

**Circumstances surrounding the death of an  
Approved Premises Resident  
In August 2004**

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

**November 2004**

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### **FOREWORD**

This is a report of an investigation into the death of a resident at a National Probation Service Approved Premises. The investigation was occasioned by the death of the resident, apparently at his own hand, in his room during August 2004.

The purpose of my investigation was to establish whether the care given to the resident was adequate, and whether the risk of self-harm had been properly assessed and managed, so far as it was possible to do so.

Two members of my investigation team carried out the investigation. I am grateful for the assistance and co-operation the investigators received from the Probation Area and, in particular, from the Manager and staff at the Approved Premises who were deeply affected by the resident's death.

It was very clear to the Investigators that this tragedy had also affected all the residents, particularly those who knew the resident well. Feelings of disbelief and shock were very much at the forefront of their minds. I am grateful for their willingness to assist the Investigators by speaking openly and willingly, not only at such a sad time, but when the demands of their licences or conditions of sentence/bail required that they remain at the Approved Premises.

The loss of a child is something that most parents do not expect to have to bear. Although the resident's mother indicated that her son's death was not entirely unexpected, her grief was no less intense. I am most grateful to her for the background that she provided to the Investigators and for a very informative letter that must have been difficult to write. I offer my sincere condolences to the resident's mother and to her family.

The Investigators conducted formal interviews with an Assistant Chief Officer, the Manager of the Approved Premises, the Deputy Manager, four other members of staff and with six hostel residents. The interviews were not recorded but the Investigators' notes have been agreed and signed by all but one interviewee.

The Investigators obtained information by telephone from the Unit, where the Resident had been treated before his remand to the Approved Premises, and the Client Support Services Manager of a vocational training centre attended by the Resident. They examined a number of documents provided by the Probation Area.

The report is organised as follows. Part 1 provides some personal details about the Resident and background information about the Approved Premises. Part 2 considers, as far as it is possible to do so, the circumstances leading to the Resident's death. My conclusions and recommendations are presented in Part 3. As the reader will find, it is a sad story with an almost inevitable conclusion.

**STEPHEN SHAW**

PRISONS AND PROBATION OMBUDSMAN

NOVEMBER 2004

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## **SUMMARY**

The Resident was a young man who had used alcohol to excess for some time. His mother said that he was unable to control his drinking but did things under the influence of alcohol that he was ashamed of when sober.

The resident was initially charged with an offence of affray and was remanded on bail by the Magistrates' Court with a condition to reside at the Approved Premises. Subsequently, he was charged with further offences. He was due to be sentenced in July 2004 but sentencing was delayed. The Resident was

also due to report to a Police Station on the day after he died to ascertain if there would be a further charge.

The referral to the Approved Premises indicated that there had been a previous attempt by the Resident to take his own life. Therefore, it was decided to place him in a shared room to minimise the risk he posed to himself by managing the time he would have to spend alone. However, the Resident was aware that his roommate would be away from the house overnight, on a date in August.

It was known that the Resident was anxious about attending the police station but he had also arranged to meet his mother, with his children, and he had told several people how much he was looking forward to seeing them.

The Resident was last seen, by staff in the house, at about 11.30pm on 16 August when he left the communal area and went to his room for the night. He had been watching other residents play pool and the Probation Residential Officer's (PRO) impression was of a contented young man in a fairly jovial mood.

The PRO on duty overnight completed his rounds at approximately 1am and 2am and, on each occasion, all was well. However, on his third round about an hour later he saw the Resident's door slightly ajar with his (the Resident's) shoulder in the gap. Having tried, unsuccessfully, to rouse the Resident, the PRO woke his sleeping colleague, called the emergency services and returned to assist the Resident. Sadly, he was beyond such help and when the emergency services arrived, the Resident's death was confirmed.

This Investigation has confirmed that the risk the Resident posed to himself was properly identified and the information was shared appropriately with hostel staff and the outside agency working with him. The identified risk was to be managed by placing him in a shared room and monitoring his behaviour. I did not identify any changes in practice or procedure that might have helped, directly, to prevent the Resident's death. Nevertheless, there are lessons to be learned and I have identified areas where systems could be improved. I have made 4 recommendations that can be found in Part 3, section 2.

## **THE CIRCUMSTANCES AND EVENTS SURROUNDING THE RESIDENT'S DEATH**

### **PART ONE - Background Information**

#### **Section 1: The Resident**

1. The resident was born in 1978. He was said to have experienced a troubled childhood and adolescence. His mother said he had suffered with depression for some time and that he had, "*been wanting to leave this world for 16 years*". She said he had made several attempts to do

so, from the time he was at school when he took a large number of paracetamol tablets in the presence of school friends.

2. He met his partner when he was aged 17 and they stayed together for some three years, having two children now aged five and seven years. When the relationship ended, the children stayed with their mother but the Resident remained close to them and had as much contact as he could.
3. After the breakdown of the relationship with his children's mother, the Resident accrued four convictions between 1998 and 2002 involving six offences that were all committed when he was under the influence of alcohol. He drank more when he was depressed and his mother told the Investigator that her son could not deal with his misuse of alcohol, under the influence of which he did things that caused him to be deeply ashamed when sober. The Resident was described by the author of a pre-sentence report as hating the way he behaved but despairing of finding a long-term answer to his problems.
4. He had been in hospital on several occasions and, most recently, had been an in-patient under the care of a consultant psychiatrist, until February 2004 when the doctor decided that the Resident's problems arose from the misuse of alcohol rather than an identifiable mental illness. The Doctor referred the Resident to a unit within the NHS Trust Area's Alcohol Service and he commenced an alcohol relapse prevention course in April.
5. In May, the Resident was allocated a place in a Housing Project where he remained until his arrest. He was also prescribed antabuse at that time. In June, when the resident informed the Unit that he had been arrested and remanded to Approved Premises, he was discharged as he was no longer in the NHS Trust Area. The Unit had no further contact with him.
6. The alleged offence of affray occurred in June 2004 when the Resident had been drinking heavily, in a hostel where he was temporarily housed. He appeared before the Magistrates Court in June and the Court Officer referred him for bail placement at the Approved Premises, by completing and faxing a referral form to the premises. The form indicated that he was a binge drinker, "either alcohol free or lots." There was information that he had used drugs in the past although there was no sign of current drug use. The Resident told the referring officer that he had a history of self-harm, cutting himself when he was depressed and under the influence of alcohol.
7. The form referred to an "old attempt" that the Resident had made to hang himself by a cord in police cells but he said he had little memory of it and no further details were provided apart from a statement that there were, "no concerns at this time." The Resident had been assessed by a Community Psychiatric Nurse (CPN) who had also

accessed his records from an alcohol unit where he had previously been treated. The CPN's statement said the writer, "did not anticipate any problems for offender in a hostel setting provided he does not start drinking alcohol. Any self-harm (cutting) is invariably of a minor nature."

8. The Deputy Manager was required to assess whether the level of risk that the Resident posed to himself could be better managed in the Approved Premises than elsewhere. He did so on the basis that the alternative seemed likely to be a remand in custody and there was evidence that the Resident had reacted badly when he was previously in a police cell. The Deputy Manager agreed to accept the Resident, provided he was made subject to extra conditions of bail including, to take no alcohol on or off the premises, to agree to random drug testing and to participate in hostel programmes. The Resident agreed to all the extra conditions and the Magistrate granted bail.

## **Section 2: The Approved Premises**

9. Probation 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. Their purpose is to provide accommodation for persons granted bail in criminal proceedings and in connection with the supervision and rehabilitation of persons convicted of offences. Hostels can provide a supportive, structured environment in the community for high risk and difficult to manage offenders. The supervision of offenders accommodated in Approved Premises is governed by the National Standards for the Supervision of Offenders.
10. Approved Premises operate on each day of the year with 24 hour staff cover on a rota basis. The Approved Premises in this case is a large, pleasant house set in attractive grounds in a quiet, residential street. The hostel has 29 places and is managed by a Senior Probation Officer. There is a Deputy Manager and a team of nine staff members, responsible for the daily management of residents.
11. The Approved Premises has an open admissions policy based on assessment of risk. Potential residents are refused only if significant, unmanageable, risk is identified to the community, to other residents or to staff, or if a proper assessment cannot be made due to lack of information. Where potential residents are charged with violent or dangerous offences, the facts of the case and information about the individual are considered carefully before a decision is taken. This was so in the Resident's case.
12. Residents are required to pay rent and to ensure that the hostel can obtain payment, if necessary, directly from benefit. The hostel provides a programme of activities and groups, in which all residents are expected to participate. As required by directions in the Approved

Premises Handbook, the hostel retains all prescribed medication and dispenses it to residents at the required intervals to ensure that there is no misuse.

13. Residents are allocated key workers who are expected to meet with them weekly, to identify any issues of concern and to assist where possible. There is also an expectation that, when offenders are subject to statutory supervision, information will be shared regularly with probation officers in the field, who are Case Managers and responsible for decisions about the management of offenders. The Resident had no Case Manager as he was not subject to a community order.

## **PART TWO - Events leading up to the Resident's death**

### **Section 1: The Resident's stay at the Approved Premises**

14. The Resident arrived at the Approved Premises as required in June and went through the induction process when the rules and safety regulations were explained to him. He was reminded that neither illicit drugs nor alcohol were allowed on the premises. The Resident had been prescribed medication as follows:  
  
Citalopram 60 ml. daily  
Zopiclone, 1 at night  
Acamprosate 2 x 3 tablets daily  
Antabuse, one each evening.
15. He was required to hand in all this medication for staff to dispense daily. The medication log indicates that the Resident was given the medicines daily, as required, until the night of his death. Arrangements were also made for him to be treated by the local G.P. who treats all residents in the house.
16. The Deputy Manager allocated the Resident a shared room in order to minimise the risk of self harm by ensuring that he would spend as little time as possible alone. On the same day in June, the Deputy Manager interviewed the Resident and talked about the circumstances that had led him to be bailed at the Approved Premises, stressing the expectation of sobriety. The Resident signed the hostel rules and the Deputy Manager completed a Suicide Risk form, stating that the Resident agreed he had tried to hang himself in a police station although there was no indication as to when the attempt took place.
17. The Deputy Manager also completed the Offender Assessment System (OASys) screening, identifying the risk of suicide, self harm and vulnerability and confirming that these risks would increase if the Resident used alcohol. The Deputy Manager signed and dated the form on that day and stated that other staff were required to take note of its contents.

- 18.** The Resident was originally due to be sentenced towards the end of June but, on that date, he was remanded again to a date in July for a pre-sentence report. Although the report was prepared in good time, for some reason it did not reach the Court. The Resident was last in Court on at the end of July, when he was remanded for sentence to the end of August 2004.
- 19.** Members of staff and other residents at the Approved Premises told the Investigators that the Resident settled well, striking up a friendship with his room-mate and with some other residents. Subsequently, both the Resident and his roommate were asked if they would prefer to transfer to single rooms but both declined. The Resident was referred to a large Vocational Training Centre, providing a high level of support and training for those with substance abuse difficulties, where staff knew of the Resident's depression and his misuse of alcohol. He attended daily.
- 20.** The Investigators were told that the Centre works very closely with the Approved Premises, and in an atmosphere of mutual trust and confidence provides regular reports on the progress of residents who are in attendance. The Client Support Services Manager said that the Centre's experience of the Resident over the three months he was with them was of a quiet, competent young man. The Resident's key worker at the Centre said that he had made a toy for his son together with a complicated piece for his mother and added that he stood out from the crowd because of his good manners and polite attention.
- 21.** Without exception, all those members of staff and residents interviewed by the Investigators described the Resident as a likeable, helpful young man. It was said that he posed no problems during his residence but the hostel log noted that, on a day in July, he was seen to be under the influence of alcohol when he became somewhat abusive in his manner towards members of staff and activated the fire alarm. The following day, he was given and signed a formal warning stating that further such behaviour would lead to exclusion.
- 22.** The warning appears to have served its purpose, as there were no further reports of less than acceptable behaviour from the Resident. None of the staff members who were interviewed were aware of any subsequent use of alcohol by him and told the Investigators that he had complied with requirements. From all that they were told, it was clear to the Investigators that the Resident was a popular, well behaved young man who took his medication regularly and showed no overt signs of depression. Indications were that he was, on the whole, managing to control his alcohol dependence and he gave no further cause for concern.

## Section 2 – The events in August.

23. On 16 August, the resident attended the Centre with a number of residents. They noted that he was quiet throughout the day and did not engage with them as usual. His closest friends believed that he was very concerned about the possible outcome of his forthcoming visit to the police station. He was also worried about how he would get there on time as he had misplaced his wallet, leaving him insufficient funds to pay for travel expenses.
24. The Probation Residential Officer responsible for the day to day administration of the Approved premises' business recalled taking a telephone call from the Resident during the day. He wanted to know if he could have a travel warrant for the next day and he was told that the request would be forwarded to the Deputy Manager for consideration. Later, the officer realised that the Resident had called her by a familiar term that he would not, normally, have used and she found this to be out of character for him.
25. The Deputy Manager last spoke to the Resident around 4.45pm. Knowing that the resident would have to leave the premises early the next morning, in order to catch his train, the Deputy Manager gave him a travel warrant for the next day. He appeared to be more cheerful, talking more positively about the future and describing the go-kart and coffee table that he was making for his family.
26. Later in the evening, the Resident spent some time outside the premises with another resident, talking and smoking. He was described as having cheered up considerably and the other resident described him as, '*having a laugh*'. Later still, around 10.15 he was seen by two PROs in the office when he came to ask if they would like to play pool. Although both declined, they recalled that he appeared relaxed and happy. However, one PRO told the Investigators that, after the resident's death, she recalled that he had addressed them in more familiar terms than she would have expected.
27. The Resident remained in the common room with two other residents until around 11.30 when the duty PRO told them it was time to go to their rooms. The Resident went to the office for his medication and there was some jovial banter with the night duty PRO. He enquired about his roommate and was told that the man would not return to the house that night, as his mother was sick in hospital. The Resident commented that his roommate had had a bad week but did not seem concerned that he would be alone that night. The three men left the common room together and went upstairs where, in the corridor, the Resident asked if he could borrow a lighter until the next morning. He was given one, said goodnight and went to his room.
28. The PRO on waking duty that night said that he checked all parts of the premises, as was required, around 1am and 2am when all was well

and the doors to residents rooms were closed. He was required to walk round the premises hourly, to ensure that residents were in their own rooms and the building was secure. Although he would listen at doors from time to time, if he were suspicious, he was neither required nor allowed to knock or open doors as a matter of course. Although the nightly rounds are hourly, the PRO said that he varied his rounds by 5 or ten minutes each night. The times of the rounds are entered in the premises' log and may be checked on the CCTV monitors, if necessary. On his 3<sup>rd</sup> round, at about 3 am the PRO noted that the Resident's door was slightly open and he could see his shoulder in the gap. He wondered if the Resident had been drinking or had an accident and fallen to the floor. The PRO said that he called something like, "come on," but after getting no response he tapped the Resident on the shoulder.

29. When there was still no response, the PRO pushed the door further open and saw blood on the Resident's leg. He then observed that there was a belt tight around the Resident's neck and fixed to the door. From the Resident's colour and position, the PRO thought that he was dead so made no attempt to either touch or move him. He went, immediately, downstairs to the office where he had left his radio and called his colleague who was the sleeping-in member of staff.
30. The PRO returned to the Resident's room where he waited for his colleague who arrived after a minute or so. Together they entered the room where they saw bloodied tissues and broken razors. An ambulance was called and the staff members were asked to move the Resident away from the door. Between them, they carefully removed the belt and gently laid the Resident on the floor. As they did so, they noticed various cuts on his legs that appeared to be self-inflicted. Both PROs said it was clear that the Resident had died and one told the Investigators that he was cold and blue. The Resident's death was confirmed by the emergency services when they arrived. The night duty PRO identified the body to the police.

### **PART THREE – Consideration and Conclusions**

31. It was my role to examine the level of care provided for the Resident during his time at the approved Premises and to consider whether the risk of self-harm had been assessed and managed. I am satisfied that the risk was properly assessed and that the Resident was treated with care and compassion during his period of residence. The Resident's mother said that he had described his stay at the premises as the happiest he had been for some time, and I have no doubt that the actions of the Approved premises' staff contributed to his sense of well being for a time. The reasons why he would have wished to take his own life, if he did so, remain something of a mystery.
32. The Resident was at the Approved Premises for almost 10 weeks, perhaps longer than a resident would usually be expected to remain

without a community order being made. The Investigators noted that, although a detailed risk of harm to self-assessment was undertaken on his admission, this was not reviewed before his death. The Assistant Chief Officer (ACO) explained that an OASys assessment is undertaken with an offender post conviction and would be reviewed every 16 weeks as part of normal case review procedures. Staff in Approved Premises in the Probation Area are under instruction to raise only a Risk of Harm assessment on those who are unconvicted.

33. However, the ACO confirmed that there is also clear instruction that significant changes should trigger an update whatever the status of the offender. In the Resident's case, no significant change was observed. None of the factors noted as exacerbating the risk was present and I am satisfied that Area instructions were complied with. Nevertheless, as bailees have no Supervising Officers or key Workers, the management of risk rests entirely with Approved Premises staff. Consequently I believe there should be regular, formal, recorded reviews of those considered to be at risk of harm to themselves, whatever their status.

**I recommend that the Probation Area reviews its instructions and considers implementing a practice of up-dating and recording risk assessments and management plans at shorter intervals for those identified as posing a risk to themselves.**

34. Probation Circular 40/2004, 'Strategy for Preventing Sudden Deaths in Approved Premises', issued in July 2004, requires Probation Areas with Approved Premises to devise a strategic plan to reduce incidents of sudden death in Approved premises within the Area, by November 2004. When the Investigators inquired about the Area's response to the circular, they were told that there was no suicide prevention policy although the strategy required to support implementation of the Circular was under development. No doubt this work will be completed within the required time scale.

**I recommend that the Probation Area issues a reminder of the contents of Circular 40/2004 to the Managers of Approved Premises together with information & guidelines about the Area suicide prevention strategy when complete.**

(Since completion of the report, Merseyside Probation Area has circulated the information to all Approved premises Managers with the Area Strategy for Preventing Sudden death which was submitted to the National Probation Directorate on time.)

35. At the Approved Premises, it is the Deputy Manager's task to undertake an assessment interview within 24 hours of a new resident's arrival. The Deputy Manager is then expected to continue to monitor the resident and to share his ongoing assessment with other staff. It is likely that some or all of those assessments would have, previously, been recorded on contact sheets but the discontinuance of these by

the Probation Area coincided with the Resident's arrival at the premises.

36. A new form of Resident's Record was adopted and came into force on 1 September. Meantime, as a bailee, the only information about the resident was, from time to time, recorded in the hostel log or by word of mouth at times of staff change over. I commend the Probation Area for the introduction of a new record that is clear and comprehensive. Although I have no recommendation to make, I trust that the Area has issued instructions to enable staff to distinguish between what should be recorded in the log and the record, and that responsibilities for recording are clear.
37. My Investigation revealed some inconsistency in the management of breaches of hostel rules and bail conditions. One of the conditions of the Resident's bail was that he should not consume alcohol on or off the premises. However, when he returned under the influence of alcohol on 10 July, he was warned and the court was not informed.
38. I recognise that it is the role of Approved Premises to manage the residents' behaviour and that in doing so account is taken of progress made. I also have no doubt that it was considered to be in the Resident's immediate best interests to remain at the hostel rather than be taken back to Court where, it was possible he would be remanded in custody. However, when one of the Investigators inquired about the number of warnings that residents would be given before being breached, he was told that each case is assessed individually. This implies that some residents might be given both formal and final warnings before action was taken, whilst others could be asked to leave without any formal warning.
39. The Resident was well liked by staff and other residents and was given the benefit of the doubt when he transgressed the rules. I do not suggest that any member of staff at the Approved Premises would treat a less popular resident unfairly, but the potential for discrimination exists. I accept that staff dealing with potentially difficult people on a daily basis must be allowed the discretion to take decisions in the best interests of the hostel and all residents. Nevertheless, the Approved premises should be able to demonstrate that such decisions are non-discriminatory.

**I recommend that the National Probation Directorate reviews its existing guidelines on the enforcement of hostel rules and breach to consider whether greater consistency is necessary and achievable.**

40. The night duty PRO has worked for the Probation Area for almost a year and been at the premises since January 2004. He was clear about his role in supervising residents and dealing with difficulties, but the Investigators were surprised that he did not carry his radio with him when he checked the premises during the night. Radios are issued to

the waking and sleeping members of night duty staff in order that the night duty PRO may summon assistance quickly when necessary. The PRO explained that he did not always carry his radio, depending upon the 'mood' of the premises and whether he had reason to believe that all would not be well. He thought that he had not been instructed to carry the radio with him at all times.

41. The Resident's room was on the first floor and, without his radio, the night duty PRO could not call his colleague until he had returned downstairs to the office where the telephone is situated, thus wasting valuable time. Although there is no evidence that a speedier response would have prevented the resident's death there may be occasions when seconds would mean the difference between life and death for others.

**I recommend that the National Probation Directorate issues a reminder to all Probation Areas about the protocols for carrying and use of radios in Approved Premises.**

**STEPHEN SHAW  
PRISONS AND PROBATION OMBUDSMAN**

November 2004

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