Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr Leo Henshaw on 7 October 2023, following his release on bail from HMP Bristol

## A report by the Prisons and Probation Ombudsman

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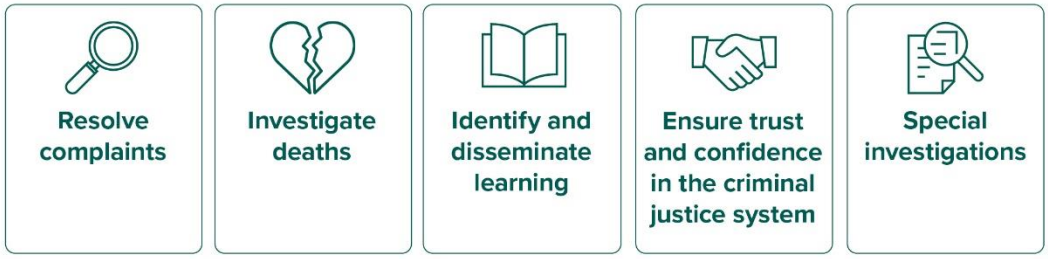
## OUR VISION

**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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# Summary

1. 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.

2. Since 6 September 2021, the PPO has been investigating post-release deaths that occur within 14 days of the person's release from prison.

3. 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.

4. Mr Leo Henshaw died of multiple injuries on 7 October 2023, after falling from the sixth floor of a block of flats. He was released from HMP Bristol on 5 October. Mr Henshaw was 22 years old. We offer our condolences to those who knew him.

5. Mr Henshaw had a history of mental ill-health and had been managed under Prison Service suicide and self-harm prevention procedures (known as ACCT) on three occasions, most recently in July 2023.

6. Mr Henshaw's release, two days before he died, was unplanned and on bail following a court videolink appearance. (Mr Henshaw was also released on post-sentence supervision due to previous offences.) Prison staff proactively contacted his community offender manager (COM) when they learnt of his impending release. His COM, who was aware of Mr Henshaw's history of mental ill-health and ACCT management, arranged to speak to Mr Henshaw before he left prison and made support arrangements with him. This was an example of good practice.

## The Investigation Process

7. We were notified of Mr Henshaw's death on 13 November 2023.

8. The PPO investigator obtained copies of relevant extracts from Mr Henshaw's prison and probation records.

9. We informed HM Coroner for Avon of the investigation. She gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

10. The Ombudsman's office contacted Mr Henshaw's mother to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Henshaw's mother asked about the support that was put in place for him on his release from prison, whether he was given any money on release, and whether he was given any medication. We have addressed these questions in the report.

11. Mr Henshaw's mother received a copy of the initial report. She did not make any comments.

12. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS found one factual inaccuracy, and this report has been amended accordingly.

# Background Information

## HMP Bristol

13. HMP Bristol is a Category B reception and resettlement prison. Oxleas NHS Foundation Trust provides physical and mental health services.

## Probation Service

14. The Probation Service work with all individuals subject to custodial and community sentences. During a person's imprisonment, they oversee their sentence plan to assist in rehabilitation, as well as prepare reports to advise the Parole Board and have links with local partnerships to whom, where appropriate, they refer people for resettlement services. Post-release, the Probation Service supervise people throughout their licence period and post-sentence supervision.

## HM Inspectorate of Prisons

15. The most recent full inspection of HMP Bristol took place in July 2023. Inspectors found that a high number of prisoners were supported by Prison Service suicide and self-harm prevention procedures (known as ACCT), reflecting the high levels of self-harm and reported mental health issues in the population. Care plans for these prisoners were reasonably good and informed by sufficient exploration of the risks and triggers for each individual. Staff also sought input from the mental health team, substance misuse service or other relevant departments. Inspectors found that oversight of ACCT case management had improved since the last inspection, and robust quality assurance and a programme of staff training were driving improvement.

16. Prisoners' immediate mental health needs were assessed on arrival, and they could refer themselves or be referred by staff at any time. A weekly multidisciplinary meeting was held for the teams to discuss new referrals, patients' ongoing needs and discharges.

17. Following the inspection, HMIP issued an 'Urgent Notification' to Bristol. They highlighted several areas for improvement, including a finding that leaders had neglected work to reduce reoffending or plan for release.

## Independent Monitoring Board

18. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to July 2023, the IMB reported that there had been an increase to both incidents of self-harm and self-inflicted deaths in custody.

# Key Events

19. On 20 April 2022, Mr Leo Henshaw was admitted to a psychiatric hospital under the Mental Health Act, following a period of anti-social behaviour. Mr Henshaw also had a history of substance misuse.

20. In July, Mr Henshaw was discharged from hospital. A consultant psychiatrist reported that he did not have an active mental health condition that could be treated. However, due to an assault on a member of staff at the hospital, Mr Henshaw was arrested on the day of discharge and subsequently remanded in custody to HMP Exeter.

21. On 2 September, Mr Henshaw appeared in court and was convicted of assault but released on post sentence supervision (PSS) due to time already spent on remand. He was allocated a place at Lawson House Approved Premises.

22. On 15 February 2023, Mr Henshaw was convicted of another assault and being in breach of his PSS. He was sent to HMP Exeter to await sentencing. At the reception screening, Mr Henshaw was reported to have an unspecified history of attempted suicide and self-harm.

23. On 20 February, the resettlement team visited Mr Henshaw to discuss his accommodation arrangements on release, and other priorities. Mr Henshaw chose not to speak to them and so failed to engage with the resettlement process. Staff sent an email to Mr Henshaw's community offender manager (COM) to inform them of his non-engagement. Staff told Mr Henshaw that he was welcome to contact the resettlement team if he changed his mind.

24. On 13 March, a staff member reported that Mr Henshaw had tied a bed sheet around his neck and was standing on the toilet. Mr Henshaw had not tied the sheet to a ligature point. He stepped down and removed the sheet when asked to do so by the staff member. Staff started suicide and self-harm prevention procedures (known as ACCT). At an ACCT case review the next day, Mr Henshaw said that he was "bored" and that this was not an attempt at suicide. He said that he did not want to see anyone from the mental health team.

25. On 17 March, prison staff closed the ACCT procedures when Mr Henshaw reiterated that he was bored and had no inclination to harm himself.

26. On 21 March, Mr Henshaw was transferred to HMP Bristol.

27. On 30 March, Mr Henshaw appeared in court and was sentenced to five months in prison for assault of an emergency worker. Mr Henshaw was returned to Bristol.

28. On 7 April, Mr Henshaw told a nurse that he "felt like killing himself". Prison staff restarted the ACCT procedures. The following day, at an assessment and first ACCT case review, Mr Henshaw said that this was an "off the cuff" statement and that he was looking forward to his upcoming release. Staff closed the ACCT procedures.

29. On 25 April, Mr Henshaw was released from prison on licence. He returned to his former address in Exeter.

30. On 28 April, Mr Henshaw was arrested and charged with the sexual assault of a male. He was recalled to custody due to breaching his licence conditions and was sent to Bristol. Healthcare staff referred Mr Henshaw to the substance misuse team as he reported recent drug use (although he tested negative for all substances), and to the mental health team.

31. The community offender manager (COM) told us told us she first met Mr Henshaw in May 2023, when he was sent to Bristol. She said that she sent an email to the prison mental health team expressing her concerns about Mr Henshaw's mental health.

32. On 12 May, probation staff held a video link interview with Mr Henshaw.

33. On 23 May, Mr Henshaw told prison staff after he had eaten his dinner that staff were "poisoning him". Mr Henshaw also mentioned that staff were always talking behind his back. Wing staff contacted the mental health team, who booked Mr Henshaw for a further assessment.

34. On 31 May, a mental health nurse assessed Mr Henshaw following a discussion with wing staff, who identified that there had been no further incidents, that Mr Henshaw was going to work, and that he had no apparent issues. Following the assessment, the nurse found that no further action was required.

35. On 13 June, probation staff held a MAPPA Level 2 review and agreed that Mr Henshaw should remain on level 2. (MAPPA is multi-agency public protection arrangements for offenders where the ongoing involvement of several agencies is needed to manage them. Once at level 2 there will be regular multi-agency public protection meetings about the offender to develop a coordinated plan.)

36. On 21 June, wing staff conducted a welfare check on Mr Henshaw after his mother called the prison concerned about him. Mr Henshaw said he was okay and that he felt supported on the wing and had no concerns.

37. On 23 June, a nurse started ACCT procedures when a court independent psychologist found Mr Henshaw unfit for court and recommended ACCT.

38. On 24 June, Mr Henshaw told an ACCT assessor that he sometimes thought about how easy it would be to hang himself. He said that he did not have any active thoughts or plan to kill himself, and just sometimes thought how easy it would be. Mr Henshaw said he had not attempted suicide in the past, and it was just a thought he had. He was re-referred to the mental health team.

39. On 17 July, Mr Henshaw told an ACCT case review panel that he had no thoughts of self-harm or suicide and had not had these thoughts for a while. Staff reported that Mr Henshaw felt he was in a much better place and was really looking to the future. They agreed to close the ACCT procedures. *An automated nDelius entry, triggered by entries made by prison staff on NOMIS, showed that Mr Henshaw had been managed under ACCT procedures and that this was now in post-closure.*

40. On 22 July, a mental health nurse assessed Mr Henshaw. She recorded that he was on a waiting list for neurodiversity support and that he had no additional needs at the time. Mental health team staff continued to review Mr Henshaw periodically while he waited for this support.

41. On 17 August, probation staff agreed a review meeting be scheduled for 12 September. The probation and prison records did not say if this took place.

42. On 9 September, a mental health nurse reviewed Mr Henshaw, noting that he said that he had been hearing voices. The nurse noted that Mr Henshaw appeared distracted and that when he spoke, he often did not make sense, so it was hard to engage with him. Mr Henshaw said that he did not have any thoughts of suicide or self-harm.

43. On 14 September, another mental health nurse completed a follow up assessment. She noted that Mr Henshaw's speech was difficult to follow and that he described hearing some voices. The nurse referred Mr Henshaw for additional therapy groups. Over the following days, she noted contact with Mr Henshaw's solicitor to discuss his ability to engage with the court process. (The outcome of these conversations was not recorded.)

44. On 2 October, Mr Henshaw approached a supervising officer (SO) who had previously been his ACCT case manager. The SO recorded that Mr Henshaw seemed strange in manner and his speech content and behaviour was very bizarre, causing her to be concerned for his mental health. She contacted the mental health team.

45. Later that day, a member of healthcare staff visited Mr Henshaw in his cell. She noted that Mr Henshaw denied having any particular concerns that he needed to speak to her about.

46. On 5 October, Mr Henshaw appeared in court by videolink. He was released on bail and on post sentence supervision to his flat with Exeter City Council. He left the prison at around 5.00pm. Prison staff said that Mr Henshaw was provided with a discharge grant and any money he had in his prison account. Mr Henshaw was not prescribed any medication at the time and was not therefore given any on his release.

**Post Release**

47. At 12.00pm on 5 October, prison staff called the COM and told her Mr Henshaw was being released from prison that day. She called the prison and spoke with Mr Henshaw directly. As the probation office would be shut when he was released, they agreed that he should report at 9.00am the following day. Mr Henshaw agreed to this and confirmed he had the key to his flat. She then informed support professionals, including the police, of this.

48. On 6 October, Mr Henshaw did not arrive for his appointment. The COM went to his flat with another probation officer, arriving at around 3.00pm. Mr Henshaw did not answer. She called Adult Social Care, as well as the council and Mr Henshaw's mental health worker, to establish if they had seen him (which they had not). Adult Social Care workers advised that neighbours had told them that they had seen lights on in the property, indicating that someone had been at home.

49. The COM told us that as Mr Henshaw had not been seen, probation staff would need to complete a MISPER. (A report for someone who is not at their placement or the place they are expected to be and their whereabouts are not known. It does not

appear that probation staff completed this report, seemingly because Mr Henshaw died shortly afterwards.)

### Circumstances of Mr Henshaw's death

50. On 7 October, Mr Henshaw jumped from the window of a sixth floor flat. (The flat was not his release accommodation that the COM had visited.) Emergency services attended and attempted to revive Mr Henshaw, but they were unable to do so and confirmed that he had died.

### Post-mortem report

51. The post-mortem report concluded that Mr Henshaw died of multiple injuries. Toxicology tests identified that Mr Henshaw had used methamphetamine (a stimulant mainly used as a recreational drug) in the time before his death.

### Support for staff

52. The COM said she was offered support from her manager after news of Mr Henshaw's death and in the days following it.

### Contact with Mr Henshaw's family

53. Police officers informed Mr Henshaw's family that he had died.

# Findings

54. Mr Henshaw was unexpectedly released from Bristol on 5 October 2023, when he was bailed. He remained under the care of the Probation Service on post-sentence supervision.

55. Mr Henshaw had some risk factors for suicide and self-harm when he was released from prison. He had been managed under ACCT procedures in prison and had told staff that he had thought about how "easy" it would be to take his own life. He also had a history of mental ill-health and substance misuse. Information about Mr Henshaw's most recent ACCT (in June-July 2023) was shared with probation practitioners via nDelius.

56. There was some good practice around Mr Henshaw's unexpected release. Prison staff telephoned his community offender manager after court to forewarn her of his impending release. She spoke with Mr Henshaw directly on the day of release to make support arrangements and confirmed these with other relevant agencies. When he did not attend his probation appointment first thing on the day following his release, she promptly liaised with partner agencies to try to establish his whereabouts.

57. We consider that prison and probation staff identified that Mr Henshaw was vulnerable on release and made efforts to support him.

# Inquest

58. The inquest into Mr Henshaw's death concluded on the 31 October 2024. The coroner confirmed that Mr Henshaw died of multiple injuries after jumping from a sixth storey window. His intention is unknown.

**Adrian Usher**
**Prisons and Probation Ombudsman** **January 2025**

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