Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ian Bains, a resident at Ozanam House Approved Premises, on 6 November 2023

A report by the Prisons and Probation Ombudsman

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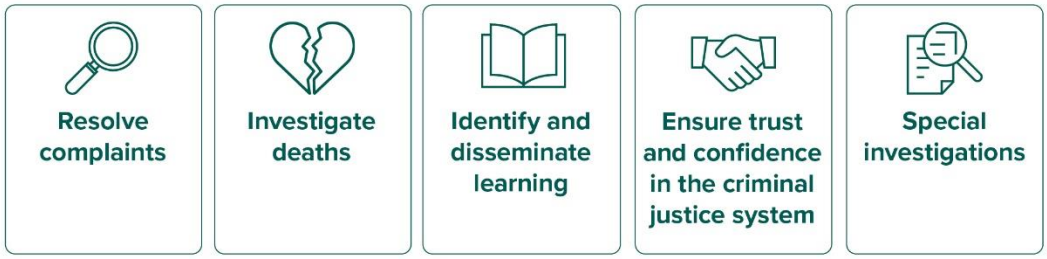
OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Ian Bains, a resident of Ozanam House Approved Premises (AP), was found hanged from a tree in a local park on 6 November 2023. He was 56 years old. I offer my condolences to Mr Bains' family and friends.

This is the only self-inflicted death of a resident of Ozanam House within the last three years.

Mr Bains had been released to Ozanam House after a two-year stay at St Nicholas' Hospital, a mental health unit. He was engaging positively with his community care plan and attended appointments with both the community mental health team and his keyworker. While he had some risk factors for suicide and self-harm, there was no evidence in the time before his death that he was having suicidal thoughts and little to indicate that he was at increased risk. I consider that Ozanam House AP staff could not have foreseen Mr Bains' death.

We make no recommendations.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Adrian Usher
Prisons and Probation Ombudsman **July 2024**

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Summary

Events

1. In July 2008, Mr Ian Bains received a life sentence for murder with a 12-year tariff. Mr Bains had a history of alcohol misuse and related mental health issues but had engaged with alcohol related programmes in prison.

2. On 3 November 2021, Mr Bains was transferred to St Nicholas' Hospital under the Mental Health Act (MHA). St Nicholas' Hospital reported that, during this time, Mr Bains had undertaken positive work and that he was assessed as low risk of harm to self and others.

3. In March 2023, St Nicholas' Hospital reviewed Mr Bains' progress and mental state and authorised a deferred discharge. He was referred to Ozanam House Approved Premises, for a six-month placement. Mr Bains appeared positive about plans to be discharged into the community.

4. On 23 October, Mr Bains arrived at Ozanam House and was inducted by staff.

5. On 6 November, Mr Bains was present for the 7.00am room check. He later left Ozanam House without signing out.

6. At 9.45am, Mr Bains' sister telephoned his keyworker. She told the keyworker that Mr Bains had phoned and said that he had a noose around his neck in Jesmond Dene Park. Staff at Ozanam House reported this to the police, contacted the community mental health team and attempted to contact Mr Bains.

7. Later that afternoon, police notified staff at Ozanam House that Mr Bains had been found hanged from a tree in Jesmond Dene.

Findings

8. We are satisfied that there was nothing to indicate that Mr Bains was at increased risk of suicide and self-harm in the days before his death. Ozanam House staff appropriately used a Support and Safety Plan (SaSP), as well as other information and good discharge planning with St Nicholas' Hospital, to accurately capture and understand his risk factors and potential triggers.

The Investigation Process

9. We were informed of Mr Bains' death on 7 November 2023.

10. The investigator issued notices to staff and residents at Ozanam House informing them of the investigation and asking anyone with relevant information to contact her. No one responded. She obtained copies of relevant extracts from Mr Bains' prison, probation and medical records.

11. An Assistant Ombudsman visited Ozanam House on 29 November and interviewed three members of staff.

12. We informed HM Coroner for Newcastle and North Tyneside of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

13. We contacted Mr Bains' mother and sister to explain the investigation and to ask if they had any matters, they wanted us to consider. Mr Bains' sister asked several questions that are outside the remit of this investigation and which we have addressed in separate correspondence.

14. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies, and this report has been amended accordingly.

15. Mr Bains' family received a copy of the draft report. They did not make any comments.

Background Information

Ozanam House Approved Premises

16. Ozanam House is an independent Approved Premises (AP) funded by the Ministry of Justice as part of St Vincent de Paul Society's AP project. Ozanam House is a psychologically informed planned environment (PIPE). PIPE APs offer expert psychological input from NHS clinicians to help staff better manage service users and are intended to support effective movement through a clear pathway of psychologically informed provision. In addition, residents are expected to register with a GP.

17. Each resident is allocated a key worker and offender manager to oversee their progress and wellbeing and ensure that they adhere to their licence conditions and premises' rules. Staff are on duty at Ozanam House for 24 hours a day.

Previous deaths at Ozanam House

18. Mr Bains was the first person to take his own life while a resident at Ozanam House since 2015. Our investigation into the death of the previous resident concluded that staff at Ozanam House could not have predicted or prevented the man's death.

Key Events

19. On 15 July 2008, Mr Ian Bains was sentenced to life in prison for murder with a tariff of 12 years. Mr Bains had a history of alcohol misuse and completed alcohol related programmes in prison. Mr Bains also had a history of mental ill health and self-harm and attempted suicide.

20. In June 2021, Mr Bains was transferred to HMP Liverpool. He lived in their healthcare inpatient unit, where his mental health quickly deteriorated, and he experienced psychotic episodes. Between June and August 2021, Mr Bains was monitored under suicide and self-harm prevention measures (known as ACCT) on two occasions, after informing prison staff that he believed he was being watched. His records indicate that he cut his throat during a period of psychosis.

21. On 3 November, Mr Bains was admitted to St Nicholas' Hospital under section 47 of the Mental Health Act 1983. Following his admission, Mr Bains was diagnosed with psychosis.

22. From December 2022, Mr Bains began having escorted leave from hospital, with no reported issues. (In May 2023, Mr Bains returned to the hospital intoxicated following a period of unescorted leave, but no further action was taken.)

23. In March 2023, staff at St Nicholas' Hospital reviewed Mr Bains' mental health and authorised a deferred discharge. Hospital staff recommended that Mr Bains should remain an inpatient at the hospital while waiting for a Parole Board hearing, despite not meeting the criteria for detention under the MHA. This decision was made to protect Mr Bains' mental health as he had told the clinical team that if he were to return to prison, he would attempt to end his life. Hospital staff also noted that Mr Bains had demonstrated significant improvement and insight into his mental health.

24. Mr Bains was subsequently referred to a Psychologically Informed Planned Environment (PIPE) Approved Premises (AP), Ozanam House, for a six-month placement. (PIPE APs aim to support the progression of offenders with complex needs and personality-related difficulties.)

25. On 29 June, Mr Bains' probation officer attended a 'Section 117 aftercare meeting' with hospital staff and the Forensic Community Service Team. (FCS, the community mental health service). They discussed Mr Bains' community care plan.

26. On 30 August, Mr Bains attended Ozanam House for a familiarisation visit. He was accompanied by hospital staff. Ozanam House staff gave him a tour of the building and answered any questions with the aim of helping him feel less anxious about his transition to the community.

27. On 28 September, a discharge meeting was held at St Nicholas' Hospital which was attended by staff from Ozanam House, the Clinical Lead, and the probation officer. Mr Bains community care plan and risk factors were discussed. Risk factors included historic self-harm, paranoid beliefs and warning signs of low mood, a lack of motivation and a willingness to engage. The care plan detailed that Mr Bains had no thoughts of suicide or self-harm at the time. The meeting did not highlight any indicators that Mr Bains was currently at increased risk of suicide and self-harm.

28. On 23 October, Mr Bains was released on licence to Ozanam House. Staff at St Nicholas' Hospital proposed a community care plan that included weekly appointments with the forensic mental health team, ongoing relapse prevention work, and regular breathalyser tests, as well as continuing to take his medication. Mr Bains was prescribed medication that included olanzapine (an antipsychotic) and gabapentin (which treats epilepsy and nerve pain).

Ozanam House

29. Prior to Mr Bains' arrival at Ozanam House, his allocated keyworker completed a pre-arrival resident plan and a Support and Safety Plan (SaSP) using information from Mr Bains' records. This detailed Mr Bains' risk factors and warning signs previously reported within his community care plan. Risk factors included historic self-harm, drug and alcohol use, a lack of engagement with support or medication and warning factors included expressing paranoid beliefs, low mood, a lack of motivation and willingness to engage.

30. Upon arrival at Ozanam House, a Project Support Worker completed Mr Bains' induction. She reported that Mr Bains presented as cheerful and that he was happy to be back in the community and was looking forward to moving on. She completed the SaSP assessment with Mr Bains, who highlighted no concerns around thoughts of suicide and self-harm. He reported that he was bullied two years prior, which led to a previous suicide attempt at HMP Liverpool (referring to when he cut his neck).

31. Mr Bains' induction appointment also included going through his licence conditions and rules of the AP. Mr Bains' licence conditions included a condition to reside at Ozanam House, abide by a curfew of 7.00pm-7.00am and to comply with any requirements specified by the supervising officer for the purpose of addressing his alcohol problems. As per AP rules, Mr Bains was also required to comply with drug and alcohol testing as requested (drug testing is a mandatory condition of Ozanam House).

32. Ozanam House operates a default high risk assessment for new residents, meaning that for three weeks additional welfare checks will take place at midnight to ensure that residents are well. Mr Bains was therefore subject to the usual daily checks and the additional midnight checks.

33. On 24 October, Mr Bains attended several appointments:

- An induction appointment with his probation officer. She revisited Mr Bains' licence conditions and noted that the forensic team would speak to Mr Bains to discuss his mental health needs.

- A post-discharge review with the FCS team from St Nicholas' Hospital. Mr Bains met with the Team Manager and Assistant Practitioner. They reviewed Mr Bains' mental health and current risks. No changes were noted following his discharge and they recorded that there was no evidence of his mental health deteriorating.

- An initial keyworker appointment with his keyworker. She discussed the activities available in the AP including the requirement that residents attend a keyworker session, an unstructured activity, and a structured activity each

week. She also discussed Mr Bains' SaSP with him. Mr Bains recapped his previous suicide attempt and shared that he was not aware of any current risk factors to his mental health. Mr Bains expressed that he was worried about completing a benefits application and that another AP worker had offered their assistance. Mr Bains reported no concerns with alcohol, stating that he had been sober for 16 years and confirmed that he understood that his medication would remain in the office and be subject to a weekly review. She told us that she did not challenge Mr Bains regarding his sobriety as she assessed that this had not been a continuous issue and that the incident in May 2023 had been isolated.

34. On 25 October, the FCS team reviewed Mr Bains. They recorded that there was no indication that there had been any changes to his mental health or risks. At the AP, Mr Bains declined activities and spent most his time in his room.

35. On 26 October, an Assistant Psychologist from St Nicholas' Hospital reviewed Mr Bains and reported no indication of any changes to his mental health or risk factors. Mr Bains declined AP activities and largely remained in his room but responded to all welfare checks.

36. On 27 October, Mr Bains remained in his room. However, was talkative with AP staff when he collected his medication and complied with a breathalyser test. The breathalyser machine was unable to give a reading due to needing recalibration. Staff reported no signs that Mr Bains had consumed alcohol. (On two further occasions in the month, staff were unable to test Mr Bains for alcohol due to the same issue with the breathalyser.)

37. On 28 October, the team manager received Mr Bains' formal discharge summary from St Nicholas' Hospital and shared this with AP staff. The discharge summary detailed the occasion in May 2023 when Mr Bains returned to hospital intoxicated after a day of unescorted leave and highlighted that his risk of self-harm was low but would likely increase if he consumed alcohol. Psychology input, relapse prevention, medication compliance, random breathalyser tests and involvement with the FCS were highlighted as methods to mitigate Mr Bains' risk.

38. On 30 October, Mr Bains had a telephone conversation with a manager, and she said that she would visit him on 6 November.

39. On 31 October, Mr Bains told AP staff that he was looking forward to seeing a movie with his brother. The FCS team reviewed Mr Bains and recorded that there was no indication of any change in his mental health or risks.

40. On 1 November, the keyworker had a keyworker session with Mr Bains, during which he spoke positively about a visit from his family and expressed that he had no urges to drink and that he was complying with his medication. Mr Bains also had appointments with staff members from St Nicholas' Hospital, who accompanied him to the local GP surgery to collect a doctor's note. She helped Mr Bains with his online universal credit application.

41. On the same day, Mr Bains attended a group reflective practice session with the AP's Higher Assistant Psychologist. Mr Bains also spoke to a Project Support

Worker, who asked whether he felt like he was getting the support he needed, to which Mr Bains said he was.

42. On 2 November, Mr Bains attended a session on healthy relationships. An Assistant Psychologist from St Nicholas' Hospital reviewed him and recorded that there was nothing of note.

43. On 3 November, Mr Bains told AP staff that he was concerned about his gabapentin prescription. Mr Bains' prescription required him to take three 300mg tablets in the morning and four in the afternoon, but the GP had only prescribed one tablet per day. The AP Manager quickly resolved this issue and notified Mr Bains, who was relieved. AP staff encouraged Mr Bains to start eating communally at the AP, which he said that he would try to do over the coming weekend.

44. On 4 November, Mr Bains participated in bingo with AP residents. A Project Support Worker reported that he had mostly been in his room and that staff had provided advice about a better data package for his mobile phone. Mr Bains planned to discuss this further with her.

45. On 5 November, Mr Bains responded to welfare checks and took his evening medication. He ordered a takeaway and told staff that he would eat half that day and the other half the following day.

6 November

46. Mr Bains was present for the 7.00am welfare check. He did not sign out of Ozanam House, and staff were unable to verify what time he left the premises. Mr Bains did not speak to any members of staff before leaving the premises.

47. At 9.45am, Mr Bains' sister called his keyworker and told her that Mr Bains had called her to say that he had a noose around his neck and was in Jesmond Dene (a large local park with substantial woodland). She advised Mr Bains' sister to report this to the police and simultaneously requested a colleague to report the matter.

48. At 9.50am, the keyworker called Mr Bains, who answered and said that he wanted to kill himself. She asked if he wanted to return to Ozanam House, where he could talk about this, but there was bad reception, and the call was cut off. She attempted to return the call three times, but there was no answer.

49. At 10.00am, the keyworker called the Clinical Team Lead for St Nicholas' Hospital. She then emailed Mr Bains' probation practitioner, informing her of the situation and action taken. Both the Clinical Team Lead and probation practitioner were unable to contact Mr Bains as his phone was now switched off.

50. By 12.40pm, the police had arrived at Ozanam House and searched Mr Bains' room. Later that afternoon, they informed AP staff that Mr Bains had been found hanged in Jesmond Dene Park after a large-scale search. (We do not know what time the police found Mr Bains.)

Contact with Mr Bains' family

51. On the afternoon of 6 November, police notified Mr Bains' mother and sister of his death. On 9 November, the probation practitioner contacted Mr Bains' mother to offer her condolences. The AP manager contacted Mr Bains' sister and advised her of the financial support available for funeral costs.

52. A manager attended Mr Bains' funeral on 21 November on behalf of Ozanam House staff.

53. Ozanam House AP contributed to the costs of Mr Bains' funeral in conjunction with HMPPS.

Support for residents and staff

54. The AP manager and a colleague met with residents of Ozanam House to notify them of Mr Bains' death and identify support available. AP staff were offered support collectively and during one-to-one supervision.

Post-mortem report

55. A post-mortem examination found that Mr Bains died from pressure on the neck due to hanging. Toxicology tests identified the presence of prescription medication (gabapentin and olanzapine), with no other significant findings.

Findings

Identifying the risk of suicide and self-harm

56. Mr Bains had several risk factors for suicide and self-harm. He had a recorded history of attempted suicide in prison and had been monitored under ACCT procedures on two occasions. Mr Bains had a diagnosis of depressive disorder with psychotic symptoms following treatment in St Nicholas' Hospital for two years. Mr Bains also had a history of alcohol misuse and had relapsed once in May 2023, during his stay in hospital.

57. Prior to Mr Bains arriving at the AP, staff from Ozanam House and Mr Bains' probation officer attended a discharge meeting with staff from St Nicholas' Hospital. The hospital produced a detailed community care plan which provided information on key community contacts, frequency of mental health appointments and a risk management plan that contained both risk factors and protective factors. Within the hospital's discharge summary, updated on 23 October but shared with the AP on 28 October, Mr Bains was assessed as low risk of harm to self and others. Mr Bains was accompanied by hospital staff upon arrival to the AP.

58. Following his arrival at Ozanam House, AP staff considered his history and risk through his induction, SaSP, resident plan and keywork sessions. Although Mr Bains denied any thoughts of suicide and self-harm, staff appropriately completed additional welfare checks in line with local policy.

59. Mr Bains had regular appointments with FCS staff from St Nicholas' Hospital and reported that he was happy with the support he was receiving. Mr Bains gave no indication to AP staff, FCS staff or family that he was at risk of suicide. He appeared to be settling into the AP, was beginning to participate in AP activities, engaged well with his keyworker and appointments with the FCS. There was no indication that any of his recognised triggers were present.

60. Despite there being a delay in the AP staff receiving Mr Bains' discharge summary from St Nicholas' hospital, which included information about Mr Bains' relapse in May 2023, this information would not have changed Mr Bains' risk assessment levels at the AP. Mr Bains had no other relapses recorded, did not present to AP staff as under the influence on any occasion during his stay and his toxicology report did not indicate he had consumed alcohol. Both AP staff and Mr Bains' probation officer attended Mr Bains' discharge meeting and were involved with his discharge planning. AP staff had sufficient information about Mr Bains' triggers and risk factors from his community care plan.

61. We are satisfied that AP staff had appropriate understanding of Mr Bains' risk factors and potential triggers. We are satisfied that in the days leading to his death there was nothing to indicate that he was at increased risk of suicide and self-harm and that it would have been difficult for staff at Ozanam House to have foreseen his death.

Good practice

62. We wish to highlight the work undertaken by all staff in preparing for Mr Bains' arrival at Ozanam House. The AP manager said that Mr Bains was the first resident they had received directly from a hospital setting. Throughout Mr Bains' hospital stay and following discharge, both probation and Ozanam House staff worked closely with the FCS to ensure Mr Bains' resettlement into the community.

AP manager to note

63. Alcohol testing was recommended by St Nicholas' Hospital staff to assist probation staff in monitoring Mr Bains' risks of mental health deterioration and risk of harm. It is a requirement that all residents at the AP comply with drug and alcohol tests. However, on four occasions the breathalyser at Ozanam House was unable to give a reading due to needing recalibration. HMPPS informed us that it is the responsibility of the company providing breathalyser machines to complete recalibration. The equipment now displays a message for equipment to be recalibrated every 6 months.

64. It appears that Mr Bains' discharge summary, dated 23 October 2023, was not available to AP staff until the 28 October 2023. Although this would not have changed Mr Bains' risk assessment, timely information sharing when moving between establishments is important to enable up to date assessments and care.

Inquest

65. The Coroner's Inquest opened on 4 December 2024 and concluded on 31 March 2025. The Inquest concluded that Mr Bains died by suicide.

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