was going, to which he replied that he was going for a walk and a sit down. He said that the man was laughing and joking with him, and he thought that he was happy. The resident said that the man who died was not well before he went into hospital, and complained of pounding headaches and hearing voices. But he did not know what the voices were saying and the man had not talked about killing himself.

73. As well as formal interviews with staff, the investigators spoke informally to a number of staff about the man. A caterer at the hostel described him as a polite young man who was always smiling. She often spoke to him, and at no time did he give her any cause for concern. A housekeeper described him as polite and quiet, and said he made a point of speaking to her. She told the investigators that she saw him on one occasion, before he was being admitted to the Carleton Clinic, sitting on the floor outside a communal

room holding his head. She remembered that he became noticeably quieter before his admittance to the clinic. Another member of staff told the investigator that, when the man returned from the clinic, he was not as upbeat as usual and appeared to have stopped looking forward.

74. One of my investigators spoke to the man's social worker, and asked her about her contact with him. She said that she had only known him since the discharge meeting in August, and had then met him every week at the hostel. She thought that he was anxious about moving on from the Approved Premises, but said that he did not display any suicidal ideas although she believed he was a risk of returning to drugs. She added that the man had discussed his plans for the future, and was looking to return to his home town to be closer to his mother. He was also planning to enrol for a college course.

75. A Consultant Chemical Pathologist at Sheffield Teaching Hospital carried out a toxicology examination and gave the following commentary in his report of 26 September:

> "There has been a potentially fatal misuse of illicit heroin with alcohol. Death is likely to have occurred rapidly following misuse and alcohol consumption. The Carbamazepine concentration is consistent with therapeutic range use."

76. Following any death in custody, it is important that staff feel supported and suitable systems are in place to allow anyone affected to share their concerns and feelings. In general, those staff on duty at the time of the man's death did feel supported. However one member of staff, who returned to work after the death, was upset at being told and felt that it would have helped had she been able to speak to someone.

ISSUES CONSIDERED DURING THE INVESTIGATION

Risk of Self Harm, Suicide and Sudden Death Policy

77. Soon after the man's arrival at the Approved Premises, he was placed on daily monitoring using a locally devised risk of self harm or suicide procedure. The procedure requires the member of staff raising the concern to open and complete form BGH 27, Risk of Self Harm or Suicide. The front cover of the document has nine possible action sections, plus three separate columns to show the date, name of person dealing with the particular action, and the names of those people who have been notified. The member of staff is also required to enter the name of the resident, their date of birth, and briefly describe the nature of their concern. Finally, the member of staff is asked to identify themselves, with the date and time the opening of the document.

78. A relief member of staff, who had not been trained to implement the policy, opened the document on 15 March with a good, comprehensive and informative record. However, she did not complete any of the nine action points, and said in interview that she was unaware that she should have done so as she had not been trained.

79. Once the document is opened, staff are expected to make a minimum of one entry per day which should assess the resident's mood, behaviour and level of contact. However, in this case, the records were not completed as expected. Excluding the period when the man was in hospital, the record shows that no observations were recorded on 11 days. On one occasion, no entries were made for two consecutive days, and on another occasion the entries were not made for three consecutive days. However, I make no formal recommendations as I am satisfied that the hostel has other recording systems which did ensure that the staff were aware and were monitoring the man.

80. The investigator interviewed the manager of the Approved Premises who said that he checks the entries every day in order to satisfy himself that staff are carrying out their instructions. However, he said that he had not been aware of the omissions and acknowledged that he should have been. The manager explained that a new system was being introduced, in line with the procedure used by the Prison Service, and that training dates were awaited. I welcome this approach and urge the manager to ensure that the training takes place as soon as possible and includes all the staff working at the hostel. In the meantime, the manager must ensure that existing systems operate correctly.

81. The suicide and self harm monitoring procedure was briefly closed after a review to which the supervising officer was not invited. In this case, fortuitously and coincidentally, she interviewed the man the same day and realised that he was still at risk. Action was taken and the procedures were immediately re-opened. In my view, the supervising officer should always be

closely involved in suicide and self harm monitoring, and should always be invited to reviews.

Cumbria Probation Area should ensure that Risk of Self Harm or Suicide procedures operate correctly and supervising officers are fully involved.

Clinical Care

82. The clinical reviewer says that the man was a complex individual who used drugs and alcohol, offended repeatedly and had bipolar disorder. His anti-social behaviour began before he was formally diagnosed as mentally ill, and so should be considered as independent of it, although the combination of problems made management more difficult. Whilst the man understood his difficulties to some degree, he only partially engaged with services and there was evidence of reckless and impulsive behaviour, including previous episodes of self harm. The reviewer reports that the man's mental health problems appear to have been recognised, and appropriate treatment had been offered. There was no evidence that he had been excluded from services on the grounds of personality difficulties.

83. When the man who later died was remanded in custody in May 2005, it was quickly recognised that he was mentally ill and appropriate treatment commenced. It was further recognised that he would require ongoing treatment after his release from hospital, and an appropriate referral was made.

84. When the man was bailed to the hostel, whilst he was not actively unwell, he was clearly vulnerable to further episodes of mental ill health and his mental state appeared to be fragile. There was a clear need for further psychiatric follow up. Whilst the prison had made efforts to secure further psychiatric follow up, the letter did not identify where he would be living, and this increased the likelihood of communication difficulties. In the event, good local procedures ensured that he was able to access mental health services. The man was registered with a doctor, who identified his mental health needs and made an appropriate referral to psychiatric services.

85. The community psychiatric nurse triaged the man appropriately, and made a referral for psychiatric assessment after which he was seen promptly. There were good local procedures for recognising and accessing appropriate help for people suffering from mental health problems at the Approved Premises. When his mental state deteriorated, the man was immediately referred to the crisis team who saw him quickly and appropriately, and arranged hospital admission as it was clear that his suicide risk was high. Throughout his contact with all the services, there was evidence of his suicidal ideas being explored and assessments of risk being undertaken.

86. Whilst in hospital, the man was treated for major depression with suicidal thoughts. At the time of his discharge, there is some evidence that his mental state was still fragile. The clinical reviewer comments that there may

have been some confusion at the discharge meeting that his discharge was so imminent. Nevertheless, a comprehensive post-discharge care plan was put together and a risk assessment undertaken. Good follow up arrangements were made and the care coordinator saw the man regularly at the hostel, asked about any suicidal ideas and liaised with the hostel staff.

Support for staff

87. During their time at the Approved Premises, my investigators asked staff members whether they had received appropriate support to deal with the man's death. The majority were satisfied, except for one person who had not been on duty at the time, and only became aware of his death when she returned to work. The member of staff was upset at the news, and would have liked the opportunity to speak to someone about her reaction but this did not happen.

88. I am satisfied that there was no intention to cause any distress and clearly those staff and residents present at the time of the man's death did feel supported. However, it is important to ensure that support is also offered to those beyond the immediate situation.

Cumbria Probation Area should review procedures for supporting staff following any serious incident.

Response by Carlisle Probation Area Response to the report

89. The Assistant Chief Officer for Cumbria Probation Area produced a comprehensive summary of my report for the Chief Officer and members of the senior management team. In his report he told the Chief Officer of the circumstance of the man's death, the investigation, findings and recommendations.

90. In his summary, the Assistant Chief Officer told the Chief Officer that my report and recommendations have been accepted and confirmed they would be implemented with care and appropriate speed. I am happy to include the Assistant Chief Officer's note of the action points that have already been dealt with:

- As part of the Quality Assurance Audit process for Approved Premises planned for 2007 the audit panel will take account of the requirement from the Ombudsman's report to ensure that all risk of self-harm or suicide procedures operate correctly and supervising officers are fully involved in reviews.

- The Self-Harm and Suicide procedures have already been reviewed by Approved Premises management staff, ACCT training is in place, a revised and refreshed staff induction programme that takes into account the points from the Ombudsman's report has been devised and will be completed by the end of May 2007. The annual quality

audit will report on progress made in relation to recommendation (1) of the Ombudsman's report.

- The Interventions ACO and the ACO with responsibility for Human Resources will meet with the Approved Premises manager and the Health and Safety Officer to review Area procedures for supporting staff following any serious incident.

- However, it should be noted that the impetus behind this particular recommendation was that one member of staff who was not on duty during the period that the man's death occurred felt that she should have been advised prior to her return to work from leave that a death had occurred.

- It is important to record that all members of staff who had been directly involved with the man clearly stated to the Ombudsman that they had felt very supported by both line managers and staff generally within the Area.

- Members of SMT are requested to note the contents of this briefing paper and comment as appropriate to confirm the actions outlined above.

RECOMMENDATIONS

1. Cumbria Probation Area should ensure that Risk of Self Harm or Suicide procedures operate correctly and supervising officers are fully involved.

2. Cumbria Probation Area should review procedures for supporting staff following any serious incident.

GOOD PRACTICE

1. The Risk of Self Harm or Suicide document was immediately re-opened after the man's supervising officer made the Approved Premises aware of additional information.

2. When the man was admitted to hospital, his supervising officer and staff from the Approved Premises visited him on more than one occasion.

3. A staff member received anonymous information from another resident that the man was not taking his medication. The staff member took immediate action to inform her colleagues and make sure that the tablets were swallowed.

4. My investigators were impressed by the level of interaction between the man and all the staff at the hostel who had a good knowledge of the challenges he faced in life. They were proactive in trying to help him develop strategies for dealing with his insecurities and everyday problems.