Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Lee Walker, a resident at Clarks House Approved Premises, on 13 March 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 Lee Walker died from multiple injuries after being hit by a vehicle on 13 March 2023, while a resident at Clarks House Approved Premises (AP). He was 35 years old. I offer my condolences to Mr Walker's family and friends.

Although Mr Walker had some risk factors for suicide and self-harm, my investigation found no evidence that he intended to die that night. Toxicology showed that he had consumed a significant amount of alcohol before he died. The Coroner's inquest in September 2023 also found insufficient evidence that Mr Walker intended to die.

A local initiative to investigate and learn lessons from Mr Walker's death at an early stage was comprehensive and robust. I recommend that this approach is adopted nationally.

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 **June 2024**

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Summary

Events

1. Mr Walker had a history of childhood trauma, self-harm by cutting, alcohol and substance misuse. He was in prison almost continuously from May 2011 until March 2023 interspersed with brief periods in the community totalling seven months.

2. In November 2017, Mr Walker was convicted of grievous bodily harm. The victim was his partner. He was sentenced to an extended determinate sentence of 64 months in prison and an extended licence period of 36 months.

3. On 10 March 2023, Mr Walker was released on licence from HMP Swaleside. He arrived later than expected at Clarks House AP the same day. Mr Walker admitted to having drunk alcohol before his arrival and a breathalyser test showed a level below the drink/drive limit.

4. Over the next three days, Mr Walker was pleasant to staff and residents and said he was looking forward to a fresh start. He complied with all the rules at Clarks House, signing in when required, completing his induction, attending appointments and obeying the curfew.

5. On 13 March, Mr Walker attended the job centre in the morning and seemed fine to staff during the day. At about 6.45pm, he returned to the AP to collect his wallet and then went out again. Just before he left, his probation officer gave him a licence compliance letter which reminded him that abstinence from alcohol was a condition of his licence.

6. Mr Walker did not return to the AP for the 7.00pm sign in or the 11.00pm curfew. Shortly after 1.00am on 14 March, police informed Clarks House staff that Mr Walker had been involved in a fatal road traffic incident at about 11.15pm. Subsequent tests showed Mr Walker had drunk a significant amount of alcohol before he died.

Findings

7. Mr Walker had some risk factors that indicated he might be at risk of suicide and self-harm, but we found no evidence that his risk was raised during his period at Clarks House AP and we cannot say whether he intended to die on 13 March.

8. Mr Walker was handed a licence compliance letter as he left the AP for the last time before his death. We do not know whether Mr Walker read the licence compliance letter before he died, or, if he did, if it had any impact on his actions. However, best practice would have been for staff to give Mr Walker the letter at a time when they could go through the contents with him. This, and other issues, were identified in a local investigation after Mr Walker's death. Further staff training occurred alongside improved quality assurance processes. We welcome such timely intervention and recommend that a similar approach is adopted nationally.

Recommendation

- The Head of the National Approved Premises Team should ensure that every death in an AP is subject to a local investigation and report similar to the process adopted in Southwest and South Central Region.

The Investigation Process

9. The National Approved Premises Team notified us of Mr Walker's death on 14 March 2023.

10. The investigator issued notices to staff and residents at Clarks House Approved Premises (AP) informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

11. The investigator visited Clarks House on 22 March 2023. She obtained copies of relevant extracts from Mr Walker's records and interviewed five members of staff and one resident. She interviewed Mr Walker's community offender manager (COM – probation officer) on 24 March and another member of staff on 27 March 2023. She obtained further information from the police investigator.

12. We informed HM Coroner for Oxfordshire of the investigation. The Coroner gave us the results of the post-mortem examination, toxicology report and inquest verdict. We have sent the Coroner a copy of this report.

13. The Ombudsman's family liaison officer contacted Mr Walker's adoptive father and stepmother to explain the investigation and to ask if they had any matters they wanted us to consider. They asked for a copy of our report but did not ask any specific questions.

Background Information

Clarks House AP

14. Prisoners are released to Approved Premises in order to resettle into the community. They live within a supportive and structured environment whilst they look for work and permanent accommodation. The residents have to abide by a number of rules and conditions. Each resident is allocated a key worker, with whom the resident discusses their progress and well-being. The key worker also ensures that residents adhere to their individual licence conditions and the rules of the approved premises.

15. Clarks House is managed by HMPPS. A maximum of 18 men can live in the AP. At least two members of staff are on duty 24 hours a day. The building is locked up for the night at 11.00pm.

Previous deaths at Clarks House

16. In 2011, a resident of Clarks House died in a road traffic accident while on home leave with his family. We did not identify any learning for Clarks House in that investigation and made no recommendations.

Key Events

17. Mr Lee Walker had a history of childhood trauma, alcohol and substance misuse. His prison record showed he self-harmed by cutting as a coping strategy.

18. Mr Walker was in prison almost continuously between May 2011 and March 2023, interspersed with brief periods in the community totalling seven months. In November 2017, Mr Walker was convicted of grievous bodily harm. The victim was his partner. He was sentenced to an extended determinate sentence of 64 months in prison and an extended licence period of 36 months.

19. Mr Walker had brewed fermenting liquid (known as hooch) several times in prison, most recently in 2022. The last reference to self-harm in his prison record was in November 2021 when he said he would harm himself after the death of his partner (who was also the victim of his offence). Mr Walker transferred to HMP Swaleside on 28 June 2022.

20. On 7 March 2023, the community offender manager (COM – probation officer) held a video conference call with Mr Walker and the prison offender manager (POM), to discuss Mr Walker's forthcoming release on licence to Clarks House AP. He said Mr Walker appeared reasonably happy about his release to Oxford and had commented that there were "worse places to be". He went through the terms of Mr Walker's licence with him, including that he should not consume alcohol, and he did not indicate he had any issues with the conditions.

Clarks House AP, Friday 10 March – Sunday 12 March 2023

21. On 10 March 2023, Mr Walker was released on licence to Clarks House AP. A residential worker said Mr Walker was due to arrive by 2.00pm but did not. At 3.00pm, he telephoned the COM and they agreed to give Mr Walker until 7.00pm because he had been in prison a long time and might have had difficulty negotiating the journey from Swaleside on public transport.

22. Mr Walker arrived at about 4.50pm. The residential worker asked him why he was late, and he said he had been for a drink. Mr Walker agreed to take a breathalyser test and the result showed that he had consumed alcohol below the drink driving limit..

23. A probation service officer said she met Mr Walker briefly when he arrived at the AP. She introduced herself as his keyworker and said she would see him early the following week for a formal session to see how he was settling in. She said Mr Walker seemed tired and naturally a bit nervous about being in a new place but responded well to her questions. She said she kept their conversation brief as she did not want to overwhelm him and left him to complete his induction.

24. Two residential workers completed Mr Walker's induction, including his Support and Safety Plan (SaSP), which addressed his risk of self-harm. Mr Walker denied any thoughts of harming himself and said he felt optimistic for his future.

25. A residential worker told the investigator that Mr Walker seemed very open in his responses. Mr Walker described his mood as nine out of ten, with ten being the

best. He acknowledged to the investigator that people often did not want to admit to feeling too low as they knew it meant more welfare checks. Nevertheless, Mr Walker seemed very positive about staying at Clarks House and referred to having a new start in a new place. He said he would speak to staff if he felt low or had any issues. He said Mr Walker seemed positive after the assessment and went out to the local shops.

26. The duty manager reviewed Mr Walker's induction paperwork and SaSP at 7.30pm. He noted Mr Walker's history of substance misuse and self-harm and concluded that staff should have one meaningful conversation with him a day for his first seven days and two extra welfare checks during the night. (AP residents are normally subject to at least one routine welfare check overnight.) He directed that Mr Walker should be drug tested the next day and every four weeks thereafter. His room was to be searched fortnightly and more often if staff noticed any low mood or if Mr Walker reported thoughts of self-harm.

27. The next day, 11 March, a residential worker completed Mr Walker's second stage induction. He said he had slept well and took his planned drug test which was negative for amphetamines, cannabis, cocaine and opiates. Mr Walker spent the day either in his room or out in Oxford. She said she asked Mr Walker how he was when he came back at about 3.00pm. He said he was fine and asked for the kitchen to be opened so he could make some food. She said Mr Walker was pleasant and did not give her any cause for concern. He said he was looking forward to a fresh start.

28. The residential worker said Mr Walker followed the same pattern of behaviour on 12 March. He spent some time in Oxford getting to know the city and spoke about wanting to live there. Again, he talked about having a fresh start. Mr Walker complied with the required sign-in times and AP rules and was back in the AP well before the 11.00pm curfew.

29. Another resident at the AP said he had known Mr Walker to say hello to when they were both in HMP Erlestoke and recognised him when he came to the AP. He said he spent about 30 minutes talking to Mr Walker over the weekend of 11/12 March. Mr Walker seemed OK and was optimistic about making a fresh start in Oxford. He said he had not noticed any signs Mr Walker was struggling and had no concerns about him.

Events of Monday 13 March

30. On 13 March, Mr Walker left Clarks House to attend the local Job Centre between 8.24am and 9.37am.

31. Due to Mr Walker's positive breathalyser test on 10 March, the COM emailed a licence compliance letter to a probation service officer at the AP, at 10.13am that morning. This is a standard letter sent if someone breaches a condition of their licence. He said in the letter that the breathalyser result did not indicate heavy use and he did not consider that it was necessary to initiate the recall process to return Mr Walker to prison. He reminded Mr Walker that he must comply with the conditions of his licence and that he should abstain from alcohol until 10 September unless he told Mr Walker before then that he could drink alcohol.

32. In his email to the probation service officer, the COM said he was happy to discuss the contents of the letter with Mr Walker if she thought it was appropriate to hand it to him the next day. He told the investigator that he had a video call booked with Mr Walker for the following afternoon and intended to go through the letter with him then.

33. The probation service officer said she and a colleague spoke to Mr Walker at about 12.00pm. She said Mr Walker was in the smallest room in the AP and they told him that a bigger room was available. Mr Walker said he was happy with the room he had and did not want to move. They laughed with him about this as he was the first person to be happy with that room and people usually moaned about having it. Mr Walker said he liked small rooms.

34. A residential worker said Mr Walker spent most of the time he was in the AP that day in his room. He went out in the afternoon between 4.30pm and 6.45pm. When he came back, he said he was just collecting his wallet and then left again. He said he was fine. She said Mr Walker's emergency payment for universal credit may have come through for him to collect since he had been at the job centre in the morning, and it usually came through the same day. As he was leaving, she handed Mr Walker the compliance letter from the COM. She said she did not know whether Mr Walker read the letter, but he took it with him. She said she just told him it was a letter that the COM had asked her to give to him.

35. Mr Walker did not sign back in and out before he left and did not return to the AP for the 7.00pm sign in or for the 11.00pm curfew. After consultation between AP night staff and the out of hours duty manager, they decided to issue an emergency recall for Mr Walker to be returned to prison.

36. At 1.00am, the residential worker who was on night duty, received a call from Thames Valley Police to say that Mr Walker had been involved in a fatal incident on the A34. Officers attended the AP the same night and tried to find details of his next of kin in his room. Staff later noticed a bag of letters from Mr Walker's deceased partner on his bed.

37. The police told the investigator that they had received an anonymous call from a driver on the A34 at about 11.15pm saying they thought they had hit a pedestrian. There was no evidence that Mr Walker had deliberately stepped in front of the vehicle and the police did not know what he had done in the five hours since he had left the AP.

38. The police confirmed to the investigator that they did not remove anything from Mr Walker's room and did not find a suicide note.

Contact with Mr Walker's family

39. Mr Walker was estranged from his significant family members and gave the name of a friend from his local church as his next of kin when he arrived at Clarks House. As he died away from AP, Thames Valley Police initially assumed responsibility for informing Mr Walker's next of kin of his death. They eventually identified that Mr Walker's adoptive father and stepmother were living abroad and told them that Mr Walker had died. The AP appointed a family liaison officer who contacted Mr Walker's father and stepmother in the week beginning 27 March.

Support for prisoners and staff

40. After Mr Walker's death, the AP manager spoke to all the staff who had met Mr Walker during his brief time at Clarks House. Staff spoke to all residents and offered support in case they had been affected by Mr Walker's death.

Post-mortem report

41. The pathologist gave the cause of death as multiple injuries. Toxicology showed Mr Walker had 350mg/dL of blood ethanol indicating he had consumed a considerable amount of alcohol. (Toxic concentration is dependent on individual tolerance and usage although levels greater than 300-400 mg/dL can be fatal due to respiratory depression.)

42. On 27 September 2023, the Coroner gave a narrative verdict at an inquest into Mr Walker's death. He said that Mr Walker was heavily intoxicated with alcohol when he died and found insufficient evidence that his death was an intentional act.

Findings

Assessment of risk

43. In common with the police investigation and Coroner's inquest into Mr Walker's death, we cannot say whether he intended to die on 13 March. Mr Walker had some risk factors that indicated he was at risk suicide and self-harm, including a history of substance misuse, a traumatic childhood and history of self-harm. However, we have not seen any evidence that his risk was raised during his period at Clarks House AP. He was pleasant to staff, said he was looking forward to a fresh start and, until he failed sign in at 7.00pm or return for the 11.00pm curfew on the night he died, was compliant with the rules.

Action taken by the AP following Mr Walker's death

44. After Mr Walker died, the Southwest and South Central Approved Premises region commissioned a local investigation to identify whether there was any learning from his death. This was a thorough investigation with practical recommendations. Among other issues, it identified that staff could have had more professional curiosity when dealing with Mr Walker, for example when he tested positive for alcohol on the day of his release. It also found that when staff gave Mr Walker his licence compliance letter, they should have ensured he read it, understood its meaning and asked him how he felt about it. Instead, we do not know whether Mr Walker read it before he died, and we cannot say whether it had any impact on his later actions.

45. The local investigation made several recommendations and, as a result, staff have received further training and quality assurance processes were improved. We therefore make no further recommendations.

Local investigation

46. The local introduction of an early investigation to identify lessons learned following a death in an AP is good practice. This was the first time that the region had adopted this approach. We found the investigation was useful and comprehensive, resulting in quick learning. This is not a national initiative but instigated by the local area on their own initiative.

47. The National Approved Premises Team told us that although they review every death informally in an AP, that this is not recorded, nor do they produce a report. We make the following recommendation:

    The Head of the National Approved Premises Team should ensure that every death in an AP is subject to a local investigation and report similar to the process adopted in Southwest and South Central Region.

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