

**Investigation into the circumstances surrounding the
death of a man in April 2008 whilst a resident at Approved
Premises in Greater Manchester**

**Report by the Prisons and Probation Ombudsman for
England and Wales**

April 2010

This is the report of an investigation into the death of a man. He was found hanging in his room at Approved Premises in the Greater Manchester Probation Area in April 2008.

I wish to offer my sincere sympathy and condolences to the man's family and friends for their loss. I should also apologise for the delay in issuing this report, which I fear may have caused the man's family additional anxiety.

This investigation was conducted by one of my Senior Investigators. I would like to thank the then Manager of the Approved Premises, the Senior Probation Officer, and his staff for their help and co-operation.

The man had been at the Approved Premises for nineteen days before his death. This is a sad case in which neither the Approved Premises staff, nor the residents, nor the man's family had any idea that he was thinking of ending his life. Although he had attempted suicide in the past, he had been making plans for the future. I understand that just over a week before his death he had signed on with the Department for Work and Pensions and asked about obtaining a Construction Skills Certificate Scheme card to help him find work in the construction industry.

I am pleased to report that all four of the recommendations made in my draft report have been accepted.

Stephen Shaw CBE
Prisons and Probation Ombudsman

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SUMMARY

At the beginning of 2007 the man appeared at Bolton Crown Court and was given a two year Community Rehabilitation Order (CRO) with a condition of residence. This followed his conviction for an offence of indecent exposure.

The man resided at two Approved Premises, both of which he had to leave - once after a fight and once after a positive drug test. Later in 2007, he was sentenced to six months imprisonment at HMP Forest Bank for breaching a previously imposed suspended sentence and for breach of a Risk of Sexual Harm Order.

In October, he was released from prison and under the terms of his CRO was given a place at an Approved Premises, Greater Manchester. The man was a registered sex offender and subject to certain restrictions placed on him by his level three Multi-Agency Public Protection Arrangements (MAPPA) status. It was clear from the start that he did not want to be at an Approved Premises, nor did he want to abide by the imposed regime.

At various times he was prescribed anti-depressant medication for anxiety and mild depression, but he frequently either forgot or chose not to take it.

The man had a relationship with a young woman who lived at a nearby 'leaving care' project. As a result of rumours circulating at her hostel that he was a paedophile, he was moved in 2008 to a second Approved Premises (AP) .

The man continued the relationship, and allegations that he made threatening telephone calls to the young woman were being investigated at the time of his death.

In 2008, the man presented staff at the second AP with a medical certificate from his doctor. It said that he should have a single room on medical grounds (which were anxiety and mild depression). As the result of that certificate, the man was moved to new Approved Premises in April.

The man continued to see the young woman and possibly others while he was at the new AP. He also continued to rebel against the system in minor ways. He was still being prescribed anti-depressant medication, but took it infrequently.

In April, he returned a few minutes late for his 9.00pm curfew because he and three other residents had been stopped and checked by the police. He appeared to be in good spirits, but a little later he received a telephone call from a girlfriend. He smashed his mobile at the end of the call and had to be calmed down by his friends. About an hour later at 10.55pm, the man was overheard talking normally to (it is presumed) another girl and telling her that he loved her. The man was seen by two members of staff after that call and he appeared to be alright.

At 7.48am the next morning, staff knocked on his door to wake him. There was no reply and the door was blocked. They forced the door open and found his body behind the door, hanging by a bathrobe tie from the metal door closing mechanism.

I have made four recommendations as the result of this investigation. The first proposes an amendment to the existing medication form used at Approved

Premises. The others relate to guidance on resuscitation and to additional emergency equipment.

THE INVESTIGATION PROCESS

1. The investigation was opened by one of my investigator, at the Approved Premises in 2008. The Manager produced the man's probation record and other documents for examination. Notices were displayed at the hostel to inform both staff and residents of the investigation.
2. A number of staff were formally interviewed regarding the man's death. The transcripts of those interviews are annexed to this report.
3. One of my family liaison officers contacted the man's family. This gave them the opportunity to discuss the scope of my investigation and raise any concerns or questions that they wanted explored and addressed. The man's family asked about his medication, and particularly why medication prescribed for a sleeping problem was stopped when he was in prison custody. They were also concerned that he was in a single room, and questioned why he was not subject to any special monitoring given that he had previously attempted to take his own life. I hope this report helps the family better understand the events leading to his death.
4. My investigator contacted HM Coroner to inform him of the nature and scope of my investigation. He requested a copy of the post mortem and toxicology reports and the man's medical record. Upon completion, this report will be sent to the Coroner to assist his enquiries into the man's death.
5. The residents who associated with the man had left the Approved Premises by the time my investigator was conducting interviews. My investigator contacted one of the residents who had returned to prison but he did not wish to be interviewed.

THE APPROVED PREMISES

6. Approved Premises were formerly known as Probation and Bail Hostels. They are approved by the Secretary of State within Section 9 of the Criminal Justice Act 2000. Approved Premises 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 Supervision of Offenders and the guidance contained in the National Approved Premises Handbook.
7. The AP where the man died is one of seven Approved Premises in the Greater Manchester Probation Area. The Area has a specialist senior manager who oversees all the Approved Premises, with managers and other staff for each hostel.
8. The AP consists of a pair of large houses in South Manchester, and has a large, well maintained garden. It provides accommodation for 27 men. The houses have been adapted and refurbished in order to meet the requirements of residents and staff. Some residents have single rooms and others, who have just arrived, share double rooms. In the domestic areas of the house there are several lounges, television, a dining area, laundry, and tea and coffee making facilities. There are also a number of CCTV cameras installed in communal areas which are monitored by staff in the main office.
9. On arrival at the AP, every resident commences stage one of the induction programme. The induction process is completed on day two. The induction ensures that residents know the hostel rules and what is expected of them. Every resident is allocated to a member of staff as their key worker, whom they will meet on a regular basis for support, to discuss their well-being, and to assist with any offence related work. Attendance at key worker sessions is part of the resident's contract, and failure to attend can be considered a breach of the rules of the Approved Premises.
10. Residents have their own keys to their rooms, which they hand into the office when they go out and collect on return. They are not allowed to bring friends into the hostel without prior permission. Breakfast and dinner are provided each day. Unless a resident is subject to individual curfew arrangements imposed by a court, they must be in the Approved Premises between the hours of 11.00pm and 6.00am. The man's curfew times were between 9.00pm and 10.00am.
11. As with all Approved Premises, the AP has rules regarding alcohol and drugs. The possession or use of alcohol, solvents and controlled substances is not allowed either in the hostel or within the grounds. Medication which is prescribed to an individual must be notified to staff and is stored securely in the main office. Room searches are carried out over a five week rolling basis; all residents' rooms are checked within this period.
12. Night duty is normally carried out by two night supervisors. They are given a handover by the day staff when they begin their shift. They look after residents'

welfare, issue medication, and patrol the hostel overnight conducting hourly checks on residents. Any issues that occur during the night are recorded in the house log books.

13. Some Probation Areas, including Greater Manchester, have developed Assessment, Care and Teamwork (ACT) arrangements to monitor residents who are thought at risk of suicide or self harm. All the staff at have been trained in ACT and in first aid.
14. There have been two previous deaths of residents of the AP where this man died since I was given responsibility for investigating all such deaths in April 2004. The first, in 2005, was a heroin overdose which occurred some distance away from the Approved Premises. The second, in August 2007, was apparently self-inflicted. Neither investigation revealed issues in common with this report into the death of the deceased.

KEY FINDINGS

15. The man appeared at Bolton Crown Court in early 2007. Following conviction for an offence of indecent exposure, he received a two year Community Rehabilitation Order (CRO) with a condition of residence. (A CRO is an order made by the court for the offender to work with their Offender Manager to address their offending behaviour.) He went to live at an Approved Premises in Manchester, but his place was withdrawn a month later for fighting.
16. He then stayed with a friend (at an address that was considered unsuitable by the Probation Service) until a place at another Approved Premises was allocated to him in later in 2007.
17. In June, he was prescribed mirtazapine, an anti-depressant, by his doctor after reporting that he was not eating properly and that the circumstances at the hostel were making him depressed.
18. After the man failed a drug test, this place was also withdrawn. He remained on bail for breaches of a Risk of Sexual Harm Order and a suspended sentence.
19. In July, the man's bail was revoked by Bolton Magistrates Court and he was remanded into custody at HMP Forest Bank. The next day he told the doctor that he had suffered from anxiety and panic attacks since his late teens, but that he was not thinking of harming himself. He said that he wanted to try counselling before any medication.
20. A member of the mental health in-reach team at the prison, saw him in August. The man told her that he was not feeling depressed, just a bit low. He had stopped taking his mirtazapine anti-depressant medication in January, as he said that he felt better without it. He also said that he did not want any medication at that time. The member of the in-reach team suggested counselling, and referred him to the Counselling, Assessment, Referral, Advice and Throughcare (CARATS) drug advisory service and to an anxiety management group.
21. In August, the man was sentenced to six months imprisonment for the breach of a previous suspended sentence and a Risk of Sexual Harm Order imposed in December 2006. (A chief officer of police may apply by complaint to a magistrates court for a Risk of Sexual Harm Order to be made against a person aged 18 or over if it seems to him that the person has on at least two previous occasions engaged in sexual activity or communication with a child or children, and as a result there is reasonable cause to believe that the Order is necessary to protect a child or children from harm arising out of future such acts by him. It is a civil preventative order but a breach is a criminal offence.)
22. The member of the mental health in-reach team saw the man again in October 2007, just before his release, when his mood was better despite receiving three warnings in September for using abusive language towards staff. She recorded that he had attended a relaxation group and she had no concerns about his mental health.

23. The man was released from HMP Forest Bank in October and, under the terms of his CRO residency order, went to an Approved Premises. He went through the standard induction procedure which he had done before at other hostels. He asked that his adopted father be listed as his next of kin. The man was asked about any previous history of self-harm. He said that a year before he had taken an overdose of tablets due to depression. (Elsewhere in his record he described being depressed at that time about restrictions in relation to visiting his son.) He also said that he was currently not receiving any medication and did not have any thoughts of suicide or self-harm. His only concern seemed to be the times he had to sign-in at the Approved Premises which then included a lunchtime curfew.
24. In October he was prescribed citalopram and sertaline (both anti-depressants) and paracetamol by his own doctor.
25. In October, the fire alarm activated in the man's room. The residents were evacuated and staff went to check. They found him in his room which was heavy with deodorant spray, and it was difficult to breathe. He explained that he had smoked a cigarette and then used the deodorant to mask the smell in his room and on his clothes. Staff suspected that he had been smoking cannabis, which he denied. He eventually admitted to smoking some cannabis two days previously. He was warned about bringing illegal substances into the Approved Premises.
26. The following day it was agreed by the man's Offender Manager (OM), that the lunchtime curfew restrictions could be relaxed at weekends so that he could visit his family.
27. In October, he became angry during a conversation with hostel staff. He wanted to miss some of the signing times that day so that he could visit his father after meeting his OM at lunchtime. The meeting was changed to 3.00pm which would have given him time to see his father and to meet with his solicitor as he also wanted to do. The man was still angry and the meeting time was changed again to the following day at the AP.
28. One of the AP residential staff, went to see the man in his room. She had a long conversation with him and recorded that he was feeling depressed because he felt that everyone was conspiring against him. She also thought that he was not taking his medication.
29. The man was seen again by the Deputy Manager. The man told him that he felt low and isolated, and said that he had forgotten to take his medication for several days. He said that he wanted to be left alone did not feel suicidal. The Deputy Manager asked whether staff could check on him every two hours, to which the man agreed.
30. The Deputy Manager opened an Assessment, Care and Teamwork (ACT) document. It was agreed that the man would be visually checked and spoken to throughout the day and checked visually during the night.

31. The following morning, he angrily left a planned meeting with his OM. He had challenged his risk assessment, saying that he was not some “mad flasher” and that he had only one conviction for a sex offence. After a cigarette, he agreed to return to the meeting and the Offender Manager discussed the man’s low mood with him. He said that he was upset following the previous day’s events and he kept forgetting to take his medication. He was adamant that he did not intend to commit suicide or harm himself because he still had things to live for. The man said that shortly after he arrived at the hostel he had seen the community practice nurse who had said he was fit and well. He did not want another referral. His Offender Manager agreed to arrange the timing of her meetings with him so that he would be able to go and see his father.
32. Over the next few days the man’s mood improved. He took his medication and ate his evening meals.
33. In November, the man and another resident were walking in a local park when two youths, allegedly armed with a machine gun, attempted to rob them of their mobile phones and cash. Nothing was stolen but the matter was reported to the police. Neither the man nor his friend was injured.
34. The ACT was closed the next day with his agreement, as it was assessed that his risk of self-harm was low.
35. The man began to complain about the mattress in his room in November. He said that it was too soft for him as he had back problems. He also said that he was not sleeping well and then getting warnings from staff about sleeping late. (Residents must not be upstairs without permission between 9.30am and 12.30pm.) The Deputy Manager, said that most of the residents were complaining about the mattresses and that there was funding to purchase two new ones. It was not certain, however, that he would have one of them.
36. The man saw a drug worker from the Oldham Drugs Intervention Project (ODIP) in November. He said that he had used cannabis the day before which was why he had not been taking his medication. The doctor with whom the man had registered when he arrived at the Approved Premises, had stressed to the staff the importance of him taking his anti-depressant medication. Otherwise, he would experience mood swings and be more likely to re-offend. The man was reminded three times that day by staff to go and collect his medication but he refused.
37. The next day he had a session with the Deputy Manager. He was asked about not taking his medication and initially said that he had just forgotten. He later said that he was well and did not need to take it. The Deputy Manager replied that only a short time previously the man had been really low and that he should see his doctor before stopping the medication. He agreed to seek the doctor’s advice.
38. In mid November, the man was again asked to go to the office to take his medication. He said that he was not taking it any more, but was told that he must see his doctor and get a letter confirming that he need not take it. He gave staff a letter from the doctor later in November. The letter simply states

that the man had asked the doctor to document the fact that he was having trouble sleeping on his bed.

39. During this period he attended various group work sessions: rent and money management, budgeting, life skills and so on. Sometimes he would engage and take an active part, but on other occasions he would remain silent.
40. In December, the man was spoken to about not attending the morning meetings (all residents are expected to attend the meetings every morning). he said that he would be better off in prison as there it was possible to lie in. The man left the office and began stamping around loudly, repeating that he would be better off in prison.
41. Late in December, the man and another resident were playing pool. They had put music on and were talking loudly. The night staff asked them to return to their rooms but they refused. He became verbally aggressive and the members of staff retreated to the office and closed the door. Both the man and the other resident began to bang on the office door and shout and argue with the staff. After a while things calmed down and he became apologetic. He was concerned that he would be sent back to prison. When he was told that this would not happen, he returned to his room. Later, when staff checked on him, they found that he had moved his wardrobe to block his door. The man removed the wardrobe when asked by the staff. He told staff later that morning that he had been concerned that the police would be called to collect him. He was assured that they had not.
42. At a key worker session on December, he told one of the residential staff that he was going to ask his doctor about his anti-depressant medication but he did not wish to take anything. He said his problems were due to smoking cannabis and he was trying to give up smoking completely with help from his doctor. The residential staff asked him how he was feeling and he said that he was okay. He was not depressed, but indicated he was unhappy with the restrictions at the hostel.
43. On New Year's Day 2008, it was recorded in his notes that he had a girlfriend. (I shall refer to her as T.) She had met him outside the hostel. He was told that she was not allowed on the premises and he said that he understood.
44. Three days later, the Deputy Manager spoke with him regarding a nearby residential project for young women. Apparently the man had been asked to leave the grounds of the project a couple of times and staff there had threatened to call the police. He agreed not to return as he did not want to get into trouble. The young woman he had been visiting (I shall refer to her as N), was over 18 but the project was for women as young as 16.
45. The man was found drunk in his room in January 2008. He admitted to drinking cans of lager outside the hostel and was left to sleep it off.
46. The next morning, staff received a call from the home where N was a resident saying that she was missing. The man was spoken to as both T and N had called at the Approved Premises the previous afternoon and he had left with

them. The man tried to call N on her mobile without success. (N turned up at her home a few hours later, safe and sound.) That evening the man was given an alcohol breath test and the reading was zero. His curfew was extended to 5.00pm to 10.00am.

47. In January, the man spoke to a member of staff and asked for permission to stay out until 7.00pm as it had been arranged for his sister to take him out for tea. He also said that he had already had a drink that morning, claiming to have drunk a litre of vodka and a can of lager. The member of staff agreed to extend his curfew. In return, the man agreed not to drink any more that day and to take a breath test when he returned. He returned at 6.40pm and provided a breath test with a very low reading of 0.08mg.
48. The next morning he had a meeting with his OM. . The man was told that he was next in line for an en-suite room provided his behaviour was stable. He now had a new mattress for his current bed. His Offender Manager and the man discussed his excessive drinking and he agreed to get help as he wanted to reduce it. He asked about getting a job as he was bored, and he agreed to attend a session to help him progress to work.
49. The man rang his Offender Manager at 4.00pm the same day and said that he did not want to abide by the 5.00pm curfew. He was advised that he must abide by the curfew and that it was implemented as much for his safety as for risk. After his call, the Offender Manager decided that the man would receive a verbal warning about his previous behaviour whilst drunk and that the curfew would then revert to 7.00pm. He would also be told that if he returned to the hostel drunk again he would receive a District Manager's warning which might lead to his bed being withdrawn. He would not have a place at the Approved Premises which could lead to him being returned to court. The man returned at 7.00pm and was given a breath test for which the reading was zero. He also provided a zero alcohol breath test the following evening.
50. In mid January, the man had a key worker session with a residential staff member. They spoke about his drinking and the fact that he was not eating much. He said that it was probably all to do with his frustration and feeling restricted by the rules and the curfew. She suggested the best way forward was for him to get up in the mornings and comply with the regime. He agreed and said that he would not drink again. He continued to provide zero or very low alcohol readings each evening.
51. Staff at the Approved Premises were concerned when a 16 year old girl called for him in early February. He said that she came because T was banned from coming. The Deputy Manager advised the man that he should not be spending time with such young and vulnerable people. He later said that the 16 year old was new at the project and seemed to be a friend of T. He agreed to keep away from her.
52. The Deputy Manager spoke to the man again in mid February regarding his attending his progress to work group accompanied by two young women. He said straight away that they were T and her friend. He asked if he was in trouble and the Deputy Manager told him that he was not.

53. Later in February, the Offender Manager went to the Approved Premises and spoke with the Deputy Manager before meeting with the man. They again discussed the fact that he was not taking his medication. The records showed that he had not done so for two weeks even though the drugs were being received at the hostel. The Deputy Manager said that he would speak with his doctor about it.
54. Later that day the man was upset. When asked what the problem was, he said that two members of staff from the hostel where T and her friend lived had gone to the friend's family and told them that he was a paedophile. The Deputy Manager spoke with the manager of the girls' hostel and assured the man that no staff from there had said anything to the girl's family. After further discussion, the man felt that T had probably jumped to conclusions and that he would speak to her. The Deputy Manager then spoke to him about whether he thought his safety had been compromised as a result of the rumours. The man agreed to speak to staff if any other issues came up.
55. On 29 February, staff went to the man's room due to an overwhelming smell of cannabis coming from it. He denied having smoked cannabis in his room but a search was carried out. Seven DVDs were found, three had 18 certificates (residents are not allowed DVDs with that rating) and the others were FBI stories about child abduction and murder which the staff also thought inappropriate. The DVDs were confiscated until a decision on them was made. The man was given a drug test which was positive for cannabis. He said that another resident, whom he refused to name, had smoked cannabis in his room, but admitted that he had also smoked some earlier in the day. He was given a warning letter.
56. The Deputy Manager spoke with the man in early March about the DVDs. The man said that they were his sister's films and that he was not aware that he was not allowed certificate 18 films. The certificate 18 films were confiscated, but the FBI films were returned to Clint on the understanding that he give them back to his sister. The man was also spoken to regarding concern that he had been seen at T's sister's house as it was thought that she had a one year old child living there.
57. In early March, the Deputy Manager spoke with the man and told him that he would be moving to another Approved Premises. The Deputy Manager had received information that T was telling other residents at her hostel that the man was a paedophile. There was concern both for the man's safety and that of the Approved Premises as T had a lot of family in the area and could cause problems. The man said that T did not believe he was a sex offender and blamed a member of staff at her hostel for spreading rumours. In the end, he accepted a move to another AP.
58. He arrived at the new AP with T and tried to take her in as a visitor. Staff refused because it was late and they thought she looked under 18 years old. It was later confirmed that, despite him saying she was almost 19, she was in fact only 17 years old.

59. The man settled well into the new AP and at a meeting with his Offender Manager in March it was noted that he was complying with the regime, attending morning meetings, and there were no immediate self-harm concerns. The Offender Manager recorded that he was not on any anti-depressant medication at that time but his mood would be explored weekly by his key worker.
60. In March, he had his first key work session with the key worker. He said that he had no thoughts of self-harm and that his mood was okay at that time. He added that he liked to keep busy as it kept him from becoming depressed.
61. The following day he met with a psychologist. The man had failed to attend two previous appointments made when he was at the previous AP. He engaged well during the session, explaining that he had seen a psychologist before for the purposes of an assessment regarding access to his son. The man told the psychologist that the main trigger which caused him stress was lack of sleep. He said that he believed he had modified his behaviour but he would “take a step back and look at things more”. The psychologist said that she would arrange another session the following month.
62. Late in March, the man telephoned his Offender Manager and asked if T could be allowed to visit him at his current AP. The Offender Manager telephoned the Manager at the AP, who said that she had specifically raised the matter when she attended the Multi-Agency Public Protection Arrangements (MAAPA) meeting. The decision was that young vulnerable women should not be allowed on to the premises. The Offender Manager informed the man who was not happy but said that he would not challenge the decision as he did not want to “work himself up about it”.
63. In early April, he had another meeting with the Offender Manager. They discussed the nature of his relationship with T, and the man was asked about an abusive and threatening conversation that was overheard whilst T was on the telephone to him. He said that the names used were said in jest and that he respected T.
64. The man was also asked about reports from staff who had seen him waiting, possibly smoking cannabis, in the car park of the Approved Premises and at the railway station with three women and a child in a pram. He said that he was with T and that the other two women and child were not with them. He also said that he did not smoke cannabis around the hostel and never on the premises because he knew the trouble that would cause.
65. Later in April, the manager at the AP contacted the Offender Manager to inform her about threatening telephone calls made by the man to his girlfriend T which had been witnessed by staff at her hostel. T also alleged that he had assaulted her. The man was spoken to and he repeated that he respected T and they planned to settle down together. The staff at T’s hostel were to investigate further and, in the meantime, they would monitor T’s telephone calls.
66. Two days later the man went into the office at the AP and handed over a medical certificate from his doctor saying that he required a single room on

medical grounds (anxiety and mild depression). He had been prescribed 1mg varenicline tablets to be taken twice a day to help with his desire to stop smoking. The man said that he was not getting much sleep due to his room mate snoring. He was told that there were no single rooms available at the AP and he would probably have to move to another Approved Premises. He was not happy about that and said that moving would only heighten his problems.

67. Nevertheless, he did move to the new hostel in April. He did not want to go but the Manager of his previous AP explained that the staff had a duty of care to him and they could not comply with his doctor's request. She also advised that staff at the new hostel should monitor his mood as it was likely to be low. She reminded them that he had a history of self-harm.
68. One morning in mid April, the man rang his Offender Manager and complained that he did not want to be at the new hostel. Ten minutes later he returned to the office asking to use the telephone again. He became very aggressive when his new key worker, told him he needed to take a photograph of him. The man said that they did not need a photo as he was not staying, and in any case they could get one from the other places where he had lived.
69. Half an hour later he met with the hostel Manager. The man was challenged about his aggressive behaviour and he in turn complained about the unhygienic state of the premises, pleaded his innocence, and made derogatory comments about the other residents. The Manager went with the man to his room and found it to be clean apart from a small mark on the floor which he scraped off with his key. He told the staff to order a new pillow and gave him another quilt until the new pillow arrived. The man then agreed to abide by the premises' rules and to have his picture taken.
70. The Manager described his impression of the man in an interview with my investigator:

“I found him to be difficult in engaging at first and I think basically he was having difficulty settling into the Approved Premises environment because he wanted to go home, basically he wanted to be with his family or his friends. I don't think he really relished the idea of the regime so to speak, you know being on curfew and being told to attend groups etc. I don't think he really wanted to be part of that and because of that a lot of his difficult behaviour was indeed for us to say, right we've had enough, you need to go home, and I suppose we weren't going to fall into that because there were risk issues.”
71. In mid April, he was drug tested using a five panel urine test (the urine is placed onto a disposable testing device which then shows a positive or negative reading for five types of drug). He tested negative for cocaine, amphetamines, ecstasy, opiates and benzodiazepines.
72. The next day there was further information from T's hostel that the man had made another abusive telephone call to her which had been overheard by staff. T had told the staff that she was terrified of him, yet she still met him daily in

Manchester. The police were consulted about the calls, but T was unwilling to make a statement.

73. A member of the hostel's staff, spoke to the man. He advised him that he should inform staff of his whereabouts when he left the Approved Premises. He was unwilling to do that. He told the hostel staff member that he would move out of the hostel if a new resident was allocated to his room. He added that he would also harm himself as he had a medical certificate from his doctor authorising a room to himself. The conversation, including the man's threat to self-harm, was recorded both electronically and in the occurrence log.
74. He called his Offender Manager the next day to complain about the possibility of having to share a room as soon as the following week. He added that the staff had told him he was at the top of the list for a single room. His Offender Manager advised him that it might not happen, and that he should talk with his key worker. He said that he would.
75. That afternoon he arrived at the Approved Premises with another young woman whom he left waiting at the door. The Manager saw the girl and, when he saw the man going out again, asked him who she was. He replied, "Nobody for you" and then accused the Manager of belittling him in a loud and aggressive way. The Manager wrote in the daily occurrence log, "the man is clearly becoming a serious risk management concern. He fails to attend morning meetings and refuses to comply with the extra monitoring systems put in place to manage his risk."
76. A short while later a police officer in the local Sex Offender Unit telephoned the Approved Premises. The officer had been told about the concerns for T and the abusive telephone calls he had made. She said that T was frightened of the man and that on one occasion he had called her 20 times in two hours.
77. The following afternoon a member of staff saw a young girl outside the hostel looking inside. The man went out to her and they both walked up the road. He looked back and could be heard swearing whilst looking at the staff watching him. He returned and asked why the staff were watching him. The member of staff told him that he had been asked to tell staff when he left the premises, which he had not been doing. The man said that he was not prepared to do that and then went on to talk about his single room request. The man was told to discuss his concerns with his Offender Manager and the hostel Manager. He then asked for and was given a complaint form. A little later the man returned to the office to apologise for his behaviour.
78. The next evening he went to the office to collect his medication (lofepramine, an anti-depressant). A member of staff asked him how he was feeling and he replied that he was still feeling depressed. When he was asked what he was depressed about the man replied:

"This place. It's getting worse and it's not like the other hostels I've stayed in. The only reason I am here is because I have got a doctor's note that says I need a single room because of my mental state and now they are

telling me that I will be sharing with someone and they want me to tell them everywhere I am going and it's getting me down."

A manager said that it could be that staff were concerned for his mental state and safety. He looked reassured and said, "Yes, it could be."

79. The man met with his key worker the next morning and repeated that he was depressed. He added that he had been to his doctor who had given him some anti-depressant medication which he had started taking a few days previously. The key worker explained that it could take a week before the medication started to take effect, and that his mood swings could vary until then. He then said that he had not been eating well due to the meal times and he did not like to eat in front of others. The key worker suggested that he go down later after most of the residents had finished. If he was still having trouble, he should see his doctor about supplements to make sure he was getting all his vitamins.
80. My investigator asked the key worker whether he was concerned either about the man's mental health or that he would harm himself. The key worker replied:
- "No. I know that in the past he had a history of self-harming and from the moment he was inducted staff had asked him and told him if he felt that he was going to self-harm to let us know and we would always make time to take time out to spend with the people who were thinking of self-harming, hurting themselves or hanging themselves or whatever. He did say he was depressed. He'd been to the doctors but whenever you questioned him you'd ask 'Is everything alright, do you feel like self-harming?' he'd always say, 'No, I'm alright, I'm on my anti-depressants.'"
81. At the end of April, the man arrived back at the hostel five minutes late for his nine o'clock curfew. He initially denied being late but then said that the clock on his mobile must be slow. He was reminded that he must be present at 9.00pm.
82. A little later in April, a member of the hostel staff saw the man outside a local public house with three other residents at 8.00pm. She said that all four residents were quite loud and rowdy. At 8.45pm, two other residents on a 9.00pm curfew told the approved premises staff member that the man and the others were being spoken to by the police outside the pub. The man and the other residents returned 11 minutes after their curfew with a slip of paper from the police explaining that they had been stopped and checked. The man was concerned that he would get into trouble for being late and was assured he would not.
83. In his interview with my investigator, the Manager said that after the man's death he heard that he had been in another resident's room after his return with the residents who had accompanied him at the public house:
- "While they were in the room, I believe he received a phone call, this is what I'm hearing and that he received the phone call and he became very upset as a consequence of the phone call. So much so that he threw down his mobile phone and it smashed to pieces and then stormed off to

his room. Another resident went off to his room with him and sat with him for a while and spoke with him for a while. I understand that he seemed much calmer and then about, I think it was about five to eleven, he apparently came downstairs and was on the main phone, speaking to someone. The staff assumed that he was speaking to one of his girlfriends and we believe he had about two or three girlfriends on the go. So the rumour is one girlfriend split up with him, that's when he smashed his phone upstairs, then he came downstairs to reconcile with another girlfriend, kind of thing."

84. At 10.55pm, the Approved Premises staff member saw that he was on the phone. She recalled the information regarding his making threatening calls and moved to a position where she could overhear him. She told my investigator that the man was talking to a girl whom he called N. He told N that he loved her and that he only had 47 pence left. The Approved Premises staff member then went to open the front door for another resident. A short while later she saw the man and asked if he was okay, to which he nodded in reply. He was seen to return to his room at 11.10pm and three minutes later he was talking with another resident.
85. That night two members of staff were on duty. Part of their duty is to walk around the building every hour and then to wake the residents at 7.45am. One of these Approved Premises staff members told my investigator that either around 11.00pm or midnight he saw the man who died and a couple of other residents chatting. Nothing about the man at that time raised any concerns with him. Nothing untoward was seen or heard during the night.
86. At 7.48am the next morning, the Approved Premises staff member knocked on the man's door to wake him. When he did not get a reply he used his key to try to open the door but it would not open. He described later that it felt as if the door was wedged or a wardrobe was blocking it. When the Approved Premises staff member could not force the door open or get a reply from the man he ran back to the office. A second member of staff had just arrived for his day duty. The two men went to the man's room and the second member of staff took the cordless telephone with him. The second member of staff managed to force the door ajar about a foot wide. He saw that the man was not in his bed and then thought to check behind the door.
87. The man was found hanging behind the door suspended by the neck from the metal door closing mechanism. His bathrobe tie was wrapped around his neck and the door closer, with his feet on the floor. A member of staff said that the man was facing the door but it is possible that forcing the door open could have turned him around.
88. The second member of staff immediately dialled the emergency services while the other member of staff went to fetch a knife from the kitchen. Both were of the opinion that the man had been in that position for some time and that he was dead. The second member of staff had completed a first aid course two weeks earlier and made the decision, based on the man's appearance, not to attempt to resuscitate him. The other member of staff cut the man down and moved him further into the room. The police arrived at 8.03am, followed two

minutes later by the paramedics. The emergency services did not attempt any resuscitation.

89. The man had listed his adopted father as his next of kin. He was contacted by the Manager at 8.30am and given the sad news.
90. After the man's death every resident who knew him sat down with a senior member of staff and had the opportunity to talk through their feelings. All were surprised and shocked by what had happened.

ISSUES

91. From the time that the man was released from HMP Forest Bank it is clear that he was not happy having to live at Approved Premises or with the restrictions and curfews imposed on him by his MAPPA status. He complained about the accommodation and curfew times, failed to attend morning meetings, and missed planned sessions with his Offender Manager.
92. At the same time, he was diagnosed with anxiety and mild depression for which he was prescribed various anti-depressant drugs. At each of the Approved Premises where he lived, he did not consistently collect his medication from the office as required. He would be reminded by the staff and warned about stopping his medication himself without consulting a doctor first. Much of the time he would say that he felt fine and did not need the drugs.
93. It is well documented that anti-depressant medication can actually lower a person's mood during the first few weeks of use, and the man's habit of only taking his drugs occasionally may have prolonged that period. However, generally staff did not notice signs of low mood or depression. He was mainly annoyed with the regime and occasionally anxious.
94. Approved Premises staff do not have any authority or power to insist or force residents to take their prescribed medication. They do have medication sheets on which are recorded the type and quantity of drug, and space for a member of staff and the resident to sign. There are very few entries on the sheets relating to him.
95. It was clear that staff were aware that he was not collecting his medication most of the time. I suggest that the sheet could be amended to include a 'not collected' box with a requirement to follow-up with the resident after a certain number of missed collection times.

The Greater Manchester Probation Trust should consider adding a 'not collected' box to the medication sheets in Approved Premises, with a requirement to follow-up with the resident after a certain number of missed collections.

96. It is clear that he had wanted a room to himself, and his doctor provided a medical certificate stating that he required a single room on medical grounds on 9 April. Although he had previously tried to take his life, the last known attempt was over a year before his death. None of the staff at the Approved Premises in which the man had lived had concerns that he would try to harm himself.
97. The two members of staff who found the man responded swiftly and professionally once they discovered him hanging behind the door of his room. I would normally expect staff to attempt resuscitation in such circumstances.

However, it is clear from their description of his body during their interviews that it would have been unnecessary and disrespectful on this occasion. My investigator has been advised that the policy of the Greater Manchester Probation Area is that all staff involved in the supervision of residents should attend a half day emergency first aid course. There is no specific guidance or expectation regarding when and if resuscitation should be attempted in an Approved Premises setting. I believe that the Greater Manchester Probation Area should consider issuing guidance to its staff setting out when staff are expected to attempt resuscitation and when they are not.

The National Offender Management Service should consider issuing guidance to Approved Premises staff regarding when resuscitation should be attempted.

98. I note that the other member of staff who found his body had to get a kitchen knife to cut the ligature as no purpose made alternative was available to him. Deaths by hanging in Approved Premises are fortunately rare but they are not unknown. I therefore make the following recommendation.

The National Offender Management Service should consider whether safe ligature cutters should be supplied to all Approved Premises.

99. When the interviewed staff were asked what could be improved regarding their response to emergency medical situations, the main suggestion was an automatic defibrillator machine. Such a machine would not have helped in this case but they have proved invaluable in other circumstances. I have made previous recommendations to the Probation Service on this matter and now do so again.

The National Offender Management Service should consider the acquisition of automatic defibrillator machines for its Approved Premises.

Conclusion

100. Although the man had harmed himself previously and was clearly frustrated by living in an Approved Premises, I do not believe that his death could reasonably have been anticipated by those who were responsible for his care. This report like others into deaths in Approved Premises has illustrated the challenges that many hostel staff face, and the sensitive and professional way in which they carry out their responsibilities to society and to those in their charge.

RECOMMENDATIONS

1. The Greater Manchester Probation Trust should consider adding a 'not collected' box to the medication sheets in Approved Premises, with a requirement to follow-up with the resident after a certain number of missed collections.
2. The National Offender Management Service should consider issuing guidance to Approved Premises staff regarding when resuscitation should be attempted.
3. The National Offender Management Service should consider whether safe ligature cutters should be supplied to all Approved Premises.
4. The National Offender Management Service should consider the acquisition of automatic defibrillator machines for its Approved Premises.

The Greater Manchester Probation Trust and the National Offender Management Service have accepted all of the above recommendations.