Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Barry Lightbown, a resident at Bowling Green Approved Premises, on 11 May 2021

A report by the Prisons and Probation Ombudsman

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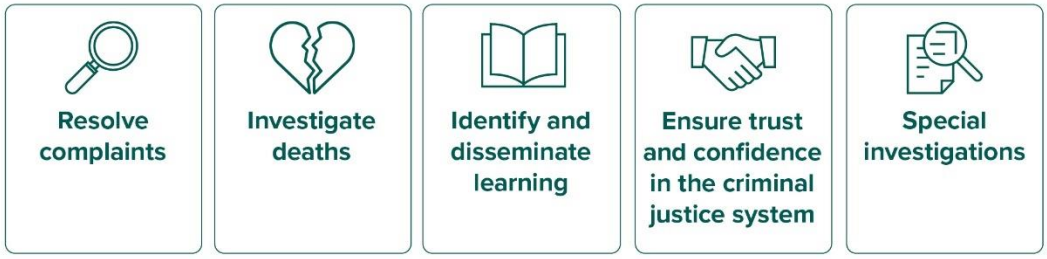
OUR VISION

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 Barry Lightbown was found hanged in the community while a resident at Bowling Green Approved Premises. He was 45 years old. I offer my condolences to Mr Lightbown's family and friends.

There have been no self-inflicted deaths at Bowling Green in the previous three years.

Although he had some risk factors for suicide and self-harm, my investigation found that there was nothing in Mr Lightbown's behaviour while he was at the approved premises to indicate that he would take his life.

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 **May 2024**

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Summary

Events

1. Mr Barry Lightbown had a history of domestic violence and harassment towards his ex-partners. He was subject to restraining orders and was not allowed contact with his children.

2. In January 2021, Mr Lightbown was convicted of breach of a restraining order preventing him from contact with his ex-partner. He was sentenced to 26 weeks in prison and sent to HMP Preston. Mr Lightbown transferred to HMP Lancaster Farms on 23 February.

3. On 27 April, Mr Lightbown was released on licence to Bowling Green Approved Premises (AP).

4. Mr Lightbown was pleasant to staff and residents and said he was looking forward to a fresh start. He initially complied with all the rules at Bowling Green, signing in when required, completing his induction and obeying the curfew. Staff assessed Mr Lightbown's risk of suicide and self-harm as low during his induction at the AP. He received a warning on 29 April after he contacted his ex-partner.

5. On 10 May, Mr Lightbown did not return to the AP for the midday sign in. Staff reported him to his community offender manager who decided that he had breached his licence conditions and should be recalled to prison. Staff reported Mr Lightbown to the police as unlawfully at large.

6. That day, Mr Lightbown contacted his son and ex-partner, apologising for his behaviour and indicating that he planned to kill himself. The police found Mr Lightbown hanged in a wooded area on 11 May.

Findings

7. Mr Lightbown had some risk factors that indicated he might be at risk of suicide and self-harm, but we found no evidence that staff should have considered his risk to be raised during his period at period at Bowling Green AP.

8. We are satisfied that AP staff appropriately assessed Mr Lightbown's risk of suicide and self-harm.

The Investigation Process

9. HMPPS notified us of Mr Lightbown's death on 12 May 2021.

10. The investigator issued notices to staff and residents at Bowling Green Approved Premises, informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

11. The investigator obtained copies of relevant extracts from Mr Lightbown's prison and probation records. She interviewed one member of staff on 9 November 2023.

12. The investigation was delayed awaiting the outcome of the Independent Office for Police Complaints (IOPC) investigation.

13. We informed HM Coroner for Cumbria of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

14. We wrote to Mr Lightbown's son to explain the investigation and to ask if he had any matters he wanted us to consider. He did not respond to our letter.

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

Background Information

Bowling Green Approved Premises (AP)

16. Approved Premises (formerly known as probation and bail hostels) provide an enhanced level of residential supervision in the community. The National Probation Service, Northwest Area, manages Bowling Green Approved Premises in Carlisle. Residents must be aged over 18. Most residents are required to stay as a condition of a court order or release licence.

17. Bowling Green AP accommodates up to 24 men. Residents are required to sign in and out of the building and follow agreed curfews. During induction, staff tell residents about the premises' rules and allocate them a key worker who is their primary contact and who holds one-to-one sessions about the issues in the offender's sentence plan. Residents are responsible for their own health and are required to register at a local doctors' surgery. As part of the conditions of residence, staff hold all prescribed medicines and issue them as prescribed.

Previous deaths at Bowling Green AP

18. In 2015, a resident of Bowling Green died by suicide in the community. We identified some learning about family liaison.

Key Events

19. On 26 January 2021, Mr Barry Lightbown was sentenced to 26 weeks in prison for breach of a restraining order and sent to HMP Preston. Mr Lightbown had a history of domestic violence and harassment and had been in prison before.

20. Prison staff managed Mr Lightbown under Prison Service suicide and self-harm monitoring procedures (known as ACCT) between 15 and 19 February after he threatened to self-harm in a letter to his son.

21. On 23 February, Mr Lightbown was transferred to HMP Lancaster Farms.

22. On 3 March, Mr Lightbown's offender manager noted that he would be released under Home Detention Curfew (a scheme which allows some people to be released early from prison if they have a suitable address to go to) to an Approved Premises (AP).

23. A nurse at Lancaster Farms saw Mr Lightbown before his release. The nurse raised no concerns about his fitness to be released. Mr Lightbown reported no mental health issues and reported no thoughts of suicide and self-harm.

24. On 27 April, Mr Lightbown was released on licence to Bowling Green AP. His licence conditions included requirements to attend appointments with his community offender manager (COM), not to delete the usage history on any internet enabled devices and to notify his COM if he developed any intimate relationships with women. Mr Lightbown was not allowed to have contact with his children without the approval of his COM and was not allowed to enter the area of Blackburn. He was required to report to AP staff and sign in at midday and 4.00pm and to be at Bowling Green AP between the hours of 8.00pm and 6.00am.

25. Mr Lightbown's licence expiry date was 27 July 2021.

Bowling Green Approved Premises

26. Mr Lightbown arrived at Bowling Green AP at 11.30am. A residential worker completed Mr Lightbown's induction. He gave him information about the AP, had a discussion with him about a reduced tolerance to drugs and an increased risk of overdose after release from prison and noted that Mr Lightbown intended to register with a GP. The residential worker completed a wellbeing assessment and noted that Mr Lightbown denied any thoughts of suicide and self-harm and said he felt optimistic for the future. He was assessed as a low risk of suicide and self-harm.

27. That day, Mr Lightbown's COM created a trigger plan which set out the actions that staff must take if Mr Lightbown failed to comply with the conditions of his licence. He assessed Mr Lightbown as a very high risk of causing serious harm to his ex-partner, the victim of his offence. There was a significant risk that Mr Lightbown would attempt to contact his ex-partner and that he could travel to her address if he chose to leave Bowling Green. The COM noted that due to his offending history, the MOSOVO (management of sexual or violent offenders) unit from Lancashire police would monitor Mr Lightbown's telephone and internet activity.

28. Probation records show that a probation services officer (PSO) was allocated as Mr Lightbown's AP keyworker. A keyworker works with the resident and their community offender manager to address any issues that the resident might have. The PSO saw Mr Lightbown regularly.

29. On 29 April, Mr Lightbown received a formal warning for breaching the conditions of his licence by deleting his internet search history and attempting to contact his ex-partner's daughter. During a meeting with his keyworker, Mr Lightbown said that he had made a mistake and did not express any other concerns.

30. On 5 May, the COM amended the conditions of Mr Lightbown's licence to include that he must not delete his text messages, telephone history or email history and messages received or sent on social media. Mr Lightbown was not allowed contact with his ex-partner's children.

31. Mr Lightbown complied with his amended licence conditions and did not give staff any cause for concern.

Events of 10 and 11 May

32. On 10 May, Mr Lightbown left Bowling Green at around 8.37am. Mr Lightbown's behaviour was normal and AP staff did not have any concerns.

33. In a statement, the COM said that at 10.00am, an independent domestic violence advocate (IDVA) for Mr Lightbown's ex-partner contacted him. This was because Mr Lightbown had updated his WhatsApp profile picture to state he still loved his ex-partner. He reported this to the MOSOVO unit, who advised that Mr Lightbown had not breached the conditions of his licence because he had not made direct contact with his ex-partner. The COM said that AP staff intended to check Mr Lightbown's mobile telephone when he returned to the AP to ensure that he was compliant with his licence conditions.

34. At midday, Mr Lightbown failed to return to the AP. Mr Lightbown's trigger plan stated that if he was 15 minutes late for any signing in time or curfew, AP staff should attempt to contact him on his mobile telephone. If staff were unable to make contact, AP staff should contact the COM or the out of hours manager.

35. The AP manager told the investigator that AP staff went to Mr Lightbown's room when he failed to return. Mr Lightbown was not in his room and staff found an empty bottle of vodka on the floor. They called Mr Lightbown on his mobile telephone, but he did not answer.

36. At around 1.00pm, the AP manager contacted the COM and told him that Mr Lightbown had not returned to the AP. At 1.15pm, the COM contacted the police to report Mr Lightbown as unlawfully at large. He gave the police details of Mr Lightbown's ex-partner to ensure welfare checks took place. Mr Lightbown's licence was revoked, and he was recalled to prison. The recall paperwork stated that Mr Lightbown would be arrested and returned to prison.

37. At 1.30pm, the COM contacted the MOSOVO unit to discuss his concerns that Mr Lightbown could go to his ex-partner's address. At 2.45pm, the MOSOVO unit

confirmed that the police had completed a welfare check on Mr Lightbown's partner and he had not contacted her.

38. Mr Lightbown's son contacted the COM at 3.00pm and said that Mr Lightbown had called him. He said that Mr Lightbown sounded drunk but did not make any threats of suicide or self-harm.

39. The IDVA contacted the COM at 4.45pm and said that Mr Lightbown had sent a picture of himself holding a rope to his ex-partner with the message, 'guess what's coming'. Mr Lightbown had also left some possessions with his ex-partner's neighbour. The COM immediately contacted the MOSOVO unit to ensure that the police were aware that Mr Lightbown was now a high risk of suicide and self-harm. He also sent emails to the force intelligence bureau (FIB) at Cumbria Police and Lancashire Police to express concern for Mr Lightbown's welfare.

40. At 8.00pm, AP staff went to Mr Lightbown's room and noted that he appeared to have taken some belongings and had urinated on the floor.

41. At 8.30am on 11 May, the police spoke to the AP manager who confirmed that Mr Lightbown had not returned to the AP.

42. At 12.30pm, the MOSOVO unit told the COM that the police had completed a welfare check on Mr Lightbown's ex-partner. She told the police that she had not heard from Mr Lightbown again.

43. Police officers from Cumbria Police attended the AP at 1.00pm, and searched Mr Lightbown's room. Officers found a note from Mr Lightbown to his ex-partner, which said that he was sorry for his behaviour and that he was going to take his own life.

44. At 5.18pm, the police found Mr Lightbown hanged in a wooded area near Blackburn.

Information received following the IOPC investigation

45. The IOPC investigation found that Mr Lightbown's ex-partner contacted Lancashire police at 1.32pm on 10 May to report that he had breached a restraining order. Mr Lightbown had telephoned his ex-partner to say goodbye.

46. Mr Lightbown's ex-partner contacted the police again at 3.24pm and said that Mr Lightbown was sending her text messages which indicated that he was going to harm himself. The investigation found that the police did not record the call as a concern for Mr Lightbown's welfare and the police continued to treat Mr Lightbown as wanted rather than a vulnerable person. This meant that the police did not commence a high-risk missing person investigation.

47. The investigation noted that the FIB at Cumbria Police and Lancashire Police did not read the COM's emails until 9.00am on 11 May because the inboxes were not constantly monitored.

48. An analysis of Mr Lightbown's mobile telephone by Cumbria Police at 1.00pm on 11 May, revealed that he had switched off his mobile telephone and there was no

record of his location. Financial checks indicated that Mr Lightbown's last transactions were made in the Lancashire area on 10 May.

49. The IOPC investigation concluded that there was no evidence to suggest that the police may have caused Mr Lightbown's death. The investigation was unable to say exactly what time Mr Lightbown died and whether the outcome would have been different had a missing person investigation been commenced when initial concerns were raised.

Contact with Mr Lightbown's family

50. Because Mr Lightbown died away from the AP, Lancashire Police initially assumed responsibility for informing Mr Lightbown's son of his death. The AP appointed the AP manager as family liaison officer, and he made several attempts to contact Mr Lightbown's son by telephone and letter. He did not receive a response. He wrote to Mr Lightbown's son again on 12 May 2022, to offer support on the anniversary of Mr Lightbown's death. He did not receive a response.

Support for prisoners and staff

51. After Mr Lightbown's death, the AP manager offered immediate support to the staff on duty. Support was offered to all the staff who worked at the AP the next day.

52. Staff held a meeting and told all the residents that Mr Lightbown had died and offered support. Notices were posted.

Post-mortem report

53. The post-mortem report gave Mr Lightbown's cause of death as hanging. Toxicology did not detect any illicit substances in Mr Lightbown's blood.

Findings

Assessment of Mr Lightburn's risk

54. During Mr Lightbown's induction, staff completed a wellbeing assessment to assess his risk of suicide and self-harm. Since Mr Lightbown's death, AP staff are now required to complete a Support and Safety Plan (SaSP) to assess and manage residents who might be at risk of suicide and self-harm. The SaSP was introduced to all Approved Premises as part of the national Collaborative Approach to Risk and Emotion (CARE) approach. All residents who arrive at an AP receive a welfare assessment and an individual support plan. This is completed by the residents and their keyworker within one day of arriving at the AP. The new approach enables AP staff to fully assess a resident's risk of suicide and self-harm and to develop an appropriate care plan.

55. Mr Lightbown had some risk factors that indicated he was at risk of suicide and self-harm, including a history of violence against his ex-partner, relationship instability and lack of family support. Two days after his arrival at the AP, Mr Lightbown received a warning for deleting his internet search history and attempting to contact his ex-partner's children. However, we have not seen any evidence that staff should have considered Mr Lightbown's risk of suicide and self-harm to be raised during his time at Bowling Green.

56. We are satisfied that AP staff considered Mr Lightbown's risk of suicide and self-harm and there was no reason for them to think that he might harm himself when he left the AP on 10 May. We are also satisfied that they took appropriate action when he failed to return to the AP.

Inquest

57. At the inquest, which took place between 11 November 2024, the Coroner concluded that Mr Lightbown died from suicide.

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