

**INVESTIGATION INTO THE CIRCUMSTANCES SURROUNDING THE
DEATH OF A MAN IN AUGUST 2007 IN APPROVED PREMISES IN
THE GREATER MANCHESTER PROBATION AREA**

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

February 2008

This is the report of an investigation into the circumstances of the death a man in August 2007 in Approved Premises in the Greater Manchester Probation Area. The exact cause of his death is still awaited from the post mortem report but it was evidently self-inflicted. The man was 51 years old.

I would like to extend my condolences to the man's family and friends for their loss.

Two colleagues conducted this investigation. I am grateful for the assistance they received from staff of the Approved Premises.

The man had been released from HMP Forest Bank to the Approved Premises on bail. He had harmed himself whilst in police custody, but made no further attempts whilst in prison or during the three months he spent at the Approved Premises. Aware that his court case was approaching, staff attempted to encourage him to share any concerns or anxieties. On what was to become his penultimate day at the hostel, the man attended court for the first day of his trial. When he returned, staff spoke with him about the events of his day and there were no concerns about his mood. Later that evening, during the night curfew check, he was checked and said he was okay. The next morning a member of staff conducting the wake up call found that the man had died.

I have found that the Approved Premises is managed by committed staff and largely in accordance with Approved Premises standards. Indeed, I commend the staff for the inclusive way in which they treated the man, who was one of the very few individuals who reside at Approved Premises before rather than after conviction. It was also very pleasing to see that information relating to his time in prison custody was shared with the hostel staff at an early stage. I do not believe that the man's death could reasonably have been predicted

Sadly, this is not the first death that I have investigated at this particular Approved Premises. I am pleased that the Probation Area has changed the arrangements for supporting residents and staff since my earlier investigation.

I have made no formal recommendations but drawn the attention of managers to a number of matters. In light of the many good things in this report, I hope a copy will also be considered by the Greater Manchester Probation Board.

Stephen Shaw CBE
Prisons and Probation Ombudsman

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SUMMARY

The man was arrested and charged with a number of offences in March 2007. He had one previous conviction many years earlier for a driving offence, and had not been in a custody before. Whilst in police custody, the man self harmed and was placed on constant watch. A self harm monitoring form was subsequently opened and he was monitored constantly. Following his attendance at court the next day, he was remanded into prison custody to await his trial.

On arrival at prison, the man still expressed suicidal thoughts. As a result, an Assessment, Care in Custody and Teamwork (ACCT) document was opened. He was monitored regularly and staff interacted with him. By 29 March, his mood had much improved and he appeared to have adjusted to life in prison whilst he awaited his trial. His ACCT document was subsequently closed.

The court released the man on bail in late May. This was subject to certain conditions, one of which was that he should reside at the Approved Premises. He completed his induction within the first two days but was anxious when he first arrived as he did not know what to expect from hostel life. However, it had the advantage over prison of better contact with his friends and family, and his sons visited regularly. The man soon settled into the hostel regime. Staff made a point of ensuring that, despite being the only unconvicted resident, he was included in all the activities that took place. He was also invited onto the various courses that were on offer, and to his credit he fully engaged in the programmes at the hostel.

The man was a quiet individual who interacted positively and frequently with staff, giving no cause for concern. He remained his normal self throughout, including the evening of the first day of his trial. He spoke with staff and talked about events at court. The man said that his son would collect him from the hostel the following morning to return to court. Staff had no concerns about his well-being.

The following morning, he failed to respond to the wake-up call. Staff entered his room to discover him in bed with an inflated transparent polythene bag over his head. A boot lace around the bottom of the bag was around his neck. Resuscitation was attempted but unfortunately was not successful. He was 51 years old.

THE INVESTIGATION PROCESS

1. The investigation was conducted by two of my senior investigating officers. I am grateful for the assistance they received from the Greater Manchester Probation Area, especially from the manager and staff at the Approved Premises. Although those interviewed were coming to terms with the man's death, they made facilities available and participated fully in the investigation.
2. My investigators visited the Approved Premises, studied records and interviewed eight staff. One of the investigating officers also liaised with the police who informed him that they had interviewed staff at the hostel, and members of the man's family and friends. They were content that there had been no third party involvement in the man's death.
3. One of my family liaison officers contacted the man's son and explained the investigation process to him. He was invited to raise any concerns or questions for the investigation to consider. The son had no questions but my report will be made available to him upon completion.

Prison procedures

Reception

4. On arrival at prison, the paperwork for prisoners is checked by prison staff before they are taken off the escort vehicle. Staff check warrants to ensure they have the correct prisoners in custody, and then set up the necessary records. The prisoner is taken from the vehicle and booked in by staff on the front reception desk. Personal and offence details are taken, along with any known or identified concerns.
5. All prisoners see prison reception officers and the member of healthcare on duty. During this process, address and next of kin details are obtained and prisoners are risk assessed. They are searched, their property is logged, and they are health screened before being located to a wing.

Assessment, Care in Custody and Teamwork (ACCT)

6. All prisons have implemented the ACCT approach to supporting and monitoring prisoners at risk of harming themselves. The key aims of ACCT are to create a safe and caring environment, to identify prisoners' individual needs, and to offer individualised care and support before, during and after a crisis.

Approved Premises

7. Approved Premises, formerly 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. They provide accommodation for people granted bail in criminal proceedings and also supervision and rehabilitation for people convicted of offences. Hostels can provide a supportive, structured environment in the community for high risk and difficult to manage offenders. The purpose of the period of residence is to ensure that the individuals concerned are subject to close oversight in the community. As the man was remanded on bail, he was not subject to supervision by an offender manager.
8. Referrals to Greater Manchester's Approved Premises are evaluated by a Central Admissions Unit where the senior probation officer decides whether or not a place can be offered. There is no contact between the staff at the hostel and a prospective resident until the day that they arrive. In the man's case, a referral was made via his solicitor through the court probation officer when he applied for release on bail.
9. The hostel where the man lived is one of seven Approved Premises in Greater Manchester. The Probation Area has a specialist senior manager over all the Approved Premises, with managers and other staff for each hostel. At the time the man's death, the manager of this hostel was a Senior Probation Officer (SPO).

10. This particular hostel has 14 members of staff, including the hostel manager. There is the deputy manager who is a probation officer, four residential support officers (RSOs), four resident service workers (RSWs, night duty officers), and two weekend supervisors. The hostel also has an office administration manager and a cook. There are also at least a further two permanent RSOs, not located in the hostel, who can be called upon to cover staff absences such as sick leave.
11. The hostel is a pair of large houses with a large, well maintained garden. It provides accommodation for 27 men. The houses have been adapted and refurbished in order to meet the requirements of residents and staff. Some residents have single rooms, and others who have just arrived share double rooms. In the domestic areas of the house there are several lounges, television, dining area, laundry and tea and coffee making facilities. There are also a number of CCTV cameras installed in communal areas of the hostel which are monitored by staff from the main office.
12. On arrival at the hostel, every resident commences stage one of the hostel induction programme. The last and second part of the induction process is conducted on day two. The induction ensures that residents know the hostel rules and what is expected of them. Every resident is allocated to a member of staff as their key worker whom they will meet on a regular basis for support, to discuss their well-being and to assist with any offence related work. Attendance at key worker sessions is part of the residents' contract and failure to attend can be considered a breach of hostel rules.
13. Residents have their own keys to their rooms, which they hand into the office when they go out and collect on return. They are not allowed to bring friends into the hostel without prior permission. Breakfast and dinner are provided each day. Unless a resident is subject to individual curfew arrangements imposed by a court, they must be on the premises between the hours of 11.00pm and 6.00am.
14. As with all hostels, this particular hostel has rules regarding alcohol and drugs. The possession or use of alcohol, solvents and controlled substances is not allowed either in the Approved Premises or within the grounds. Medication which is prescribed to an individual must be notified to staff and stored securely in the main office. Room searches are carried out over a five week rolling basis and all residents' rooms are checked within this period.
15. Night duty is normally supervised by two night supervisors. They are given a handover by the day staff when they begin their shift. They keep order and look after residents' welfare, issue medication, and patrol the premises overnight conducting hourly checks on residents. Any issues that occur during the night are recorded in the house log.
16. Some parts of the Probation Service, including Greater Manchester, have developed Assessment, Care and Teamwork (ACT) arrangements to monitor residents who are at risk of suicide or self harm. (The arrangements are similar but not identical to the ACCT procedures used by the Prison Service.) ACT is

currently being reviewed to determine whether it is effective and, if so, whether it should be implemented across England and Wales. All the staff at the hostel where the man lived have been ACT trained and first aid trained.

17. The hostel runs a number of weekly life skills group work sessions such as Tenancy, Men's Health and Living in Hostels Moving On (LIHMO) programmes. Residents also have to attend a daily morning meeting where they are kept informed of key issues and events. The programmes encourage residents to access services within the community and offer basic skills assessment and tuition. The hostel also has links with a number of community organisations including a local college that provides a computer-training course and a basic skills assessment programme.

KEY FINDINGS

Events before 29 August

18. In March 2007, the man was arrested, charged with a number of offences and taken into police custody. He was taken to court the following day and it was recorded on the escort form that he had suicidal tendencies and had tried to swallow toilet roll. The escort officer considered that he was vulnerable and opened a self harm document. Staff made frequent observations of him throughout the day.
19. The man's court hearing was later adjourned to another date, when he intended to plead not guilty to the charges. He was remanded into the custody of HMP Manchester and the escort documentation was passed to prison staff.
20. The man went through the normal prison reception process and the First Night Induction. Reception staff completed a cell sharing risk assessment (CSRA) document. He requested to be considered as a vulnerable prisoner (VP) and was later located on to K wing, the VP section. He told staff he had taken an overdose of paracetamol approximately 18 months earlier, as well as admitting that he had tried to commit suicide whilst in police custody by swallowing toilet tissue. The man said he did this as he felt he could not go on with life. He also disclosed that he was taking medication to keep him calm. He said that, if locked in a cell with another prisoner, he would not know how he would react. This was the man's first time in prison custody.
21. During his assessment with the healthcare nurse, he said he wanted to end his life and wanted closure for everybody's sake. She assessed him as a 'medium' risk of harm to others and it was later deemed appropriate that he could share a cell. Because of the information from the man, an ACCT document was opened and arrangements were made for an ACCT assessment to be carried out within 24 hours. The man was placed on an observation level of four times during the day and night to try and reduce the risk of him self harming.
22. On 4 March, the day after the man's arrival at Manchester, he attended an ACCT assessment interview. He told the ACCT assessor that he was disgusted with himself for the offences he had committed and felt that by killing himself, would give closure to the matter. He admitted that two members of his family had in the past attempted suicide. As for his current well-being, he said he felt calmer now. The prison doctor had prescribed anti-depressants which had helped. He still expressed that he would like to be dead although followed this up by saying he had no intention of taking his life in the near future.
23. In March, the man appeared at the Magistrates' Court where he pleaded not guilty to the charges laid against him. His case was referred to be heard at the Crown Court in June. The man was again remanded into custody and was taken to another prison in the Manchester area, HMP Forest Bank. He arrived at Forest Bank at around 3.50pm and again went through the prison reception process. He was later located on E wing, the VP area. His ACCT document remained open, and he was placed on hourly observations.

24. On 12 March, additional evidence was brought to the attention of the police regarding further alleged offences. The man was taken back into police custody for questioning and was charged with further offences. He returned to Forest Bank later that day.
25. An ACCT assessment interview was conducted on 20 March. The ACCT assessor recorded that, although the man was now used to the prison regime, he was spending a lot of time sleeping in his cell. He no longer had any suicidal thoughts and was aware of the prison's support mechanisms that were available to him. He told staff he looked forward to visits from his family and friends.
26. Immediately after seeing the ACCT assessor, the man attended an ACCT case review meeting. It was attended by the senior wing manager, a member of staff from Probation, Mental Health In-Reach team and the chaplaincy. The man was in a much brighter mood, although he was quiet when he talked about his family ties. He reiterated that he felt settled in prison now. The ACCT document remained open and the monitoring continued.
27. On 28 March, the man returned to the Magistrates' Court where he spent the day, later returning to Forest Bank. He went through the prison reception process again, with no concerns being noted.
28. An ACCT case review meeting was held the following day (29 March) which was attended by three members of staff and the man himself. He said he had no more thought of self harm or suicide, felt quite upbeat and more settled with life in prison. He had not attempted to self harm since being in prison custody. The case review board agreed that he presented as a low risk of self harm or suicide and so his ACCT document was closed.
29. A week later (7 April), an ACCT closure review meeting was held to assess his progress since the closing of the ACCT document. The man said he was coming to terms with prison life and had no issues or concerns. He had had some visits and phone calls and was feeling positive about them.
30. Staff noted on his wing history sheet that he was always polite and compliant. He rarely left his cell and no concerns were raised. He was relocated to a normal residential wing on 10 April.
31. On 16 May, the man was escorted to the Crown Court for a hearing. Communication had taken place between the man's solicitor and the prison's probation clerk. An application was submitted for him to be granted bail to await trial. Bail was to be considered by the court and, in the meantime, the man returned to Forest Bank.
32. The man had been located on a normal residential wing for approximately a month when, on 19 May, he reported that he was being threatened by other prisoners because of the nature of his offence. Staff took immediate action by returning him to E wing for his own protection.

33. On 21 May, having considered the man's bail application, the Crown Court granted bail subject to a variety of conditions. He was required to:
- live and sleep each night at the Approved Premises
 - not to contact directly or indirectly any prosecution witness
 - not to enter Denton
 - to abide by all the rules of the bail hostel
 - not to associate with any female under the age of 18 years.

Should the man default on any of the conditions, he would be remanded back into prison custody.

The man's arrival at the Approved Premises

34. Later that day, at around 7.00pm on 21 May 2007, the man was released from Forest Bank and made his way to the Approved Premises. He had not previously stayed at an Approved Premises. He arrived at the hostel around 8.40pm and was greeted by the first residential services officer (**RSO**), who carried out stage one of the hostel induction process.
35. The first RSO told my investigators that the man was very anxious when he arrived. He had never been in trouble before and was finding it hard to make the adjustments to his present situation and environment. The man told him that in September 2005 he had taken an excess amount of paracetamol in an attempt to take his life. Whilst in prison, the man said he had thought of harming himself and, as a consequence, an ACCT document was opened.
36. The RSO explained the rules of the hostel. He gave the man a tour of the premises, showing him where his room, which he would share with another resident, was located. The RSO explained to the man that he should contact any member of the hostel staff team at any time if he felt anxious.
37. After seeing the first RSO, the man met the deputy manager. She told my investigators that he was relieved to be out of prison custody and to be able to see his friends and family. She was aware that he was on bail and so was not required to complete any rehabilitation programmes at the hostel. However, she encouraged him to engage in the hostel regime so that he would not feel excluded from activities that other residents were involved in. The man said he was willing to do all the work programmes that were on offer.
38. The deputy manager said that the custody information, received via the Central Admissions Unit, recorded that the man had made a suicide attempt. She was aware that he had been placed on an ACCT document for a short period of time whilst in prison. She considered whether to open an ACT document but did not do so as he did not display any suicidal intentions. She said that staff were aware that residents experiencing or about to experience the court process found it to be a worrying time. The deputy manager said that staff automatically took this as an indicator to be more vigilant and look for possible risk of self harm.

39. The man spent his first night at the hostel without raising any concerns. The following morning, the second RSO introduced himself as the man's keyworker and proceeded to complete stage two of the hostel induction. The keyworker noted on the hostel contact log sheet that there were no concerns or issues with the man.
40. Four days later (26 May), the man had his next session with his keyworker. The keyworker told my investigators that he spent a great deal of time talking to him about the hostel and reassured him about staying there. In response, the man talked about his life and his pending court case. The man was clearly upset throughout their conversation as he spoke about the breakdown of some family relationships. However, he was pleased that he was still in contact with his two sons.
41. During the meeting, the keyworker talked to the man about his past suicide attempt and he said that he had no current suicidal feelings. The keyworker explained to him that staff could offer support whenever his mood was low. The man was due to appear in court in June and his trial was scheduled to start in August 2007. The man said that, once he had settled into the hostel, he intended to seek employment.
42. The hostel has bi-monthly staff meetings to review any issues or concerns about residents. One such meeting took place on 30 May. It was the first occasion when the man was discussed. The meeting noted that the man had been assigned the second RSO as his keyworker. The man was compliant and raised no concerns. It was noted that he was still awaiting his social security benefits in order to pay for his hostel rent.
43. As the man had not been convicted, he was not required under his bail conditions to attend any rehabilitation programmes. Staff did not want to exclude him from the regime and activities of the hostel and arranged for him to attend the Leaving Here and Moving On (LIHMO) and Tenancy programmes. These sessions were held on Tuesday and Thursday mornings, and Friday afternoons respectively. He also later attended the Men's Healthcare sessions.
44. On 31 May, the man attended his first LIHMO group work session which was run by the first residential support worker (RSW). She told my investigators that initially the man told her he felt stressed and was unsure if he would participate in the group. He said he had several meetings to attend with his solicitor and barrister about his case. She told him that no pressure would be put on him, but he decided to attend. He participated fully, was talkative and contributed well throughout. Unfortunately, the following day, due to a prearranged appointment, the man was unable to attend his first session of the Tenancy Support programme. On 4 June, he did attend the Men's Health session where staff said he once again participated well.
45. The first RSW described the man as someone who kept himself to himself and who stayed in his room a lot of the time. Staff were aware of his routine and his responses to their regular interactions allayed any concerns that he was

isolated. The man mixed with other residents at tea times and was frequently taken out on Saturdays by his son.

46. A further resident's review meeting was held on 5 June. It was noted that the man stayed in his room a lot, was quiet and withdrawn. He was older than the other residents and was the only one who was awaiting trial. The man said that he was worried about his court appearance as he expected to receive a custodial sentence. Aside from this, he complied with the hostel rules and attended the LIHMO and Men's Health group sessions. He was expecting his social security benefits very soon which would be used to pay his hostel rent.
47. The man's hostel medication record for 5 June recorded that he handed in a packet of 20 co-codamol tablets. There is no record that he used them and the medication remained untouched.
48. On 7 June at 6.00pm, the man went to his keyworker meeting and, as usual, was on time. He said he had now settled in well to the hostel and had attended a number of the group work life skills sessions. He had an interest in working in the garden and had joined the garden party team. The key worker told my investigators that they talked at great length about the man's concerns about his court case, including any media interest that it might attract. To allay any fears, the key worker reassured him that the hostel would take steps and deal with any matter immediately, should anything untoward occur.
49. Another LIHMO session entitled Stop & Think was held on 12 June. Although the man attended, staff noted his participation was limited and he was quiet throughout most of the session. At the next LIHMO session two days later, his mood appeared to have improved. He was described as his normal self, and participated fully with the work and enjoyed the session.
50. The manager of the hostel had occasional contact with the man. He told my investigators that the man spent a lot of time by himself in his room. From the few conversations they had, he was aware that the man's alleged offence had caused a rift in his family. This caused him a great deal of depression initially, and he was very pleased when his sons subsequently said they were prepared to talk to him. The man's son came to see him on Fathers Day (Sunday 17 June), and the hostel manager said that he noticed a change in his mood afterwards. The manager referred to the man as a changed individual, although he was still quiet and spent a lot of time in his room reading or talking on his mobile phone.
51. The hostel manager said that he continually reminded staff to keep an eye on the man to make sure he was well because, by staying in his room, he was not seen as frequently as other residents. No concerns were ever raised by staff and it was simply believed that the man was of a quiet nature.
52. At the keyworker meeting on 18 June, the man said that his two sons had come to visit him on Father's Day. He was very pleased about this and welcomed the opportunity to spend time together. The man was still apprehensive about his forthcoming court case on 19 June. His only request was to be allocated a

single room. His keyworker concurred with the request and judged that the man was a quiet individual who kept himself to himself. He told him that there was no issue about a single room being allocated and he would be in line to receive the next to become available. Later that day, the man attended another of the Men's Health sessions where it was noted that he contributed well and showed motivation.

53. At the resident's review meeting on 20 June no concerns were raised about the man. He was said to be compliant and there was no change to his circumstances since the last review meeting.
54. Between 21 and 26 June, the man attended LIHMO and Men's Health session groups, where he participated and enjoyed the workshops. On 29 June, he was unable to attend the Tenancy Support group session because of a pre-arranged appointment at the Job Centre. Not wanting to have missed out, the man arranged to go through the contents of the workshop with a member of the hostel staff when he returned. The following week (3 July), he attended a further LIHMO session. Once more, there were no concerns about him as he fully participated and was positive.
55. The man's request for a single room was granted on 6 July. He had a keywork meeting at 12.00pm and told his keyworker that he was quite happy in the hostel and had settled into his new room. He was next due to appear in court on 17 July for a plea and management hearing. The man was receiving his social security payments and his hostel rent was paid up to date. He told his keyworker that he would not be looking for employment for the time being. The keyworker asked him if there was anything he would like him to do or look into for him, to which he responded that there was not.
56. Over the next couple of days, the man attended the last sessions in the programmes for the Tenancy and Men's Health workgroup and it was recorded that he contributed well throughout.
57. At the resident's review meeting on 31 July, staff once more noted that the man liked to keep himself to himself. He was seen but rarely heard. He had now completed all life skills group work and continued to comply with the hostel rules. There were no issues or concerns relating to drugs, alcohol or mental health. The only concern mentioned at the meeting was that he was in rent arrears amounting to £47.
58. In the absence of the man's keyworker, who was on long term sick leave, the first RSO conducted a keywork session with the man at 2.45pm on 10 August. The man still spent a great deal of time in his room but, when asked about his well being, said he was fine. He was due to see his solicitor in a week's time as his trial, which he had been told might last about five days, was due to begin very soon. The man said he had no issues that the hostel staff could help him with at present.
59. On 24 August, the first RSO conducted his second keywork session with the man. Since arriving at the hostel, the man had had a number of meetings with

his solicitors and barristers. The first RSO noted on the hostel contact sheet that the man was okay. At a recent meeting with his barrister, the man had been told his trial would start the following week. The RSO told my investigators that, conscious of the man's forthcoming trial and knowing he spent a lot of time alone, staff ensured that they continued to engage with him and offered further support.

60. On the morning of Tuesday 28 August, the second RSW, the third RSO and the first RSO were in the office. The man came in and asked for a loan of around £4 to travel to court and this was agreed. The second RSW's shift came to an end and he left the hostel. Very soon afterwards, the man's son met him at the hostel and they made their way to the court.
61. The third RSW was also on duty in the evening of Tuesday 28 August. He described the man as someone who kept himself to himself, but who always came out at meal times. He told my investigators that staff were concerned about quiet residents who could become isolated. However, this was not considered to be the case for the man who talked to staff whenever he came into contact with them. He was one of the few mature residents and the RSW believed that was why he did not socialise with the other younger residents. All the other residents had already served a custodial sentence and were not awaiting their trial date.
62. The third RSO and the first RSO were in the office at around 5.50pm when the man returned from court. He came to collect his room key and evening meal. Having been in court for the day, he had missed the meal time and his food had been saved for him. Both the first and third RSOs engaged in general conversation with the man. They discussed his entitlement to a loan for bus fares which the third RSO said they would arrange. The man told them that his son would collect him the following morning to accompany him to court. He asked whether his son could leave his car outside the hostel from where they would take public transport to court. The third RSO told him that, although he could not park in the hostel car park, there was ample space on the road.
63. The first and the third RSOs told my investigators that they also asked the man how his court case had gone. The man said that the day was quite uneventful. It had taken until around 3.45pm before the jury were sworn in whilst the prosecution and defence barristers sorted out the logistics of the case. The third RSO said that they had quite a lengthy conversation about events, and the man was very forthcoming with information. The third RSO was aware that court appearances can have a negative impact on an individual's mood, but had no concerns about the man. He described him as his normal self during their conversation. The fact that he was making arrangements for the following day reinforced the impression that there was no cause for concern.
64. The third RSW arrived at the hostel around 8.00pm for her night duty. On arrival, she read the day log and had a handover talk with the third RSO. The RSW told my investigators that the third RSO went through the events of the day, which included the fact that the man was to be given £9 bus fares to travel

to court. The third RSO's duty ended shortly after the handover was completed and he left the hostel for the evening.

65. Around 9.00pm, whilst serving supper, the third RSW had a fall in the kitchen and pulled a muscle in her back. She served the supper and then returned to the office. The second RSW had returned to the hostel for his night duty shift and the third RSW asked him to hand out the medications to residents as she did not want to aggravate her injury any further.
66. The second RSW also carried out the 11.00pm hostel curfew check. The hostel was locked for the night and he checked that all residents were present. The procedure for the check does not stipulate that the member of staff has to go into a resident's room to see the resident. The second RSW told my investigators that, when he conducts curfew checks, he sometimes goes into a resident's room, especially if the resident is new to the hostel and not known to him. If he is familiar with a resident and knows their voice he would not necessarily enter their room. Double occupancy rooms were always entered when carrying out checks.
67. The second RSW said that it was normal for the man to be in bed quite early. When he got to his room, he knocked on the door and asked if he was okay. The man replied through the door and said that all was well. The RSW said he did not notice anything untoward about the way the man responded.
68. There were no issues or concerns noted throughout the night and nothing unusual was detected by the night duty officers on the CCTV. As usual the second and third RSW's completed a number of their administrative duties.
69. The following morning (29 August 2007), the man's keyworker began his duty at 7.30am and was updated in the office by the second and third RSW's. At 7.45am, the second RSW left the office to wake up residents. The wake-up call is for residents to come downstairs for their breakfast and to attend the morning meeting which starts at 9.00am. This was a routine carried out every day at around the same time. The keyworker made his way to the kitchen to make a cup of tea.
70. The man's room was one of the first that the second RSW reached. He knocked on the door, but did not get a response. As expected the door was locked, so he unlocked it and went inside, again calling the man's name. There was still no response and the room was dark as the curtains were closed.
71. The second RSW switched the light on and saw the man lying face down on the bed with an inflated transparent polythene bag over his head. As he moved closer to the bed, he saw that the man did not appear to be breathing. The second RSW also noticed what looked like a boot lace around the bottom of the bag around the man's neck. He immediately tore the bag open and felt that the man's arms were cold. The second RSW, who was not first aid trained, then ran to the office downstairs for assistance.

72. The second RSW arrived at the office within seconds, told the third RSW that he had found the man with a bag over his head and asked her to ring for an ambulance. The third RSW, aware that the man's keyworker was in the kitchen, quickly informed him of the discovery so that he could assist whilst she called an ambulance. The keyworker is first aid trained.
73. The keyworker told my investigators that he grabbed the resuscitation mask equipment from the office and quickly made his way to the man's room. The second RSW had returned and was standing outside, looking shocked. The keyworker said they both entered the room. He saw the man lying in a normal sleeping position, with his arm and foot hanging out of the bed. The second RSW told my investigators that he touched the man's arm and it was cold, clammy and grey. The keyworker said the man's feet were cold, but his chest was warm. He confirmed that an ambulance had been called, and then laid the man on his back to check for signs of life. Whilst the keyworker was doing this, the second RSW continued with the wake up call to check on the other residents.
74. The keyworker took the bag off the man's head and untied the black lace that was round his neck. He rolled him over again and checked for signs of life. The man was not breathing so he removed him from the bed, feet first, on to the floor. He lifted the man's top half down and proceeded to carry out cardio pulmonary resuscitation (CPR).
75. The third RSW telephoned the ambulance service and explained the situation. She was told by the paramedic to go to the man's room with a mobile phone so that she could pass on instructions to the keyworker. She locked the office and quickly made her way to the man's room. When she arrived, she described to the paramedic what the keyworker was doing and they passed on instructions to be relayed to him regarding life support. As she is also first aid trained, she was aware of what was happening.
76. Within ten minutes of the man being discovered, the ambulance arrived at 7.55am. The police followed at 8.00am. The paramedics took over trying to resuscitate the man but unfortunately their attempts were without success. Shortly afterwards they declared that the man had died.

Events after the man's death

77. The police sealed the man's room so they could carry out their investigations. The hostel manager had already been informed by the third RSW at around 7.55am about the events of the morning. He arrived at 8.30am to find the police and ambulance crew in the hostel. He was immediately briefed by the police, paramedics and hostel staff.
78. The hostel manager told my investigators that, once he was aware of the current situation, he immediately downloaded the death in hostel procedures from the probation intranet. He followed the instructions and contacted the various agencies that needed to be informed. The hostel manager also called the SPO of a neighbouring hostel for support. She had past experience dealing

with deaths in Approved Premises. The SPO soon arrived at the hostel and helped to support staff and residents. The deputy manager was notified and, although she was on annual leave, came into the hostel to offer support. The hostel manager also ensured that staff made statements as soon as they could to record the events of the morning.

79. The man's son arrived soon afterwards to take his father to court. The keyworker saw him approach the hostel and quickly left the building to meet him. He was introduced to the police who informed him about the death of his father. The man's son was naturally distressed at learning this news and telephoned his brother. Staff then offered him support, in between the police and paramedics speaking to him.
80. There was an unusual level of activity in the hostel and so the hostel manager gathered the residents together for their 9.00am meeting. He announced that the man had been found dead and that the police were still carrying out their enquiries. The residents were shocked at this news and, throughout the day, the hostel manager, his deputy and the fellow SPO, supported them and the staff. Counsellors were made available should any one, including staff and residents, need extra support. The second RSW and the keyworker were offered compassionate leave should they wish to take it. The hostel was also visited by the Chief and Deputy Chief Officers of the Greater Manchester Probation Area.
81. The man's body was removed from the hostel around 11.00am. Later that day, after the police had left the hostel and things had settled down, the hostel manager conducted a briefing meeting to give staff the opportunity to discuss any issues arising out of what had occurred. The staff sat down together and described their experiences and what had happened. They all offered support to each other.
82. Later that day, the deputy manager opened an ACT document on a resident whom she felt needed extra support due to the death of the man. This resident had taken the man's death quite badly as he considered the man to be like a father to him.
83. A couple of days after the man's death, the hostel manager arranged for his room to be thoroughly cleaned. He collected the man's personal belongings (including his mobile phone), neatly folded his clothes and placed them in a suitcase. He also bought some flowers and a condolence card which was signed by all the staff.
84. When the man's son came to collect his father's belongings, he thanked the hostel staff for their help in looking after his father. He gave the hostel manager a thank you card to this effect and donated the portable television that was amongst his father's possessions. The man's son also told the hostel manager that his father had apparently sent a text message to a friend at around 1.30am the morning before he was found. The message gave no indication that he was in distress.

85. The man was cremated the following week. His son gave an invitation to the hostel manager to attend the funeral, but unfortunately he was due to be on annual leave at that time. Staff made a collection and arranged for a wreath to be sent on their behalf. The residents had a collection and have arranged to use the proceeds to plant a tree in recognition of the hard work the man had put into garden.

Post Mortem

86. The post mortem report is still awaited from the Coroner.

ISSUES RAISED IN THE INVESTIGATION

Knowledge of the man's previous self harm attempt

87. The hostel received information from the court about the man's previous self harm attempt whilst in prison custody. There had been no further incidents whilst he was in prison and the ACCT procedures were closed two months earlier. Being familiar with the ACCT process, and able to operate a similar process within the hostel, staff took appropriate action to assess any current thoughts of self harm with the man as part of his induction. He was anxious but staff ensured his induction was carried out swiftly to help him ease into hostel life. Appropriately, in my view, they did not consider that an ACT document was required.

The man's interactions with staff

88. I am pleased to say that staff had positive interactions with the man on a regular basis. Evidence suggests that, even prior to arriving at the hostel, he was a quiet man. When in prison custody he spent a lot of time in his cell, and this was mirrored during his time at the hostel. It would have been easy for staff to have overlooked him because of his age and quiet nature. In fact, staff had frequent contact with him, checking on his well-being and offering support.
89. Despite being on bail and having different circumstances to all the other residents, the man was included in all activities and was offered support on a regular basis. He gave no indication of distress or of appearing anything other than his normal self to the staff to whom he spoke.

I commend the staff at the Approved Premises for their continued efforts in ensuring the man was supported, and treated fairly and well.

First aid training

90. The member of staff who discovered the man was not first aid trained and therefore could not immediately perform CPR. However, the other two members of staff on duty were first aid trained and worked quickly together by calling an ambulance and then carrying out resuscitation. Given their prompt response, there was only a minimal delay in the man receiving life support.
91. In spite of the above, I believe all hostel staff should be first aid trained so that they can attend to someone in a life threatening situation, immediately. This is even more important during the night when only two members of staff are on duty.
92. I am pleased to add that since the man's death, the Probation Area has reviewed first aid training of all staff and measures have been put in place to ensure all staff complete or take refresher first aid courses.

Actions of staff after discovering the man

93. Having raised the alarm with staff in the office, and then momentarily returning to the man's room, the second RSW continued the wake up call for hostel residents. On the one hand, it was necessary to confirm the well-being of all other residents. At the same time, the keyworker was left in a room by himself without anyone at the open doorway to ensure no unauthorised entry or untoward attention from other residents. I am pleased to note that nothing untoward occurred. Staff should however be aware (as stated in the Prevention of Sudden Deaths in Approved Premises guidelines) that in such instances they should "keep the area as free as possible from other residents and unnecessary staff".
94. I make no criticism of the member of staff who discovered the man. I also make no formal recommendation on this matter. However, the manager of the hostel may wish to review the contingency plans to see how such a situation could best be managed in the future.

Death in Approved Premises Action list

95. The hostel manager had not previously experienced a death in an Approved Premises. On his arrival at the hostel, the death in approved premises action list had to be downloaded from the probation intranet so that he could begin to take appropriate action. He quickly set about his task of ensuring that all the correct action was taken.
96. Should the probation intranet not have been available, there might have been a delay in making sure that all the correct authorities had been informed. This was not an issue in this particular case, and downloading the action list provided the most recent and up-to date procedure. For someone unfamiliar with the circumstances, such as the hostel manager, this was no doubt the best option to take. However, I suggest that the action list should also be accessible in hard copy format within the hostel office (and checked regularly to ensure it is up to date).

Support for family and staff

97. The man's son was told of his father's death almost immediately as he arrived at the hostel to collect him for court. The hostel staff were on hand to offer support. The hostel manager was also able to offer the hostel's condolences in the quiet confines of his office.
98. The hostel manager contacted an SPO from a neighbouring hostel who came to the hostel to offer support. The deputy manager, although on a day's annual leave, also came to the hostel to assist. The services of a counsellor were engaged for any member of staff or resident who felt they needed further support. From interviews with staff, my investigators found that the level of support was ongoing, and both welcomed and appreciated.

99. I think it was good practice on the hostel manager's part to contact a more experienced SPO for support, and it was commendable that this SPO made herself immediately available. Similarly, the hostel deputy manager made herself available to assist throughout the day. I cannot overstate how valuable such support is when a death occurs in the circumstances described in this report. I am also pleased that the Probation Area's most senior managers attended the hostel very quickly after the man's death to offer their support. There is much in all this of which the Greater Manchester Probation Area can be proud and I hope this will be drawn to the attention of the Probation Board for their consideration.

CONCLUSIONS

100. Due to the good information sharing arrangements, hostel staff were aware of the man's background, including that he had harmed himself, before he arrived at the Approved Premises. When he did arrive, the man had some anxiety about staying in a hostel. However, he was relieved not to be in custody as he now enjoyed the benefit of being able to have more regular contact with his friends and family. Staff welcomed him and helped him to settle and participate with the regime. The man appeared to benefit and he enjoyed being involved in the programmes the hostel offers.
101. Throughout the man's stay at the hostel, he remained a quiet man who liked to stay in his room. However, when not in his room, he would socialise with others in the hostel and was never shy of conversation with staff. His behaviour was that of a model resident. For their part, staff provided a high level of support. The man gave staff no indication of particular distress or cause for concern. He maintained this attitude right up until the last contact he had with staff the evening before his death, and just hours after appearing in court for the start of his trial.
102. There is no merit in my speculating what may have been the man's actual state of mind, or whether his mood changed during the night of 28/29 August 2007. He was aware that a custodial sentence was likely to be imposed, but attending court may have made him realise what might unfold during and after his trial.
103. I do not believe that the death of this man could reasonably have been anticipated by those responsible for his care.