INVESTIGATION INTO THE CIRCUMSTANCES SURROUNDING THE

DEATH OF A MAN ON 11 APRIL2005, AT ST LEONARD'S, A

PROBATION SERVICE APPROVED PREMISES UNDER THE

MANAGEMENT OF THE THAMES VALLEY PROBATION AREA

Report by the Prisons and Probation Ombudsman for England and Wales

October 2005

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This is the report of an investigation into the death of a man who died on 11 April 2005. He had been a resident of St. Leonard's Approved Premises in Reading for a short time, departing from the hostel the day before his death. He was on conditional bail. He died apparently at his own hand.

The purpose of my investigation was to discover whether the level of care provided for him at St Leonard's was sufficient, and whether there are any lessons that can be learned to help prevent a similar tragedy in the future.

The man had been recently estranged from his family, but I have no doubt that his death in such shocking circumstances affected them. I offer his family and friends my sincere condolences. Although the man's mother was contacted by one of my family liaison officers, she did not wish to be involved in the investigation and I understand and respect her wishes.

Given that he had been at St Leonard's for only a few days, the man was not well known to either staff or residents. As he had not returned to the house on the day before he died, the circumstances of his death were not made known to the other residents. Staff members were unhappy that they had not been aware of the extent of his distress.

Two investigators from this office conducted the investigation, with the co-operation of the Thames Valley Probation Area. I am grateful for the assistance that the investigators received from the police and, in particular, from the manager and staff at St Leonard's. I am conscious that the investigation placed an extra burden upon the manager and her staff who, nevertheless, made facilities readily available and participated fully in the inquiry.

The investigators conducted formal interviews with the hostel manager, the deputy manager and two assistant wardens. The investigators also examined documents provided by St Leonard's. The senior investigator liaised with the police and spoke on the telephone with the solicitor who had represented the man in the criminal matter, and with the court duty officer who made the referral to St Leonard's.

The responsibility to manage numbers of high risk offenders on a daily basis is onerous, but I am satisfied that St Leonard's is managed in a professional way and staffed by dedicated people. I have found no evidence to indicate that the man's actions could have been prevented. However, where opportunities for general improvement have been identified, I make three recommendations.

STEPHEN SHAW CBE
PRISONS AND PROBATION OMBUDSMAN
OCTOBER 2005

Summary

On 6 April 2005, at Woking Magistrates' Court, the man admitted to an offence against a child. He was remanded on bail to be sentenced at the Crown Court but he was unable to return home. A condition for him to reside at Approved Premises in Reading was therefore imposed. He was admitted to St Leonard's during the evening of the same day.

He was described as a quiet, mild man who conformed to requirements and caused no problems in the short time he was a resident. It was known that the circumstances in which his offence was committed and discovered had led him to experience suicidal feelings, but he gave no indication to staff at St Leonard's that he was depressed. On the contrary, he appeared to be in control of his affairs, and keen to prove to his family that he accepted responsibility for his actions.

On Sunday 10 April, when he had been resident at the Approved Premises for five days, he had an amicable conversation with two assistant wardens about local towns and areas of interest. He then left the premises and was not seen again. He failed to keep an appointment with his key worker at 7:00pm that day and, when he had not returned by the 11:00pm curfew, the police were informed that he had breached his bail.

Later that night, police informed St Leonard's that the man would be listed as a missing person. The following morning, staff were informed that there was concern for his safety as he had contacted his wife telling her of his intention to take his life.

At approximately 1:30pm on Monday 11 April, police were informed of a burning body that had been found in woodland. The body was close to a car containing a suicide note from him indicating that he could not live with the guilt over the nature of his offence. There were also taped messages indicating that he had been trying to find the courage to throw himself from Beachy Head. The body was subsequently identified as the man's body.

St Leonard's Approved Premises

1. Approved premises were formerly known as Probation and Bail Hostels and are approved by the Secretary of State within Section 9 of the Criminal Justice and Court Services Act 2000. Their purpose is to provide accommodation for persons granted bail in criminal proceedings, and in connection with the supervision and rehabilitation of persons convicted of offences. Approved Premises can provide a supportive, structured environment in the community for high risk and difficult to manage offenders. The management of offenders accommodated in Approved Premises is governed by the National Standards for the Supervision of Offenders and the guidance contained in the National Approved Premises Handbook.

2. St Leonard's is managed by the Thames Valley Probation Area. The premises consist of a main building together with an annex. It can usually accommodate 22 residents, although there is a further bed that may be utilised in an emergency. There are two shared rooms, the remainder being for single occupancy. The Approved Premises accepts offenders on bail, those subject to community orders and those on licence following prison sentences. All those on bail are accommodated in the main house where there is CCTV and an alarm sounds if the front door is opened during the hours of curfew. Residents must be over the age of 18, but any type of offender will be considered.

3. Until about ten years ago, Approved Premises offered accommodation to offenders who had nowhere else to go but, in recent years the resident profile has changed. Nowadays, Approved Premises cater largely for dangerous or serious offenders who are assessed as posing a risk of re-offending or harm to the public. At any given time, St Leonard's manages a number of 'high risk' offenders.

4. The house operates a number of day-time projects to ensure that residents use their time purposefully. All residents are required to participate in morning and afternoon projects each weekday with the exception of Tuesday and Friday afternoons. Some are conducted by hostel staff and some by representatives from the community, such as the local college. Each resident is required to sign in and out of the house at all times, and to hand in their room keys when they leave the premises. A log book is kept of the signing out routine. Residents are also subject to curfew restrictions, usually from 11:00pm to 7:00am, although other curfew hours may be enforced if either their court orders or licences stipulate.

5. The house is usually managed by two Senior Probation Officers, each based at St Leonard's for half the week although, at the time of the man's death, one half of the post was vacant. The managers are assisted by a deputy manager, an administrator, and six assistant wardens, with relief staff on duty at weekends. Each assistant warden acts as a key worker for a number of residents. Key workers are responsible for monitoring the

behaviour of their residents and for providing advice and encouragement. They are expected to work with case managers to address offending behaviour. As those on bail are either un-convicted or un-sentenced, they do not have a case manager and the key worker's role is largely supportive. All permanent members of staff participate in a core training programme that includes input on the management of risk. At times of staff shortage, the Approved Premises relies upon the use of agency staff. At least two experienced members of staff are on duty at all times during the day.

6. There are two members of staff on the premises each night although both are 'sleeping-in'. This is unusual in that many Approved Premises are staffed during the night by one waking and one sleeping member of staff. A recent resource review undertaken by the National Probation Directorate recommended a move towards double waking night cover and, in the light of this, the Thames Valley area is currently reviewing its staffing of Approved Premises. Night staff are responsible for checking the premises to ensure that all is well at curfew and that each resident is in his room. They do this in pairs and are required to knock, open doors and enter rooms if the occupant cannot be identified.

Events leading to the man's death

7. The man appeared at Woking Magistrates' Court on 6 April and pleaded guilty to an offence against a child. He was committed to Crown Court for sentence and, as he could not return home, he was bailed with a condition of residence at St. Leonard's Approved Premises. There was a further condition that he should not attempt to contact the victim or any witnesses.

8. The court duty officer who interviewed him at court and completed the hostel referral form was aware that the Crown Prosecution Service had objected to bail for a number of reasons - including the possibility that the man could harm himself given the nature of the offence and the likelihood of a custodial sentence. The Prison and Probation Services use an 'Offender Assessment System' (OASys) to identify and assess the level of risk that offenders pose to the public and to themselves. There is an initial screening that triggers a full analysis if risk is identified. The OASys form was completed in full and assessed that he had a current risk of suicide and self harm.

9. When he arrived in his car at St Leonard's around 7:30pm on 6 April, the man had nothing but the clothes he was wearing. It was noted that arrangements would have to be made for him to retrieve his belongings. He went through the induction procedure when the rules of the house were explained to him and he agreed to abide by them. The assistant warden who inducted him was an experienced member of staff. She told the investigators that she was aware of the nature of his offence, and knew that he was a person in crisis as was the case with many residents. She read the referral form and the OASys screening document but, in her view, there was nothing on the forms to indicate that he was any more at risk than other residents and he did not present as depressed or anxious.

10. The assistant warden explained the house's anti-bullying procedures, and advised him not to disclose the nature of his offence to other residents. She said she tried to be as reassuring as she could and referred him to various information leaflets that were available, including one produced by the Samaritans. The assistant warden explained that she was to be his key worker with responsibility to meet him weekly and assist with any issues that were troubling him. She arranged to conduct the first key-working session with him four days later (on the evening of Sunday 10 April). At the end of the induction procedure, after more than an hour, he confirmed that he felt fine and was shown to his room. The man had been allocated a shared room so that he would not be alone but, in fact, the other resident failed to return that night.

11. Around 9:00pm, the man left the premises after asking directions to the nearest public house. During the evening there was a telephone call from the police at Woking to check if the man had arrived, and the hostel rules were faxed to the police station. The assistant warden said it is unusual for police to check if residents have arrived, but she confirmed that their

concern was to ensure he did not bother his family.

12. The man returned in good time for curfew. He smelled strongly of alcohol but was co-operative and caused no problems. He retired to his room where he remained until the morning of 7 April. After the morning meeting, he was allowed to use the office telephone to speak with his solicitor. The solicitor confirmed that he said he was fine, and the staff had been supportive. He asked the staff for directions to the nearest police station where he was required to sign the sex offenders' register and, having done so, he returned to the Approved Premises where he handed in his passport for safe keeping. He asked advice about local solicitors who could deal with family matters and he left the house.

13. During the day, he telephoned his solicitor again to tell her of the various arrangements he had made, including making contact with a family solicitor to deal with his domestic issues. He talked about the need to sort out his finances, as he had been informed by letter that the Borough Council had suspended his Private Hire Driver's Licence, and he would be unable to work during the period of bail. The solicitor said she was impressed by how organised he appeared to be.

14. When he returned to St Leonard's that afternoon, he was asked if he could produce his vehicle documents to verify ownership but they were at his home. It was explained that he was not allowed to park on the premises' grounds until the documents had been checked. The man took this in good part and asked advice about the safest, nearby street parking. That evening, when the assistant warden on duty carried out the curfew check, she noticed a strong smell of alcohol in the room although he was asleep. The investigators were told that the use of alcohol off the premises is tolerated, provided it is not perceived as problematic and does not cause a resident to be disruptive. If residents return in time for curfew and are the worse for drink, they are advised to go to their rooms and 'sleep it off'.

15. On Friday 8 and Saturday 9 April, he spent much of his time away from St Leonard's. The deputy manager recalled a conversation with him when he chatted about various things. The man told the deputy manager that he had arranged to see a family solicitor the following Monday, as he believed his wife would seek a divorce. The deputy manager described him as a compliant, quiet man with a mild manner who was organised and able to make his own arrangements with little assistance from members of staff. The deputy manager was not aware of him interacting with other residents, but said this was not unusual during the first few days of residence. He did not perceive him to be any more depressed or stressed than would be expected of anyone in his situation.

16. When the man returned to St Leonard's during the evening of 9 April, a member of staff reminded him that he should complete a numeracy and literacy assessment form before his required attendance at a basic skills course on Monday morning. The man asked for the form to complete in his room so that he would not need to spend time on it the next day. He

did not appear reluctant to complete the form and gave no indication that he did not wish to attend the course. He returned the completed form early the next morning.

17. The man left St Leonard's around 8:45am on Sunday 10 April. Before doing so he had a conversation with the two members of staff who had been on duty overnight, commenting on the pleasant weather. He asked about other towns close by, indicating that he was bored with looking around Reading and wanted to go further afield. The members of staff said he did not appear worried or agitated when he left.

18. The key worker said that she was not too worried when he missed his appointment with her on Sunday evening. She thought she would see him later and talk about it. However, when he had not returned by 10:00pm the key worker became concerned. When he failed to appear by the 11:00pm curfew, he was in breach of the Approved Premises rules and consequently in breach of a bail condition. The key worker was required to complete the necessary paperwork that would enable police to arrest him, and she did so immediately. Due to the serious nature of the breach, the key worker contacted local police by telephone before midnight. She said she had no reason to be concerned for his welfare, beyond the fact that he was likely to be remanded in custody.

19. The Approved Premises records indicate that, around 3:15am on 11 April, police informed staff that a 'missing person' report would be made on him and the following morning police visited the premises. The man's wife had advised them that her husband had indicated his intention to take his life and that he seemed serious. Although a member of staff was able to say what he had been wearing when he left St Leonard's, the registration number of his car could not be provided as it had not been recorded.

20. Later that day, the deputy manager was informed that a body, subsequently identified as his body, had been found in woods in Sussex. The man's car was nearby. Inside was a dictation machine on which he had left messages indicating that he was trying to find the courage to take his life. The man had attempted to telephone his wife several times during the night, and left a note indicating that he could not live with the knowledge of his offence.

Consideration and conclusions

21. It was the role of this investigation to consider if the risk of self harm had been properly assessed and managed, and whether the level of care provided for him during his brief stay at St Leonard's was adequate. In doing so, I also considered whether the hostel procedures were commensurate with the requirements for all such hostels as defined in the Approved Premises Handbook, and familiar to staff. It was clear that the premises provide a safe environment for residents who present a high level of risk. The members of staff interviewed were confident about their roles and procedures to be followed. Although no residents were interviewed, the man had told his solicitor of the supportive environment provided by St Leonard's.

22. The man's solicitor told the investigator that the court duty officer who interviewed the man and referred him to the Approved Premises was thorough, sensitive, and treated him with respect. On the referral form, the officer noted that the man told police he had felt suicidal after committing the offence but, rather than harm himself, he decided, to hand himself in to police and face the consequences of his actions. The man told the court duty officer that he had talked of suicide because he felt guilty and upset after the offence was discovered.

23. From the referral form and the OASys assessment, staff at St Leonard's knew that he could pose a risk to himself. However, he had no history of depression or mental health problems, there were no indications of drug or alcohol abuse and there had been plenty of opportunity for him to harm himself, if he wished to do so, before he surrendered to police custody. In the few days that he spent at St Leonard's, nothing he said or did gave staff any reason to suppose that he intended to harm himself. His solicitor said that she had spent a good deal of time with him and was convinced that he wanted his family to know that he accepted full responsibility. She was both surprised and shocked when she heard of his death.

24. The investigators asked whether all staff would be aware of the risk assessment. The deputy manager explained that the two assistant wardens on duty when a referral is received decide whether the person should be accepted, and their decision is ratified by either the deputy manager or the manager. The manager said that all members of staff are expected to familiarise themselves with referrals of new residents and to draw significant information to the attention of staff on the next shift. The deputy manager could not say for certain that all members of staff were aware of this requirement. Commendably, St Leonard's has since introduced a system requiring staff to sign a form, stored in the resident's file, indicating that they have read all the relevant paperwork.

I recommend that the National Probation Directorate considers introducing a requirement for all appropriate Approved Premises' staff to record that they have read and noted relevant information

about residents.

25. All Probation Areas were required by the National Probation Directorate to devise a strategic plan to reduce incidents of sudden death in Approved Premises. The Thames Valley area has such a plan in place and available at its Approved Premises. St Leonard's has identified a member of staff responsible for co-ordinating work on self-harm issues. Since the man's death, St Leonard's has developed an 'emotional well-being' form consisting of a yes/no checklist that is completed at induction and includes reminders about the symptoms of depression. If the form indicates that a resident has significant problems, a risk management form is used, similar to the F2052SH in use by the Prison Service for identifying and monitoring risk of self-harm. I commend this good practice initiative.

26. The deputy manager commented that not all prisons pass on the F2052SH form when a prisoner is released, and there have been times when he has struggled to obtain information necessary for comprehensive assessment of risk. This is not an issue relevant to the man who had not been in custody, but it is one that has been identified by Approved Premises in other areas, and upon which I have commented in previous reports. At a recent inquest into the death of prisoner, a Coroner commented that it was the duty of every person involved with an offender, including health care professionals and legal professionals, to forward any relevant information that could assist a prison to care appropriately for a person. If appropriate care is to continue beyond the prison gates, it is equally important that prisons pass on relevant information to the Probation Service. I repeat a recent recommendation.

    I recommend that the National Probation Directorate and the Prison Service should work together to produce a protocol for the sharing of information pertaining to risk where appropriate, on those who are released from prison and subject to Probation Service intervention.

27. During his stay at St Leonard's, the man had the use of his car. In order to park the vehicle on the premises, he was required to provide proof of ownership, insurance etc. The man was unable to do so as the relevant documents were not in his possession and he could not retrieve them from his home address. Consequently, no details of the vehicle were noted and, when he was listed as missing, the vehicle registration number was not immediately available to police. It is unlikely that earlier access to the registration number would have prevented his death or enabled him to be found more quickly, but such information could be of assistance in other situations particularly if residents abscond.

    I recommend that the National Probation Directorate requires all Approved Premises to record the registration numbers of vehicles being used by residents.

Recommendations:

I recommend that the National Probation Directorate considers introducing a requirement for all appropriate Approved Premises' staff to record that they have read and noted relevant information about residents.

After reading this report in draft, the National Probation Directorate agreed that staff in Approved Premises should be fully aware of the relevant information held on a resident's file and that shift handovers should be conducted to pass on details of developments. The directorate will ensure that these points are included in the further guidance currently being produced for probation Areas.)

I recommend that the National Probation Directorate and the Prison Service should work together to produce a protocol for the sharing of information pertaining to risk where appropriate, on those who are released from prison subject to Probation Service intervention.

The National Probation Directorate has said that this recommendation is accepted and is already in hand via the guidance being developed to support the implementation of ACCT, the Prison service's new suicide and self harm management framework

I recommend that the National Probation Directorate requires all Approved Premises to record the registration numbers of vehicles being used by residents.

The National Probation Directorate has said that this recommendation is accepted in principle but the directorate will seek legal advice on whether it can be enforced in all cases rather than on a case by case basis.