Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Nathan Shepherd, a resident of Ascot House Approved Premises, on 16 January 2024

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 020 7633 4100

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 Nathan Shepherd died in hospital on 16 January 2024, after being found hanging in his room at Ascot House Approved Premises on 11 January. He was 34 years old. I offer my condolences to Mr Shepherd's family and friends.

This is the first self-inflicted death of a resident of Ascot House for 16 years.

Mr Shepherd had been released from prison to Ascot House Approved Premises three days before he died. Whilst he had some risk factors for suicide and self-harm, there was little to indicate to staff at Ascot House that he was at increased risk in the time before his death. However, the investigation identified some of his risk history was not properly shared between probation and approved premises' staff.

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 **October 2024**

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Summary

Events

1. On 9 August 2022, Mr Nathan Shepherd was recalled to HMP Forest Bank after breaching the conditions of his licence. On 10 August, Mr Shepherd received an additional six-month sentence for stalking. He was transferred to HMP Berwyn in December.

2. Mr Shepherd had a history of self-harm, substance misuse and was diagnosed with anxiety and depression. During this period in custody, he was monitored under suicide and self-harm procedures (known as ACCT) on two occasions.

3. On 8 January 2024, Mr Shepherd was released from HMP Berwyn to live at Ascot House Approved Premises (AP). On the day of his release, he received an induction from probation staff as well as an induction at the AP.

4. At 1.28am on 11 January, Mr Shepherd spoke to another resident. At around 5.45am, he left a voicemail text message on the AP phone stating that he "could not do this anymore". A residential support worker went up to his room but was unable to get in because the door was blocked by a wardrobe.

5. At 6.00am, the residential support worker managed to enter the room and found Mr Shepherd hanging from a ligature attached to the smoke alarm. She immediately started CPR. At 6.10am, ambulance staff arrived and took over Mr Shepherd's care. Mr Shepherd was taken to hospital where he died on 16 January.

Findings

Identifying the risk of suicide and self-harm

6. Mr Shepherd had some risk factors for suicide and self-harm and had last been managed under ACCT procedures around eight months before his release from prison. Ascot House staff appropriately considered his risk when he arrived at the AP, and we are satisfied that there was nothing to indicate that Mr Shepherd was at increased risk of suicide and self-harm in the days before his death.

7. The investigation found that probation staff did not share all of Mr Shepherd's risk information with AP staff. AP staff were not aware that Mr Shepherd had been managed under ACCT procedures in the 12 months prior to his release from prison. Whilst it is unlikely that this would have had an impact on staff's assessment of his risk, it is important that all necessary information is shared to gain a complete picture.

Recommendations

- The Regional Probation Director should ensure that accurate and up to date information about a resident's risk is shared with AP staff prior to their arrival, in line with national instructions.

The Investigation Process

8. The PPO was informed of Mr Shepherd's death on 16 January 2024.

9. The investigator issued notices to staff and residents at Ascot House informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

10. The investigator obtained copies of relevant extracts from Mr Shepherd's probation, prison and medical records. She also obtained CCTV and body worn video footage of the emergency response as well as Northwest Ambulance Service records.

11. The investigator interviewed eight members of staff over February and March 2024. Interviews were conducted at Ascot House and over Teams. She also interviewed a former AP resident in March 2024.

12. We informed HM Coroner for Manchester South of the investigation. The Coroner gave us the cause of death. We have sent the Coroner a copy of this report.

13. The Ombudsman's office contacted Mr Shepherd's parents to explain the investigation and to ask if they had any matters they wanted us to consider.

14. Mr Shepherd's mother asked how many staff were on duty on the night of the 10 January, and why the ambulance took so long to get to Mr Shepherd. She also said that Mr Shepherd was concerned about not being able to see his children and thought that this was the for reason for his actions.

15. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

16. Mr Shepherd's family received a copy of the draft report. They did not make any comments.

Background Information

Ascot House Approved Premises (AP)

17. Approved Premises (formerly known as probation and bail hostels) accommodate offenders released from prison on licence and those directed to live there by the courts as a condition of bail. Their purpose is to provide an enhanced level of residential supervision in the community, as well as a supportive and structured environment. Residents are responsible for their own health and are expected to register with a GP.

18. Ascot House, in Stockport, is managed by HM Prison and Probation Service (HMPPS). The AP accommodates up to 25 residents. Residents are required to sign in and out of the building and follow agreed curfews. Each resident is allocated a keyworker to oversee their progress and wellbeing, and to ensure that they adhere to licence conditions and the rules of the AP. HMPPS employees are on duty at Ascot House 24 hours a day.

Previous deaths at Ascot House

19. Mr Shepherd was the first resident to die at Ascot House since 2007. There are no significant similarities between his death and that of the previous resident.

HM Inspectorate of Probation

20. The most recent inspection of Manchester North Probation Delivery Unit (PDU) was published in May 2023. The inspection concluded that the PDU required improvement and made nine recommendations. The recommendations included improving the quality of work to assess and manage risk of harm ensuring that all available information is accessed and utilised. Another recommendation looked at reviewing the efficacy of work with people on probation both before leaving custody and upon release.

Key Events

21. On 10 February 2020, Mr Nathan Shepherd was remanded in custody and sent to HMP Forest Bank. In June, he was sentenced to four years and six months in prison for robbery. Mr Shepherd had been in prison before.

22. Mr Shepherd had a history of anxiety and depression and was prescribed antidepressant medication. He also had a history of substance misuse and while in prison engaged with substance misuse teams. Mr Shepherd had previously harmed himself by cutting and had previously attempted suicide by overdose and hanging, both in the community and in prison. During his time in custody, he had been managed on several occasions under Prison Service suicide and self-harm prevention measures (known as ACCT).

23. Between February 2020 and December 2021, Mr Shepherd was monitored under ACCT procedures on four occasions. On one of these occasions, he attempted to hang himself. He explained to staff that this was due to problems with his partner and not being allowed to speak to his three children.

24. On 13 May 2022, Mr Shepherd was released on licence. In August 2022, he was recalled to prison for breaching his licence conditions and sentenced to an additional six months for stalking his former partner. He also received a three-year restraining order. He spent time in Forest Bank before transferring to HMP Berwyn on 9 December 2022.

25. Between August 2022 and Mr Shepherd's release, prison staff managed him under ACCT procedures on two occasions, with the most recent being in May 2023. On this occasion, Mr Shepherd took an overdose of prescribed and non-prescribed medication but told prison staff he had no intention to die. He said that he felt he was being treated unfairly in comparison to another prisoner. Prison staff closed the ACCT procedures at the first case review the following day.

26. In July 2023, a GP at Berwyn stopped Mr Shepherd's antidepressant prescription, as he had stopped collecting the medication.

27. Mr Shepherd was subject to a restraining order which prevented contact with his former partner. In addition, upon transferring to HMP Berwyn he was not able to have contact with his children, because of domestic violence risks identified by probation staff.

28. In August 2023, a staff member from the North Manchester probation team referred Mr Shepherd for a place at an Approved Premises upon his release. Mr Shepherd was assessed as high risk to both the public and to his ex-partner. The referral form stated that a history of ACCT management and self-harm was "not applicable". However, there was a line within the referral which commented that Mr Shepherd had openly engaged with ACCT reviews.

29. In November, Mr Shepherd tested positive for cannabis, ketamine and synthetic cannabinoids. Prison staff referred him to the substance misuse service.

30. On 12 December, the Parole Board directed Mr Shepherd's release on licence to Ascot House Approved Premises. Mr Shepherd told his prison offender manager at

Berwyn that when he got out he intended to visit his children. She reminded Mr Shepherd that this was in breach of his restraining order, and he should do this the proper way by working with the family court.

31. On 15 December, a probation service officer at Ascot House completed Mr Shepherd's residence plan. She recorded that Mr Shepherd did not have a history of self-harm. She told us that to develop the residence plan she used information contained in a pre-release information form, the AP referral form, OASys and NDelius.

32. On 31 December, Mr Shepherd had a session with his prison key worker. He told her that he was feeling fine and that he was focused on getting out of prison and going home.

Ascot House Approved Premises

33. On 8 January 2024, Mr Shepherd was released on licence to Ascot House AP. His licence expiry date was 10 August 2024. At the time of his release from prison, Mr Shepherd was not prescribed any medication.

34. Mr Shepherd's licence conditions required him to be at Ascot House from 8.00pm to 7.00am, and to sign in at 1.00pm every day. His licence also required him to undertake regular drug testing, not to communicate with his children without the approval of his community offender manager (COM) and to keep in touch with his COM. Mr Shepherd was not allowed to enter part of Manchester and was provided with a map to show the exclusion zone.

35. Upon his release, Mr Shepherd was instructed to go straight to the AP, but instead attended Redfern House (a probation contact centre) at 1.00pm.

36. A probation officer told the investigator that she received a call from the Redfern House reception explaining that Mr Shepherd had arrived at the front desk and appeared agitated. As Mr Shepherd's COM was unavailable, she went down with another colleague to meet him. She had not met Mr Shepherd before.

37. The probation officer said that Mr Shepherd did not appear agitated to her, but came across as impatient to get on with going to the AP. She decided to complete his probation induction on behalf of the COM. She said that Mr Shepherd did not raise any concerns but had some questions about his licence conditions. She explained she would pass these questions to Mr Shepherd's COM.

38. During this induction, the probation officer noted that Mr Shepherd smelt of alcohol but did not appear drunk or intoxicated. She shared this information with the COM following the induction. She asked him to pass this on to the AP, but there is no evidence that he did.

39. At around 3.00pm, Mr Shepherd arrived at Ascot House. A residential support worker completed his induction. She reported that he was chatty and that it was a long induction. She stated that Mr Shepherd seemed a bit overwhelmed. He explained that this was due to him coming to terms with being out of prison. She told the investigator that she took their time with the induction and that the longer they talked the more Mr Shepherd appeared to settle into the process and calm down.

40. The residential support worker said that at first Mr Shepherd told her that he did not want to be out of prison but went on to say he was happy to be out because he could do things for his children and make a change for them. He shared that he did not want to be at the AP but wanted to try.

41. The residential support worker completed a Support and Safety Plan (SaSP), a guided welfare assessment to identify and manage residents who need additional support. Mr Shepherd denied having any thoughts of suicide or self-harm. Mr Shepherd explained to her that he had been managed under ACCT procedures in 2021, for an attempted suicide by hanging.

42. The residential support worker asked Mr Shepherd whether he wanted to be referred to the Samaritans. (This is a process in which the Samaritans will telephone a resident for a private conversation.) Mr Shepherd opted out because he believed that they might report him to the police. The residential support worker explained that this was not the case and that the service was anonymous. She gave him the helpline number for the Samaritans.

43. In addition, the residential support worker completed a medication in-possession assessment. She noted that due to Mr Shepherd's history of suicide attempts and appearing overwhelmed during the induction he would not be able to keep any medication in his room. (Instead, were he to be prescribed medication, Mr Shepherd would have to collect and take it at the staff office.) She noted that they wanted to give Mr Shepherd a chance to settle in and for staff to gain a further insight into his current state of mind.

44. As per AP policy, Mr Shepherd was required to undertake a drugs test. The residential support worker recorded in the SaSP that Mr Shepherd said that he would test positive for ketamine. She told the investigator that Mr Shepherd actually said that he would test positive for cannabis (rather than ketamine, which she seemingly wrote in error) as he had smoked this before his release. The results were received after Mr Shepherd's death and showed that Mr Shepherd tested positive for gabapentin, pregabalin (neither of which he was prescribed) and synthetic cannabinoids.

45. After his induction, the residential support worker asked for Mr Shepherd to be put on a roused response at 1.00am each day. This is usually put in place if a resident is an active substance user. These occur during the night shift and staff have to wake the resident or get some sort of verbal response from them. She told the investigator that she considered this appropriate due to Mr Shepherd appearing overwhelmed.

46. At 5.46pm, Mr Shepherd left the AP and told staff that he was going to the local shop. He returned at 6.30pm.

47. That evening, Mr Shepherd explained to the residential support worker that he had changed his mind and wanted to be referred to the Samaritans. He said that he wanted to show the family courts that he was working on himself and felt a Samaritans referral on his record might help. She explained to Mr Shepherd that she would make a referral, but that he could call the helpline at any time. She explained that she waited for Mr Shepherd to get his own phone before she made a referral, which she attempted to do on Wednesday 10 January.

48. At 11.00pm, staff completed a welfare check and did not record any concerns. In a number of welfare check entries there is minimal information recorded. The AP manager told the investigator that since Mr Shepherd's death she has spoken to AP staff about the importance of making comprehensive entries.

Events of 9 January

49. At 1.00am and 6.30am, the residential support worker conducted welfare checks and did not note any concerns.

50. At 9.00am, Mr Shepherd attended a drop-in session at the AP. (This is a voluntary session for residents to ask any questions or seek support.) Mr Shepherd spoke about setting up universal credit and his bank account. A probation service officer agreed that they would support him with this and said that Mr Shepherd did not raise any other concerns. He told us that Mr Shepherd left shortly after he realised that this was not a mandatory session.

51. At 9.35am, Mr Shepherd left the AP stating he was going to the local shop. He returned at 11.53am.

52. At 1.00pm, Mr Shepherd had a three-way meeting with his COM, his AP keyworker (a probation service officer) and a police officer. (Mr Shepherd had been referred into the Integrated Offender Management cohort meaning that police and probation staff worked collaboratively to manage Mr Shepherd's supervision.) During this meeting, the COM recorded that Mr Shepherd shared that he felt "dislocated". He was reassured by those present that this feeling would diminish.

53. The group discussed Mr Shepherd's request for a new COM. The COM explained to Mr Shepherd that this would not happen. He said that Mr Shepherd would be expected to work with him and that he would give him his full support. He informed Mr Shepherd he had the right to complain, but Mr Shepherd said that he did not wish to do so.

54. The COM left the Probation Service shortly after Mr Shepherd's death and we have been unable to interview him as part of this investigation. A senior probation officer explained that she believed Mr Shepherd had requested a new probation officer because the COM had not supported his release from prison.

55. Mr Shepherd stated that he wanted access to his children. The COM told him that there was a licence condition which needed to be approved in order to do this, and asked Mr Shepherd to be patient. Mr Shepherd explained that he had an upcoming family court date in February and had the support of CAFCASS (an advisory and support service who represent the interests of children in family court cases) and Barnardo's.

56. Mr Shepherd also raised concerns about his exclusion zone and move on accommodation. Mr Shepherd's keyworker told the investigator that at this point Mr Shepherd became a bit "shouty". Mr Shepherd said that if his move on accommodation was not sorted he would "go out robbing".

57. Mr Shepherd spoke about his substance misuse and told the group that he "loved" cocaine. The keyworker explained it was not clear from the conversation whether he was going to use it. Mr Shepherd said he would like to attend a Narcotics

Anonymous group in a nearby church to show Children's Services that he was addressing his cocaine use.

58. At 2.09pm, Mr Shepherd left the AP and said he was going to the local shop. AP records show that that he returned at 9.35pm. This was an hour and thirty-five minutes after his curfew. The AP manager told us that she believes this was a recording error. She has now implemented a curfew sign-in form for all residents which was not in place at the time of Mr Shepherd's death. (It is not clear what time Mr Shepherd actually returned to Ascot House.)

59. A residential support worker told the investigator that when she saw Mr Shepherd that evening, he was quite chatty and was socialising with other residents in the pool room. She reported that he seemed to be doing okay. She said that Mr Shepherd seemed a lot more relaxed than he had been the day before.

60. A former resident of Ascot House told the investigator that he believed he heard Mr Shepherd call probation staff a number of times during his time at Ascot House. He did not recall what day these calls were made.

61. On one occasion, the former resident said he heard Mr Shepherd say, "I can't stay here. It's affecting me badly". On another occasion he said that he heard Mr Shepherd say the words, "I'm struggling". There is no record of these calls in Mr Shepherd's probation records and no evidence to suggest AP staff were made aware of this. We have asked the police for Mr Shepherd's mobile phone records, but we have not received them.

62. At 11.00pm, the residential support worker conducted a welfare check. She noted that Mr Shepherd was asleep in bed but woke and acknowledged her.

Events of 10 and 11 January

63. At 1.00am, the residential support worker conducted a welfare check. She noted that Mr Shepherd acknowledged her but did not have any concerns.

64. At 6.00am, Mr Shepherd was signed out of the AP to visit Bolton. This was an hour before his curfew ended. He was not signed back in. The residential support worker, who was on duty at the time, told us she would not have let Mr Shepherd out at 6.00am and thought this was a case of mistaken identity. She said that Mr Shepherd did not leave Ascot House at this time.

65. At 6.30am, the residential support worker completed a welfare check. She noted that Mr Shepherd was in bed and that he acknowledged her.

66. At 9.00am, Mr Shepherd attended an AP induction session. The aim was to recap on the key commitments and expectations at the AP and provide an opportunity for new residents to ask any questions. Mr Shepherd did not raise any concerns in this session. The AP manager briefly attended this session and introduced herself to Mr Shepherd.

67. At 9.27am, Mr Shepherd left the AP and said that he was going to the GP. He returned at approximately 10.00am and handed in medication (naproxen – for pain and swelling, and diazepam – for muscle spasms) that he had been prescribed for ongoing left knee pain.

68. At 1.21pm, Mr Shepherd left the AP saying that he was going to a vape shop. He returned at 2.45pm.

69. At around 3.30pm, the AP manager held a weekly practice meeting (a meeting between the AP manager and probation service officers to go through all residents and review any roused responses). Due to Mr Shepherd's history of substance misuse, she decided to keep him on one roused response per night.

70. At 4.00pm, a residential support worker completed a welfare check with a colleague. She told the investigator that she did not have any concerns about Mr Shepherd. She explained that his room was clean, and he seemed very chatty. Mr Shepherd told her that he was getting on fine. He mentioned that there was a leak coming from behind his sink. She told Mr Shepherd that she would let someone know about this.

71. At 8.35pm, a residential support worker gave Mr Shepherd his prescribed medication.

72. The residential support worker told the investigator that, during the evening, Mr Shepherd spoke to other residents. Mr Shepherd went to his room at 10.36pm.

73. We have not been able to view CCTV footage of most of the events of 10-11 January. Our timeline is based on records made by the police when they viewed footage when they initially attended Ascot House. AP staff did not retain footage from the evening before Mr Shepherd died, despite requests from the police and the PPO. The only footage we have been able to view is that of the emergency response, from around 5.45am on 11 January.

74. At 11.00pm, the residential support worker completed a welfare check. She told the investigator that when she went up to Mr Shepherd's room he was on his bed and that another resident was standing by the door. Both residents were looking at their phones. Mr Shepherd said he was fine.

75. CCTV showed Mr Shepherd having a conversation with the other resident at 12.01am and again at 12.07am. The resident told the investigator that they shared stories from when they were children. He said that Mr Shepherd said that he wanted to do something with his life.

76. At 12.10am, Mr Shepherd opened the door to his room with his phone in his hand. He did not appear to speak to anyone and then closed the door around a minute later.

77. At 12.12am, Mr Shepherd sent a text voicemail to the main Ascot House phone asking someone to come up to his room. (This is a text message sent to a landline number. When the message is sent, the receiving telephone rings and the message is read by an automated voice when the call is answered.)

78. The residential support worker told us that she went to Mr Shepherd's room to see if he was okay. This interaction is not recorded on the CCTV timeline that the police made when they attended Ascot House.

79. The residential support worker told us that she went to the room as the other resident was leaving. She said that Mr Shepherd told her that he was fine and was

going to bed but had just wanted the other resident to leave his door. She reminded Mr Shepherd that he had a roused response at 1.00am, so they would see him in an hour.

80. At 1.00am, an agency night shift worker conducted a roused response. He noted no concerns but told the residential support worker that Mr Shepherd asked why staff kept coming into his room. He has since left his agency. We contacted him via the agency, but he did not respond to our requests for an interview, and we were told that he had been abroad for much of this time.

81. At 1.28am, Mr Shepherd had an eight-minute-long conversation with the other resident at his door. The residential support worker told us that she saw this conversation on the CCTV display in the staff office, and that Mr Shepherd was smiling.

82. During the early hours of the morning, Mr Shepherd exchanged text messages with other residents. Three residents showed these messages to the AP staff after Mr Shepherd had been taken to hospital. In a message to a resident, Mr Shepherd indicated that he may have taken drugs. (The resident told us that he knew that Mr Shepherd had used drugs outside of the premises the previous day.) The messages also indicated that Mr Shepherd was concerned about people targeting him.

83. At 5.19am and 5.37am, Mr Shepherd sent messages to other residents. He said that “it’s been nice knowing you” and that he would be “gone soon”. There is no indication that the residents saw these messages before Mr Shepherd was taken to hospital.

84. At approximately 5.45am, Mr Shepherd sent a text voicemail to the Ascot House phone which stated, “I can’t do this. I’ve blocked the door”. (This was not recorded on the Ascot House call log, and we do not therefore know exactly when the message was sent.)

85. The residential support worker told us that she went straight to Mr Shepherd’s room. CCTV shows that she arrived at the room at 5.48am. She took the emergency medical bag with her. She could not open Mr Shepherd’s door as he had blocked it with the wardrobe. She said that she heard Mr Shepherd moving in his room and called out to him. She received no response but told us that she could hear gurgling.

86. At 5.49am, the residential support worker called 999 and told the operator that she was not able to get into Mr Shepherd’s bedroom but had concerns for his safety. As she was on the phone, she continued to try to open the door. At 5.50am, the agency night shift worker came to join her outside the room. CCTV shows that he mainly watched her push the door and did not assist her.

87. The residential support worker told the operator that she thought Mr Shepherd was having a seizure and that she thought he may have hanged himself. The operator explained that she would inform the police and that an ambulance had been arranged but that there was currently a three-hour wait. The operator told her to call again if she was able to get in the room or the situation changed.

88. At 6.00am, she managed to get the door open and found Mr Shepherd on the floor beside the door with a ligature around his neck made from bedding. She cut the ligature while the agency night shift worker supported Mr Shepherd's body. She then instructed him to call 999. He was put through to the police, who contacted the ambulance service at 6.04am to arrange for an emergency ambulance to attend.

89. She started cardiopulmonary resuscitation (CPR) and instructed the agency worker to fetch the defibrillator. She told the investigator that he did not appear to know where the defibrillator was kept.

90. She continued CPR and, at 6.04am, the agency worker brought the defibrillator to the room. She told us that he was not able to find the defibrillator pads and appeared unconfident with administering CPR and so she continued alone.

91. At 6.08am, the residential support worker instructed the agency night shift worker to go downstairs to wait for the ambulance. At 6.10am, a paramedic entered Mr Shepherd's room and took over Mr Shepherd's care. At 6.38am, Mr Shepherd's heart started beating but he remained unconscious.

92. At around 6.45am, paramedics took Mr Shepherd to Stepping Hill Hospital. Mr Shepherd's death was verified at 2.40am on 16 January.

Contact with Mr Shepherd's family

93. Later, on 11 January, police officers informed Mr Shepherd's family of the incident and they visited him in hospital. They were present with him when he died.

94. Mr Shepherd's parents and sister attended Ascot House on 11 January and spoke to the AP manager. They returned on 22 January, following his death. The AP manager offered assistance with funeral expenses, in line with national guidelines.

Support for residents and staff

95. After Mr Shepherd had been taken to hospital, the AP manager arranged a meeting to keep residents updated and offer support. She held another residents' meeting when Mr Shepherd had died. A debrief session, run by a forensic psychologist, was also offered for residents.

96. The AP manager offered immediate support to staff involved in the emergency response and an initial debrief session with other staff who had interacted with Mr Shepherd. A debrief session, run by PAM Assist, was offered for all staff around a month after Mr Shepherd's death.

Post-mortem report

97. There was no post-mortem or toxicology conducted for Mr Shepherd. The cause of death recorded was hypoxic brain injury and self-hanging.

Findings

Identifying the risk of suicide and self-harm

98. Mr Shepherd had some risk factors for suicide and self-harm. He had a history of self-harm and attempted suicide and had been monitored under ACCT procedures on several occasions in prison, the most recent being in May 2023. Mr Shepherd also had a diagnosis of anxiety and depression, a history of substance misuse and was not allowed contact with his children. He told staff at Ascot House that he had an upcoming hearing at a family court and showed evidence of decisions and plans he had made to contribute to this.

99. Following Mr Shepherd's arrival at Ascot House, AP staff considered his risk of suicide and self-harm through his induction and SaSP. They noted that Mr Shepherd appeared overwhelmed but denied any thoughts of suicide or self-harm. Due to his history of self-harm and the fact that he stated he felt overwhelmed, staff appropriately decided to put Mr Shepherd on an additional roused response check and deemed that he should not hold any prescribed medication in his possession.

100. Over the few days in which Mr Shepherd was at the AP there was nothing to suggest to AP staff that he was at increased risk of suicide and self-harm. It was noted by staff that he seemed to relax and settle into the AP. We understand from a former resident that he believed Mr Shepherd made several calls to his probation officer, and explained in one that he was struggling. We do not have any evidence of this from probation records and there is no evidence that any information was shared or known by staff at the AP. The nature of Mr Shepherd's text messages to other AP residents in the early hours of 11 January suggested he was in crisis, but it seems that no-one shared any concerns with staff.

101. We are satisfied that there was little to indicate to AP staff that Mr Shepherd was at increased risk of suicide and self-harm in the time before his death.

Information sharing

102. Prison Service Instruction (PSI) 64/2011, on managing prisoner safety, states that if a prisoner is due to be released who has been supported by ACCT procedures in the 12 months preceding release, relevant risk information from their most recent ACCT must be shared by the Offender Management Unit with probation colleagues as appropriate. While HMP Berwyn shared Mr Shepherd's most recent ACCT history with his then community offender manager, probation staff did not include this information on the AP referral form, to ensure that AP staff were aware of Mr Shepherd's risk.

103. PSI 32/2014 states that the community offender manager should, prior to admission, provide the AP with a full OASys risk assessment, a risk management plan, a supervision plan and any other relevant information (e.g. about risk of self-harm) that may be necessary to enable AP staff to support, supervise and manage the resident. Mr Shepherd's OASys record, updated in October 2023, did not include full information about his ACCT history. Mr Shepherd had been monitored under ACCT procedures ten times from 2015 until May 2023. Only two of these occasions were noted on his OASys and this did not include the most recent ACCT.

A senior probation officer explained that this would have been an oversight at the point of completing the OASys. In addition, the pre-release information form sent by Mr Shepherd's community offender manager to the AP stated that there was no self-harm or suicidal ideation known. We have not been able to interview the COM as part of this investigation and therefore do not know the reason for this.

104. During Mr Shepherd's probation induction, a probation officer noted that he smelt of alcohol but did not appear intoxicated. Mr Shepherd was not asked about this and there is no evidence that this was shared with any staff at the AP.

105. The AP residence plan recorded that Mr Shepherd had no history of self-harm. We were told that this plan was mainly based on information contained in the AP referral form and OASys. While his history of self-harm was not apparent in the AP referral form, there was evidence of this on OASys and discrepancies should have been followed up with Mr Shepherd's community offender manager.

106. It is evident that not all relevant risk information was shared with AP staff prior to Mr Shepherd's arrival. While it is unlikely that this would have had an impact on the staff's assessment of his risk, it is important that all necessary information is shared to gain a complete picture. We therefore make the following recommendation:

The Regional Probation Director should ensure that accurate and up to date information about a resident's risk is shared with AP staff prior to their arrival, in line with national instructions.

AP manager to note

107. When the residential support worker arrived at Mr Shepherd's door and found that it was obstructed, she tried repeatedly to open the door while also calling an ambulance. While the agency night shift worker came to join her soon after, CCTV footage shows that he provided little assistance. There was a delay of 12 minutes between staff arriving at Mr Shepherd's door and entering his room. It is possible that the door to Mr Shepherd's room might have been opened more quickly had he assisted her in her attempt to push it open. We cannot say that this delay affected the outcome for Mr Shepherd, but early intervention is crucial to improving the outcome in cases of hanging. As noted, he was employed through an agency and could not be interviewed during the investigation.

108. Once staff had opened Mr Shepherd's room, the residential support worker quickly started CPR. She instructed the agency worker to call 999 and fetch the defibrillator. She told us that he did not know where the defibrillator was and that she had to tell him.

109. The residential support worker told us that, when he returned with the defibrillator, the agency worker did not know how to use it. When she asked him to administer CPR while she set up the defibrillator, he was not confident and she decided, in line with advice from the police on the phone, to continue with CPR until the ambulance came.

110. The AP manager and Sodexo have confirmed that both staff members on duty that evening were first aid trained. The AP manager said that she makes all staff aware that agency workers should do a building walk and check they know where the

emergency bags and defibrillators are kept. She also told us that Sodexo sometimes send support workers who are not first aid trained.

111. Whilst Sodexo have confirmed that all agency staff attending Ascot House are required to have first aid training, in this particular case there is clearly a performance issue with an agency staff member. The AP manager will want to consider the learning from this investigation and whether current arrangements provide sufficient protection against poor performance.

CCTV footage

112. The residential support worker told us in interview that at around midnight on 10 January she received a text voicemail on the general phone from Mr Shepherd asking her to come up to his room. She informed us she went to the room and had a conversation with Mr Shepherd which lasted about a minute. This interaction is not included on the timeline which the police made upon viewing the footage. Despite requests from the police and the PPO, the CCTV footage was not retained and so we are unable to confirm what happened.

113. The AP manager should ensure that all electronic evidence requested by the PPO, or the police is appropriately secured and retained to assist with investigations.

Substance misuse

114. Mr Shepherd stated at his induction that he would test positive for cannabis/ketamine and was put on a roused response. Staff we spoke to did not believe that Mr Shepherd had been under the influence at any point during his time at Ascot House.

115. A text message to a fellow resident indicated that Mr Shepherd may have been taking drugs. This resident told us in interview that he knew Mr Shepherd had used cocaine outside of Ascot House. Toxicology tests were not undertaken and as such we do not know whether Mr Shepherd used illicit drugs during his time at Ascot House.

116. This same resident told us that he witnessed drug taking (by other residents) at Ascot House and he believed that staff were aware. We do not have any other evidence to substantiate this, but it is concerning. The AP manager should ensure that residents suspected of using illicit drugs in the premises are appropriately challenged, drug tests are carried out where there are suspicions and that staff search their rooms in line with current guidelines.

Good practice

117. The residential support worker was persistent in her efforts to open Mr Shepherd's door. On accessing the room, she swiftly commenced CPR, while also speaking to the police. She acted quickly and decisively and should be commended for her efforts.

Inquest

118. The inquest into Mr Shepherd's death concluded on 20 December 2024, and recorded a verdict of suicide. Following the inquest, the coroner issued a Regulation 28 (a report to prevent further deaths) to the Ministry of Justice. This highlighted matters of concern including that the Probation Service had no policy which covered incidents of residents barricading themselves, that there were no checks ensuring that agency staff could deliver first aid as set out in the national contract and that it appeared that key documents were regularly being completed by probation staff who were not the allocated probation officer and so were unfamiliar with the person's history.

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 020 7633 4100