Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Ms Angela Thompson, on 11 April 2022, following her release from HMP Styal

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

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. From 6 September 2021, the PPO is investigating post-release deaths that occur within 14 days of the prisoner's release.

3. If my office is to best assist HM 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. Ms Angela Thompson died from chest injuries after being hit by a car on 11 April 2022, following her release from HMP Styal five days earlier. She was 62 years old. We offer our condolences to her family and friends.

5. In the days following her release from prison, Ms Thompson laid in the road several times. She repeated this behaviour at the time of her death, which appeared to be a deliberate attempt at suicide or self-harm.

6. Ms Thompson had long and extensive contact with community mental health services. She was diagnosed with emotionally unstable personality disorder and post-traumatic stress disorder. Ms Thompson was often managed under Prison Service suicide and self-harm prevention procedures (known as ACCT), including in the time immediately before her final release.

7. The ACCT procedures in the time before Ms Thompson’s release were poorly managed. There was little input from mental health professionals, case reviews were inconsistently attended, and little consideration was given to release planning and the impact her impending release might have on Ms Thompson’s risk of suicide and self-harm.

8. The clinical reviewer concluded that the clinical care that Ms Thompson received at HMP Styal was poor. Despite her extensive history of self-harm and risk-taking behaviour, a referral to community mental health services was not completed until the day before her release. Poor communication between operational and healthcare staff meant that this referral was sent to the wrong area. Opportunities were also missed to ensure that Ms Thompson had a priority assessment by the psychiatrist at Styal.

Recommendations

- The Head of Healthcare should review the priority system for prisoners who need urgent access to a psychiatrist and ensure that those with complex needs and ongoing self-harming behaviour are given appropriate priority.

- The Governor and Head of Healthcare should ensure that release planning processes are timely, collaborative and robust, including that appropriate referrals are made to community mental health providers for prisoners with complex needs and ongoing self-harming behaviour.

- The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidance, including that:

    - ACCT case reviews are multidisciplinary and include all relevant people involved in the prisoner's care, including healthcare staff and those providing through the gate services where relevant;

    - A named case co-ordinator is appointed who attends all ACCT case reviews whenever possible; and

    - Case reviews and care plans consider relevant actions to support those prisoners who are nearing release.

The Investigation Process

9. On 28 April 2022, the PPO was informed that Ms Thompson had died.

10. NHS England commissioned an independent clinical reviewer to review Ms Thompson's clinical care at Styal.

11. The PPO investigator obtained copies of relevant extracts from Ms Thompson's prison and probation records.

12. The investigator and clinical reviewer interviewed eight members of staff by video: six on 4 November 2022, one on 15 December, and one on 15 February 2023.

13. On 20 February 2023, the PPO investigation was reassigned to another investigator.

14. We informed HM Coroner for Hull and East Riding of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

15. The Ombudsman's office wrote to Ms Thompson's daughter to explain the investigation and to ask if she had any matters she wanted us to consider. She had no specific questions.

16. We share the initial report with HM Prison and Probation Service. They highlighted two factual inaccuracies, and we have made amendments in this final report.

17. We also shared the initial report with Ms Thompson's daughter. She did not respond.

Background Information

HMP Styal

18. HMP Styal holds convicted or remanded women. Spectrum Community Health runs healthcare services at the prison. Greater Manchester West Mental Health NHS Foundation Trust provides mental health services.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Styal was in September and October 2021. Inspectors reported that an impressive, weekly safety intervention meeting (SIM) sought to understand the needs of and provide for those most at risk. Inspectors reported that rates of self-harm were high, but three-quarters of all incidents in recent months had involved a small number of women who had repeatedly self-harmed. The rate of self-harm had steadily decreased over the last eight months and the strategy of targeted support and engagement ensured very good and proactive care for women with complex needs. The quality of record keeping in assessment, care in custody and teamwork (ACCT) documents was poor.

Independent Monitoring Board

20. 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 annual report, for the year to 30 April 2023, the IMB reported that there were high levels of self-harm but that this was concentrated around a small number of prisoners. They identified that the lack of a predictable regime was a primary trigger for self-harm.

Probation Service

21. Probation services supervise individuals serving community orders, provide offenders with resettlement services while they are in prison (in anticipation of their release) and supervise all individuals sentenced for offences committed after the Offender Rehabilitation Act 2014, for a minimum of 12 months after they are released from prison.

HM Inspectorate of Probation

22. The most recent inspection of NPS Northeast Division was in June 2019. Inspectors reported that the division suffered significant staff shortages, resulting in high workloads and a reduction in the capacity of staff to deliver quality work. Inspectors reported that work with high-risk offenders was generally good. However, risk management plans were not sufficiently responsive to changes which impacted upon the risk of harm. Persons on probation that inspectors talked to had lost confidence in community sentences, in part because they were not clear on what activity was delivered on rehabilitation activity requirement days. Inspectors said that more needed to be done to improve communication with persons on probation and to restore their confidence in probation services.

Assessment, Care in Custody and Teamwork

23. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner.

24. As part of the process, support actions are put in place. The ACCT plan should not be closed until all the support actions have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

25. Ms Angela Thompson had long and extensive contact with community mental health services, dating from 1986. She was diagnosed with emotionally unstable personality disorder (where the individual experiences intense and fluctuating emotions) and post-traumatic stress disorder (PTSD). Ms Thompson had intermittent periods of stability when she would disengage from mental health services. As such, her presentation and needs were very complex. Ms Thompson was on occasions psychotic and her mood would fluctuate between manic and low. She had an extensive history of suicidal and self-harming behaviours. Ms Thompson had previously placed herself at risk by laying in the road, drinking bleach, jumping from a bridge and overdosing on her prescribed (physical health) medications. In July 2021, Ms Thompson set fire to herself causing 10% burns to her body. Ms Thompson was detained under Section 2 of the Mental Health Act (compulsory detention for assessment) while in hospital for treatment for her burns. Ms Thompson was not prescribed medication for mental ill-health.

26. In December 2021 and January 2022, Ms Thompson engaged in extreme anti-social behaviour, including making 69 calls to the emergency services on Christmas Day and smashing the doors and windows of her neighbours' houses (for which she was convicted of criminal damage). Ms Thompson also flooded her own house after leaving the taps running. On 13 January 2022, she was sentenced to 12 weeks in prison and was sent to HMP New Hall.

27. On 11 February, Ms Thompson was accepted for a place at Adelaide House Approved Premises (AP), Liverpool, for five weeks before a return to her home address on post-sentence supervision.

28. On 16 February, Ms Thompson told an anti-social behaviour officer from Hull City Council that she was giving notice to leave her property in Hull. Ms Thompson said that she was ashamed of her actions and how it had affected her neighbours. He emailed Ms Thompson's community offender manager (COM) and explained that Ms Thompson would like to be considered for sheltered housing with warden support.

29. On 18 February, the COM referred Ms Thompson to Willowgarth Residential Care Village near Hull (a 68-bed residential home which supports rehabilitation and recovery for people with severe and enduring mental health needs).

30. On 23 February, the COM completed an assessment of Ms Thompson's risks and needs in the community. She assessed that Ms Thompson was at risk of causing serious harm to herself if she did not engage with community mental health services.

31. On 23 February, Ms Thompson was released on licence from HMP New Hall. Her licence conditions required her to report at 2.00pm to the duty probation officer at Adelaide House AP. She had a travel warrant from Wakefield to Liverpool. At 3.00pm, she had not arrived at the AP. At 5.00pm, the COM recalled Ms Thompson to prison. At 7.30pm, Ms Thompson arrived at Adelaide House and told a residential officer that she went home to Hull as she wanted to get some clean clothes,

although she was aware that she was not supposed to. At 8.45pm, police officers collected Ms Thompson from the AP.

32. On 24 February, Ms Thompson was recalled to HMP Styal.

HMP Styal

33. Prison staff started ACCT procedures when Ms Thompson arrived at Styal. They closed the ACCT procedures the following day.

34. Healthcare staff referred Ms Thompson to the mental health team. She was allocated a keyworker.

35. On 25 February, Ms Thompson was allocated a prison offender manager (POM). On 1 March, he met Ms Thompson to introduce himself and discuss her recall.

36. On the same day, Ms Thompson was referred to the psychiatrist at Styal. Due to the waiting list, and the short time she was at Styal, the psychiatrist did not see Ms Thompson during her time at the prison. She was allocated a named nurse in the mental health team.

37. On 4 March, a resettlement officer completed a basic custody screen. She emailed the COM to ask her if she had any further information on Ms Thompson's housing situation because she was aware that she had handed in her tenancy with Hull City Council.

38. On 9 March, Ms Thompson attended a video link assessment for the Willowgarth Residential Care Village. Ms Thompson's application was rejected "due to her presentation" as she "was on the floor having a fit" during the assessment.

39. On 13 March, Ms Thompson tied a hoover lead around her neck. Officers restarted ACCT procedures. Including the previous ACCT case review on 25 February, healthcare staff attended two out of nine case reviews held at Styal. A different case co-ordinator chaired every ACCT review held from 13 March.

40. On 14 March, the POM emailed the COM and told her that Ms Thompson had had a bad weekend, had ligatured and later placed a bin bag over her head and was now on twice-hourly observations.

41. On 17 March, a housing tenancy manager from Hull City Council emailed the POM and told him that their plan was for Ms Thompson to move to short-term housing (they identified a specific address for Ms Thompson) until they could find more suitable accommodation. She said that if Ms Thompson breached the terms of her residence, she would be asked to leave, and the housing department would discharge their duties under the Homelessness Act.

42. On 18 March, a housing officer from Hull City Council emailed the COM with a copy of the tenancy agreement for Ms Thompson's new property. He said that he would give her the keys so that she could give them to Ms Thompson on the day of her release.

43. On 22 March, officers closed the ACCT procedures.

44. On 23 March, the COM completed an assessment of Ms Thompson's risks and needs in the community. She assessed that Ms Thompson was at risk of suicide and causing serious harm to herself if she did not engage with community mental health services. She recommended that Ms Thompson engage with the Together Women's Project (TWP - an inclusive assessment and support service which provides support for women with multiple and complex needs). She noted that Ms Thompson should have regular contact with the community mental health team.

45. On 25 March, the COM met Ms Thompson by video link to discuss release planning, temporary housing, and her licence conditions.

46. On 25 March, prison staff restarted ACCT procedures when they found Ms Thompson with a ligature around her neck. At the first ACCT case review, Ms Thompson said that she did this to end her life.

47. Ms Thompson made seven more attempts to tie ligatures around her neck during the period of ACCT monitoring, including four attempts on the same day on 2 April. She remained under ACCT monitoring until her release on 6 April.

48. On 28 March, at an ACCT case review, Ms Thompson said that she was looking forward to her release. She spoke about her future plans and was looking forward to the prospect of living in her release address.

49. On 29 March, the POM met Ms Thompson to discuss plans for the day of release. He confirmed that prison staff would take her to Manchester Piccadilly Train Station, so that she could catch a train to Hull.

50. On 31 March, prison staff removed a ligature from Ms Thompson. At an ACCT case review afterwards, she spoke about how nervous she felt ahead of her impending release.

51. On 3 April, prison staff held an ACCT case review after Ms Thompson had "self-harmed with a ligature throughout the night". The supervising officer (SO) who led the case review incorrectly recorded that post-release housing was an outstanding issue for Ms Thompson. He noted that Ms Thompson was looking forward to her release, but "intends to keep ligaturing" until that point.

52. On 5 April, a nurse completed a pre-discharge referral to the community mental health team in Liverpool. She told the clinical reviewer that the reason for the late referral was because the prison's offender management unit (OMU) had not provided Ms Thompson's release address. She said that she incorrectly made the referral to Liverpool as, on telephoning the OMU, she was told that Ms Thompson would be released to Adelaide House AP, as that was the address they had on their system.

53. On 6 April, the Liverpool community mental health team telephoned the healthcare unit at Styal and informed them that Ms Thompson was not residing at Adelaide House. It does not appear that a referral was made to community mental health services in Ms Thompson's release area.

54. On the same day, a nurse saw Ms Thompson to complete a final assessment. She noted that Ms Thompson was not receiving any prescribed mental health medication and was fit to be released from prison.

55. A SO chaired an ACCT case review in Reception before Ms Thompson left. He recorded that she was in "good spirits" although a little nervous about moving into a property that she had not previously seen.

56. On 6 April, Ms Thompson was released from HMP Styal on post-sentence supervision. (Offenders who receive a custodial sentence shorter than two years are subject to post-sentence supervision when their licence expires. The licence and supervision period together add up to 12 months.)

57. A Custodial Manager (CM) saw Ms Thompson and told her to report to the COM at 2.00pm, at the Hull Probation Office, where she would also collect the keys to her new property. The SO took Ms Thompson to Manchester Piccadilly Train Station, gave her a train ticket to Hull and saw her get on the train. The SO emailed the COM and told her that Ms Thompson was on the train and would arrive in Hull at around 1.30pm. The SO told the COM that Ms Thompson was well behaved but nervous about her new property.

Post-release

58. At about 2.15pm, police officers brought Ms Thompson to the Hull Probation Office. They said that they went to Hull Bus Station, where Ms Thompson had laid down in front of a bus. The officers spoke to her and let her go but she laid down again in a busy road. The officers telephoned the local mental health crisis team to access support for her. Ms Thompson told the crisis team that she was okay and refused support. The crisis team asked the officers to take her to the probation office. The police officers left Ms Thompson in the reception area, but she immediately went outside and laid down in the road again. The officers brought her back into the office and stayed with her while she met with probation staff.

59. The COM and a senior probation officer met Ms Thompson. Ms Thompson told them that she could not cope and wanted to end her life. The COM telephoned the mental health crisis team. Ms Thompson told the crisis team that she was okay and wanted to go home. The COM told them that she was not confident that Ms Thompson would be safe, and that Ms Thompson had placed herself and others at significant risk and had presented to her as confused and distressed. Ms Thompson refused treatment and the crisis team said that she had capacity to make this decision and was fully aware of the consequences. The mental health crisis team told the COM that they could not force Ms Thompson to accept support.

60. The COM told us that she, the senior probation officer and the police officers were not happy that Ms Thompson could not access mental health support. The officers detained Ms Thompson under section 136 of the Mental Health Act (an emergency power to take a person from a public place to a place of safety). The COM gave Ms Thompson the keys to her new property and reassured her that her personal possessions were at the property. She told Ms Thompson to attend a supervision appointment at the probation office on 13 April.

61. The police officers took Ms Thompson to a local mental health assessment unit where staff released her. Ms Thompson went to her property.

62. On 8 April, the COM telephoned Ms Thompson. Ms Thompson said that she was upset with the house and was struggling. Ms Thompson told her that she had been

returned to her property by police officers during the night after they had found her in the road again. The COM referred Ms Thompson to the Hull and East Riding Giving Circle (a charity that supports women in Hull).

63. On the same day, the COM emailed a mental health nurse at Styal and asked if they had made a referral for Ms Thompson. Later that afternoon, the COM received a telephone call from a member of the mental health team at Styal who asked if Ms Thompson was at home and living in Hull. She updated Styal with the information that she had been taken to the assessment unit under Section 136 of the Mental Health Act. The Styal member of staff said she would speak to the local mental health team to see if they had picked up the case. The COM emailed the community mental health team to see if a referral had been made to them. (No referral had been made.)

64. On the morning of 11 April, the COM received a telephone call from a police officer who said that Ms Thompson had been lying in the road. She gave the officer the contact details of the community mental health crisis team and asked him to chase up the referral with them. Later that morning, she called the community mental health team. They did not answer the telephone call.

65. On 12 April, the COM telephoned the community mental health team to find out if the mental health referral had been made. There was no answer, so she emailed them requesting the information. A nurse from the community mental health team telephoned her to inform her that Ms Thompson had died on 11 April.

Circumstances of Ms Thompson's death

66. On 11 April, police reported that Ms Thompson was found in the road several times throughout the day and that officers detained her under Section 136 of the Mental Health Act and took her to the community mental health team for assessment. On each occasion she was released.

67. At about 9.00pm, Ms Thompson, dressed in black clothing, laid down in the road and was struck by a taxi. Ambulance paramedics went to the scene and found that Ms Thompson had died.

Post-mortem report

68. The post-mortem concluded that Ms Thompson died from chest injuries caused by a road traffic collision in which she was a pedestrian.

69. Toxicology tests showed that Ms Thompson had taken her prescribed physical health medication within the range associated with therapeutic amounts of the drug. No alcohol or illicit drugs were detected.

Support for staff

70. After Ms Thompson died, the COM was offered support by her colleagues, but said that she was not offered formal support from her managers.

Contact with Ms Thompson family

71. Police officers told Ms Thompson's daughter that she had died.

Findings

Clinical care

72. The clinical reviewer found that the clinical care that Ms Thompson received at HMP Styal was not of a good standard and was not equivalent to that which she would expect to receive in the community.

Access to psychiatrist

73. Ms Thompson had a diagnosis of emotionally unstable personality disorder (EUPD) and post-traumatic stress disorder (PTSD) The clinical reviewer found that, given her complex needs, history and risk-taking behaviours, she should have had an urgent appointment with a psychiatrist. While she found that the short time that Ms Thompson spent at Styal prevented her from having a psychiatrist appointment due to the waiting times, the clinical reviewer identified that there was no consideration to prioritise an appointment given her escalating self-harm incidents and past mental health needs.

Release planning

74. The clinical reviewer found that release planning was of a poor standard. There was no comprehensive discussion of Ms Thompson's needs on release between operational and healthcare staff and release services and no overarching mental health release plan. There was no evidence of consideration for referral to Adult Safeguarding, which the clinical reviewer found should have been considered given Ms Thompson's extensive self-harm.

75. Pre-discharge plans and referrals were not made until the day before Ms Thompson's release. Even then, the referral was sent to the wrong area. This appears to have been a result of poor communication between operational and healthcare staff at Styal, with no one taking the initiative to consider and prioritise a referral for a woman with particularly complex behaviour and needs.

76. We make the following recommendations:

The Head of Healthcare should review the priority system for prisoners who need urgent access to a psychiatrist and ensure that those with complex needs and ongoing self-harming behaviour are given appropriate priority.

The Governor and Head of Healthcare should ensure that release planning processes are timely, collaborative and robust, including that appropriate referrals are made to community mental health providers for prisoners with complex needs and ongoing self-harming behaviour.

Managing the risk of suicide and self-harm

77. Prison Service Instruction (PSI) 64/2011 provides instructions and guidance on managing prisoners at risk of suicide and self-harm. It states that the case co-ordinator must ensure that healthcare staff are always invited to attend, or provide a written contribution to, the first case review and any subsequent case reviews

where they are relevant to supporting the prisoner. There were healthcare staff present at just two of nine ACCT case reviews held from 25 February 2022 (with unspecified verbal contributions made to another four), despite Ms Thompson's mental ill-health being a significant contributory factor to her distress. PSI 64/2011 also identifies the importance of including healthcare professionals in case reviews before release, and this might have resulted in better co-ordination between operational and healthcare disciplines and a more timely and appropriate referral to community mental health services.

78. PSI 64/2011 provides actions points for the case co-ordinator when a prisoner being managed under ACCT procedures is due to be released from custody. These include inviting relevant professionals from the Probation Service (both internal and external to the prison) to case reviews in the lead up to release and sharing relevant information, including key information from the ACCT document, with them. PSI 64/2011 also identifies that relevant specialists providing 'through the gate' services to the prisoner should be invited to participate in case reviews. None of these agencies were invited to Ms Thompson's ACCT case reviews, despite her apprehension ahead of release being noted as a motivating factor behind her self-harm in prison. A lack of consistent case management – a different case co-ordinator chaired every ACCT case review from March 2022 – might have contributed to the lack of consideration for release planning.

79. There were some examples of good practice, particularly that prison staff escorted Ms Thompson to Manchester Piccadilly station and ensured that she boarded the correct train to her release accommodation.

80. We make the following recommendation:

The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidance, including that:

- **ACCT case reviews are multidisciplinary and include all relevant people involved in the prisoner's care, including healthcare staff and those providing through the gate services where relevant;**
- **A named case co-ordinator is appointed who attends all ACCT case reviews whenever possible; and**
- **Case reviews and care plans consider relevant actions to support those prisoners who are nearing release.**

81. Following her release from prison, Ms Thompson's behaviour indicated that she was at very high risk of suicide and self-harm. Probation staff, along with police officers, recognised her risk and appropriately ensured that she was taken for urgent mental health assessments. We do not know whether more appropriate referral to community mental health services prior to Ms Thompson's release from prison might have led to a different outcome.

Regional Probation Director to note

82. Ms Thompson was recalled to prison in February 2022, on the same day that she was released from custody. Her recall was begun when she was three hours late arriving at her designated release accommodation. (Ms Thompson arrived at the accommodation five and a half hours late.) Ms Thompson had to travel from Wakefield to Liverpool to get to her release accommodation. While she should not have gone to her home address on the way to the Approved Premises, the decision to recall her – about which she had no recourse to appeal – would appear to be unduly punitive in the circumstances.

83. The COM told us that she did not receive formal support from her managers following Ms Thompson's death.

Inquest

84. The inquest into Ms Thompson's death concluded on 22 September 2025, and returned a verdict of suicide. Following the inquest, the Coroner sent a Regulation 28 report (to prevent future deaths) to HMPPS, highlighting lack of liaison between prison medical services and community mental health services in the prisoner's home area at the time of release.

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