

**Investigation into the circumstances surrounding the
death of a man whilst a resident at Chorlton Approved
Premises, Greater Manchester Probation Trust**

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

November 2010

This is the report of an investigation into the death of a man. The man was found hanging in his room at Chorlton Approved Premises, a hostel managed by Greater Manchester Probation Trust in 2009.

I would like to offer my sincere sympathy and condolences to the man's family and friends for their loss. I apologise for the delay in issuing my report and any additional distress this may have caused.

This investigation was conducted by one of my senior investigators. I would like to thank the then manager of Chorlton and the staff at Chorlton for their help and cooperation.

The man moved into Chorlton on 23 June 2009, having spent 13 days in custody at HMP Forest Bank. He was a popular and a generally well liked resident who, along with others, landscaped the garden at Chorlton, creating an attractive and very useful space for all those who use the hostel.

Whilst in custody, the man was interviewed by court and prison staff about a previous suicide attempt and other statements he had made about harming himself if he was remanded into custody. Unfortunately, staff at Chorlton were not given any explicit warnings that the man might consider suicide.

On the eve of his death, the man returned to Chorlton after going out for a drink. A confrontation ensued and he threatened another resident with a pool cue. He was sent to his room by staff but, an hour later, was found hanging from a coat hook. Although staff attempted to resuscitate him, the man was pronounced dead on arrival at hospital.

I make seven recommendations as a result of this investigation. They relate to the use of ligature cutters, involving residents in resuscitation attempts, first aid training and offender records, managing risk of self harm and bullying, and managing bail conditions set by the courts.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and residents involved in my investigation.

Jane Webb
Acting Prisons and Probation Ombudsman

November 2010

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SUMMARY

In January 2009, the man appeared at Crown Court having been charged with serious offences dating from 1994. He was initially remanded into custody at HMP Forest Bank.

The man made an application to be bailed from prison to an approved premises in the Manchester area. He was granted bail on 23 June by the Crown Court and directed to live at Chorlton Approved Premises.

The man settled at Chorlton in a very positive manner. Although he was initially nervous at being in an approved premises for the first time, he quickly made friends and established himself as a cooperative and friendly resident who posed no significant management problems to staff. He also took part in the hostel programme.

On 6 July, the hostel management team reviewed the man's residence. It was noted on his record that he had previously been subject to hourly watches for two nights because of concerns that he might harm himself. None of the staff interviewed could tell my investigator where this information originated from but did not think the information to be relevant to his time at Chorlton. One staff member told my investigator that he believed the information referred to time spent in Forest Bank.

The man experienced some bullying by other residents at Chorlton which was addressed by staff. The hostel manager at the time told my investigator that he directly challenged another resident over unacceptable behaviour towards the man. Hostel staff also told my investigator that other residents made negative comments to the man about his good relationships with staff as well as comments about the offences which led to him coming to Chorlton.

A requirement of the man's bail was that he should not consume alcohol to the extent that he would be in excess of the legal drink drive limit. He was in breach of this condition on at least three occasions including the night when he died.

On the eve of his death, the man returned to the hostel in the evening having been out for a drink. He went to a communal area in the hostel and quickly became involved in an argument with two other residents. The man was observed by staff on CCTV brandishing a pool cue in a threatening manner. Staff attended and intervened, sending the man to his room. The incident was reported to the on call manager who advised staff to make regular checks on him.

Staff went to the man's room to check on him at 11.00pm and discovered him hanging from a coat hook attached to a wall.

I make seven recommendations as a result of this investigation. They relate to the use of ligature cutters, involving of residents in resuscitation attempts, first aid training and offender records, managing risk of self harm and bullying, and managing bail conditions set by the courts.

THE INVESTIGATION PROCESS

1. The investigation was opened by one of my investigators on 14 October 2009. The then manager at Chorlton produced a file containing various documents relating to the man's time there. Notices were displayed at the hostel to inform both staff and residents of the investigation.
2. My investigator also visited HMP Forest Bank and obtained the man's prison records in order to gather relevant information about his time there on remand before he was bailed to Chorlton.
3. My investigator formally interviewed six staff from Chorlton and the on call manager who dealt with the period following the man's death. None of the residents who knew the man at Chorlton chose to be interviewed during the investigation.
4. One of the Ombudsman's family liaison officers contacted the man's mother to inform her about the Ombudsman's investigation and to ask her if she had any concerns or questions about the care her son received. She told her that she had spoken to her son at about 6.25pm on the evening he died and he sounded alright. He asked her when she would be visiting again so seemed to be looking to the future. She did not raise any concerns about the care the hostel provided to her son and described him as being very happy there. She was also thankful for the kind support she received from staff and residents at the hostel following her son's death.

CHORLTON APPROVED PREMISES

5. Approved premises are approved by the Secretary for State within section 9 of the Criminal Justice Act and Court Services Act 2000. They provide a structured, supportive environment in the community for high risk offenders many of whom have been released from prison to approved premises as part of a supervision plan agreed with the offender's probation officer. Occasionally places are offered to unsentenced individuals such as this man, but this is becoming increasingly rare.
6. There are seven approved premises in the Greater Manchester area managed by Greater Manchester Probation Trust (GMPT). The Trust has an Assistant Chief Executive who oversees all of the approved premises, each of which has a manager, probation officer and residential support staff.
7. Chorlton Approved Premises is a pair of large Victorian houses which have been joined together, providing accommodation for up to 27 men. The accommodation is a mixture of single and double rooms, communal lounges, dining room, laundry and other areas used for group work as well as quiet areas. The hostel has a number of CCTV cameras covering communal areas, which are monitored by staff in the main office.
8. On arrival at Chorlton, every resident undertakes a two stage induction process which ensures each resident understands and accepts the rules and regulations relevant to their residence and the expectations placed upon them. Every resident is allocated a key worker who is a member of staff with whom the resident meets to discuss their progress, well being, participation in the regime of activities and group work. Failure to follow the regime is taken very seriously and can represent a breach of hostel rules.
9. Each resident has his own key to his room which must be handed in when they leave the house and collected on return. Residents can have visitors as long as they have the permission of the manager and they must also abide by the hostel's curfew between 11.00pm and 6.00am. (The man was subject to an extended curfew set by the court between 9.00pm to 9.00am.)
10. All approved premises have strict rules regarding alcohol and illegal drugs. The possession of alcohol, solvents and controlled drugs is not allowed. This is reinforced by random but regular room searches. Prescribed medication must be handed to staff for safe storage, following which compliance with medication is closely monitored. New residents are advised about a number of local medical practices who will accept registration from residents. It is the resident's responsibility, however, to register with the practice.
11. Night duty is carried out by two night supervisors. At the beginning of their shift, the night supervisors receive a briefing from the day staff about the events of that day and advice about individual residents who may need

support, guidance or whose behaviour is causing some concern. Their duties also include patrolling the hostel at night, conducting checks on residents and writing up their observations in the hostel log book.

12. GMPT use the Assessment, Care and Teamwork (ACT) procedure which is designed to help staff support residents who are at risk of self harm and suicide. ACT was introduced in 2006 and is similar but not identical to the procedures used by the Prison Service.
13. There have been three previous deaths at Chorlton since the Ombudsman was given responsibility for investigating all deaths in Approved Premises in April 2004. All three deaths have been self inflicted. There are some issues in common with this man's death and the last death of a resident at Chorlton in April 2008. They concern the supply, issue and use of ligature cutters, and managing cardio pulmonary resuscitation.

KEY FINDINGS

14. The man was arrested by Greater Manchester Police on 22 January 2009 on suspicion of committing serious offences in 1994. He was initially remanded on police bail to March 2009.
15. On 10 June, the man was remanded into custody at HMP Forest Bank by a Magistrates' Court. Greater Manchester Probation Trust staff working at the court completed a self injury/suicide warning notice which stated:

“Since he (the man) has been questioned and charged he has harmed himself on a number of occasions, he has told the Police that he will harm himself seriously if he is remanded.”

16. When the man arrived at Forest Bank, staff opened an ACCT document (ACCT – Assessment, Care in Custody and Teamwork - is the process used by the Prison Service to monitor and support prisoners at risk of suicide or harming themselves) and interviewed him further about his statements regarding self harm. Prison staff wrote in the man's medical record that his comments about self harm were the result of being fed up and worried about how he would be treated in prison.
17. During his health screening on reception to Forest Bank, the man told prison staff that he had been diagnosed with Bell's palsy, a condition which leads to the inability to control facial muscles in a particular area of the face. The man also told prison staff that he had an appointment to attend Wigan Infirmary on 9 June for further treatment. However, the man had been in police custody that day, and was unable to attend the appointment although he was seen by a police doctor.
18. Whilst in Forest Bank, the man applied to the GMPT Approved Premises central referral office for a place in an Approved Premises in order to make an application for bail. The application was approved and, on 23 June, he was granted bail to Chorlton Approved Premises by Crown Court with the following bail conditions:

“To live and sleep at each night at 10-12 Oswald Road, Chorlton, Manchester M21 9LH.

To observe a curfew between the hours of 21:00 and 09:00.

Comply with the approved premises rules and regimes.

Comply fully with all instructions given by approved premises staff.

Not to contact directly or indirectly any prosecution witness.

Not to consume alcohol in excess of the drink drive limit.

Comply with assessment treatment and testing in relation to alcohol and illicit substances.

Sign in at approved premises daily at 13:00 and 17:00 (suspended until 31.8.09)

Not to enter a designated area save for the purposes of appointments with solicitors and to attend court.

No unsupervised contact with any person under the age of eighteen.”

19. The man arrived at Chorlton at 3.00pm on 23 June. He was met by staff and was given the first stage of induction by a staff member. (Induction is an important part of the introduction to approved premises for new residents. It covers important events in day to day hostel life, such as meal times, fire regulations, expectations about behaviour and next of kin details.)

20. On 25 June at 2.00pm, the man met with the probation officer for Chorlton. Her role with regard to the man was to ensure that he complied with his bail conditions and engaged with the regime. If necessary, she would report any problems to the Crown Court. In his personal formal record on Delius (GMPT’s case recording system), she wrote:

“Went through bail conditions. Made aware of hostel rules and regulations ... reminded of importance of keeping the hostel rules and expectations. Curfew 7.00pm- 9.30am, signing times 1.00pm and 5.00pm. ... Agreed that I would see him weekly at the end of his trial. Indicated that he would be entering a plea of not guilty. Indicated that he is receiving considerable support from his extended family. Raised the issue of suicide and self harm. Said he did not have a history of self harm or attempted suicide. Explained the support available if he felt unhappy about his current situation.”

21. Four days later, on 29 June, the man completed the second stage induction with his key worker. (A key worker is the member of staff responsible for delivering interventions designed to reduce the risk of reoffending.) The second stage of induction is aimed at setting up the key worker meetings, encouraging participation with the hostel regime, employment and personal development opportunities. The key worker arrangement also encourages the resident to trust their key worker and be open and frank about their feelings. This is important because residents will often discuss problems such as depression or poor family relationships. Key workers can then ensure that staff are vigilant with residents who are vulnerable to ensure they do not become isolated in the hostel.

22. Later on 29 June, whilst on night duty, a staff member wrote up the notes from a management meeting held earlier that day on the man’s Delius record. This note included the reasons for the man’s residence, comments about his behaviour and involvement in hostel activities. The staff member

also wrote “hourly watch tonight and tomorrow night”. There is no link to any other previous entry concerning hourly watches. In interview with my investigator, the probation officer for Chorlton said that she did not know when or where the comments regarding hourly watch were made. On the same date in a resident review, the staff member also wrote “hourly watch tonight and tomorrow night”.

23. On 1 July, the probation officer for Chorlton wrote on Delius that the man said he had settled into the routine of the hostel. She also wrote that she told the man that she had discussed a variation of his curfew and signing times with his solicitor and there might be a change to his bail conditions. She told him that he would be allocated to the self management group, which is designed to help residents learn skills for life. She also noted that he was involved in redesigning the hostel garden.
24. Two days later, the man had a meeting with his key worker. During this meeting, the man told his key worker that he would plead not guilty to the offences he was charged with. He also asked if it was possible to stay at Chorlton if he was found not guilty. The man’s key worker explained that the Probation Service would not have responsibility for him if he was not convicted. He also wrote that the man was keeping himself busy working on the garden with another resident.
25. On 6 July, the man’s residence was reviewed by the Chorlton management team. They considered the man’s overall cooperation. Items discussed included risk factors, behaviour and compliance with the hostel regime and any self harm or suicide concerns that the staff might have noticed. The conclusions were that the man was very cooperative, helpful around the hostel and had successfully completed his induction. They also discussed that he had completed his Manchester City College assessment and claimed his state benefits. The hostel had notified Greater Manchester Police Sex Offender Management Unit of the man’s residence (this is a local arrangement between Greater Manchester Police and GMPT).
26. The man continued to cooperate with all aspects of his residence. He was very involved with a project developing the garden at Chorlton which was overseen by a local community college. The garden was to be entered into a gardening competition involving all GMPT approved premises.
27. During a consultation with his key worker on 19 July, the man told him that he was being bullied by another resident at the hostel. His key worker wrote in the man’s Delius record that two other residents at Chorlton had confirmed that he was being bullied.
28. The man’s key worker challenged the person identified as bullying the man. The person denied bullying and the matter was referred to the hostel manager. In interview with my investigator, the hostel manager said that he investigated the allegations and agreed with the man that the behaviour was bullying. The hostel manager told my investigator that the man was the victim of inappropriate sexual approaches from another resident. The

resident was disciplined and, in a key worker session with the man's key worker on 23 July, he told him that the bullying had stopped.

29. During the same meeting, the man's key worker became concerned that the thought of his trial was starting to affect the man and that he was putting on "a brave face". The meeting concluded with the man's key worker reminding him that he could talk to any of the hostel staff at any time.
30. On 6 August, the man was suspected of consuming more alcohol than allowed under the limit set out in his bail conditions. A staff member recorded in the man's Delius record that his "speech was slurring" and that there was a "strong smell of alcohol coming from his person". The staff member breathalysed him and he was found to be under the legal drive limit which was in line with his bail conditions. The staff member told my investigator that, when he had been drinking, the man could be challenging to deal with.
31. The man continued to make good progress while on bail and his records at Chorlton show him to be a popular resident who continued to enjoy gardening. He was considering applying for a training course in horticulture, having been unsuccessful in seeking employment.
32. On 26 August, the man reported an incident to staff. He said that a woman he did not know approached him in Manchester city centre, stared at him and followed him. Although no words were exchanged, the man told staff that he was unsettled by the incident and felt very uncomfortable.
33. The next day, the man attended the hostel's health and well being session which focussed on depression. On his Delius record, a staff member wrote "he is always [a] good participant and seems to enjoy the sessions".
34. At 9.13pm the same day, the man returned to the hostel five minutes late for his curfew. He told a residential officer at Chorlton House that he had been into town for a meal and a drink. She wrote on his Delius record that the man was concerned at being late and was slightly upset. He was also breathalysed and his reading was 0.65mg/l (which is almost double the drink drive limit and therefore a breach of his bail conditions).
35. The residential officer at Chorlton House contacted the on call duty manager regarding the two breaches of the man's bail: being late for the curfew and consuming too much alcohol. She was advised not to take action but to refer the matter to the probation officer for Chorlton for action the following morning. (There is no record on Delius to show whether any further action was taken.)
36. Later the same evening, the man told a staff member that he had been receiving inappropriate texts from another resident and had saved the messages on his mobile phone. The staff member recorded this on Delius

as “Important- Read Me!!!”. (My investigator has not found any record that shows that the issue was followed up.)

37. Following the breach of his bail conditions, the man continued to cooperate with the hostel regime, submitted to random breathalyser tests, attended programmes and worked on the hostel garden. The man also started a course at Manchester City College.
38. On 14 September, the man attended Crown Court and his case was adjourned to 12 October. He returned from court and, speaking to the probation officer for Chorlton, said he was pleased about the hearing and in particular that his defence was supported by new information received by his solicitor.
39. The man also told her that he had consumed three pints of lager after the court hearing. The probation officer for Chorlton impressed the importance of monitoring his alcohol consumption as this was part of his bail conditions. After the interview with her, the hostel records show that the man again settled down into the routine of the hostel, involving himself in the programme in a constructive and helpful manner.

Events on the eve of the man’s death

40. On the eve of the man’s death at 9.50pm, he became involved in an argument with two other residents in a communal area within the hostel. Staff observed the man brandishing a pool cue and two male staff members intervened and moved him to the staff office.
41. In the office, the man told staff that he felt that other residents were “having a go” at him for no apparent reason. He also told the staff “If I told you everything I would be here all week”. The other residents involved were also interviewed and, when matters had calmed down, the man was advised to go to his room at 10.00pm by one of the male staff members.
42. One of the staff members had been on duty since 9.30am and was due to go off shift at 9.30pm. He decided to stay on longer that night to help his colleagues deal with the man. In interview with my investigator, the staff member said that he had witnessed a previous self inflicted death in a different approved premises and that the man’s behaviour reminded him of that occasion. In interview with the investigator the staff member said that he passed his concern to the on call duty manager.
43. Three members of staff agreed that there should be extra checks made around the hostel that night to monitor the atmosphere. One staff member reported full details of the incident to the duty manager, a Senior Probation Officer who worked in approved premises. The staff member and the duty manager discussed whether there were possible reasons for the man’s behaviour, such as a forthcoming court appearance. His file was checked and they both agreed that there were no issues that gave them any concern that he might harm himself. In her written statement of 12

October, the duty manager wrote that staff could not access the Delius system to check the man's records. My investigator was told that the Delius system was not working that weekend. According to Delius records supplied to my investigator, the man was due in court on 12 October.

44. The duty manager advised that staff should monitor the man throughout the night when conducting checks and, although no specific interval between the checks was discussed, duty staff decided to do so hourly. However, in interview a staff member told my investigator that she believed the intervals to be half hourly. One of the three staff members left Chorlton House at 10.45pm.
45. The further two staff members, one male, one female, started to undertake their hostel checks as normal on night duty and they arrived at the man's room at 11.00pm. The male staff member went into the room and, at first, he could not see the man. He checked the bathroom and sleeping area before noticing the man suspended from a coat hook attached to the wall behind the door by a ligature made of shoe laces.
46. The male staff member told my investigator that he told his colleague to call for an ambulance and immediately started to lift the man's body to relieve the pressure from the ligature. The female staff member used her portable emergency alarm to call the police, and made her way to the office to call for an ambulance.
47. Another hostel resident came into the room and helped the male staff member remove the ligature. He then placed the man on his bed and started chest compressions. He told my investigator that he believed the man to be responding as he was "making a noise" with each compression.
48. The male staff member used his mobile telephone to connect to the ambulance control room. He was advised to place the man on the floor for the purpose of cardio pulmonary resuscitation (CPR). He and another resident, who had been involved in the earlier altercation with the man, again administered CPR.
49. Police officers arrived at approximately 11.10pm, followed shortly afterwards by paramedics. The man was transferred to hospital and his death was pronounced at midnight. Duty staff and the duty manager (who had come to the approved premises after being alerted) stayed on duty to support residents.
50. The man's next of kin, his mother, was informed of his death in person by Greater Manchester Police. All staff interviewed by my investigator confirmed that they were offered the support of their employer.
51. A toxicology report was prepared by a doctor from the Manchester Royal Infirmary as part of the post mortem. It showed that the man had significantly higher levels of alcohol in his blood and urine than the legal driving limit. The doctor also wrote that levels were probably higher a few

hours before death. The man's post mortem report mentions that there was an empty half bottle of vodka on his bed as well as a packet of shoe laces.

52. Some time after his death, the man's mother went to Chorlton to collect her son's belongings. In interview, the probation officer for Chorlton told the investigator that the man's mother told her that her son had telephoned her the night of his death. She said that his only worries were financial concerns and he gave no indication to her of any other problems that might have affected him.

ISSUES

The man's use of alcohol.

53. The man was released on bail to Chorlton with a number of conditions. One of these was that he should not consume alcohol above the legal drink drive limit. He exceeded this limit on a couple of occasions when no action was taken. He also consumed alcohol on the night he died, as shown in the toxicology report.
54. The female staff member told my investigator that, although she had no direct experience of the man being difficult to manage when he had been drinking, she was aware that other staff found him argumentative. She also said in interview that she believed the man to be a "regular drinker". She said that she was aware of situations where staff had intervened with the man to stop arguments with other residents after he had consumed alcohol.
55. One of the members of staff on duty on the night the man died said in his statement that when the man had been drinking his behaviour could be very challenging and aggressive. However, other staff who were interviewed told my investigator that the man presented no significant management problems to them.
56. The man may have benefited from some structured warnings or other interventions concerning his alcohol use. Given that this was one of the conditions of his bail, I am concerned that this matter was not satisfactorily addressed at an earlier stage and, in particular, after he was found to be over the legal limit on 27 August.

Greater Manchester Probation Trust should ensure that appropriate action is taken when a bail condition is breached.

Response to the man's allegation that he was receiving inappropriate texts

57. The man told a staff member on 27 August that he had received what he believed to be inappropriate texts from another resident. The staff member made a note of this, but it is unclear whether any action was taken as a result. Given that only a month earlier the man had been bullied by another resident, I believe that further investigation by staff was necessary. I do not think however that these texts contributed directly to the man's decision to take his own life.

Greater Manchester Probation Trust should ensure that significant events, such as bullying, are followed up by staff and appropriate action taken.

Should an ACT document have been opened for the man?

58. The actions of the duty staff on the night the man died suggest that they had serious concerns about his behaviour and state of mind. They took action after consultation with the on call manager, and decided to check the man at regular intervals. Whilst it is to the duty manager's credit that she took the call from Chorlton seriously and advised staff as to what action to take, it is my opinion that consideration should have been given to opening an ACT document on the man. This would have given staff an opportunity to discuss his concerns further and to formally offer him support both that night and over the coming days. It would have also ensured that he was aware that staff were concerned about him.

Greater Manchester Probation Trust should satisfy itself that approved premises staff are aware of the Trust's policy on ACT and ACT procedures.

In response to the draft report, GMPT responded to this paragraph directly. They said that the duty manager (who has now retired)

“was the division lead on ACT and her decision to ask staff to observe [the man] more closely appears to be an informed view that opening an ACT was under active consideration but not yet reached at that point.”

Use of ligature cutters

59. An investigation onto a death at Chorlton in 2008 recommended the National Offender Management Service (NOMS) consider whether safe ligature cutters should be supplied to all approved premises. This recommendation was accepted. Although present on the premises, ligature scissors were not used to cut the man down. When my investigator asked about this, GMPT replied that they had been progressing the issue locally in the absence of any NOMS directive. The hostel manager at the time told my investigator that he was sure that ligature cutters would be on GMPT's Health and Safety committee agenda on 17 December.

60. The hostel manager at the time confirmed in interview with my investigator that there had been no training or instructions issued as to how to use the scissors. He also said in interview that approved premises managers have been told to wait until proper training or guidance had been given.

61. My investigator has spoken to the Head of Approved Premises at NOMS to clarify the position on ligature cutters. The Head of Approved Premises at NOMS replied that if GMPT has obtained cutters, that they were free to use them but that they should organise training directly if they were planning to use them. Whilst it is commendable that the ligature cutters are available to staff, they are only useful if staff have the knowledge to use them.

Greater Manchester Probation Trust should provide training in the use of ligature cutters.

Resuscitation

62. The staff member who discovered the man told my investigator that another resident of Chorlton House helped him to lift the man down. He added that he did not know whether the resident who took over CPR from him was qualified to do so. However, the staff member did say that, as an experienced first aider, he considered that the resident's actions in administering CPR were correct. While the resident's actions in this instance are worthy of praise, it would be wise for GMPT to issue instructions to staff about the help they should allow from other residents.

Greater Manchester Probation Trust should consider whether residents of approved premises are allowed to participate in the resuscitation of other residents in the absence of evidence of their competence.

63. I believe that the member of staff handled a difficult situation well and, while attempting to relieve the pressure of the ligature and commence CPR, he also asked his colleague to call an ambulance. He then sought the advice of the ambulance control staff. However, it was only when he made this call that he was told that CPR needed to be performed on a hard surface and that the man needed to be moved to the floor.

64. I intend no criticism of that member of staff, who was doing everything he could in the circumstances. However, GMPT may wish to review the level of first aid training given to staff in approved premises, to make sure that staff have up to date training.

Greater Manchester Probation Trust should ensure that staff at approved premises have up to date first aid training.

Change of a formal record post death

65. On 5 November, my investigator received an email from the then Area Manager for approved premises in Greater Manchester. She wrote that, whilst preparing paperwork to assist the investigation, staff brought to her attention that a member of staff had edited the Delius entries on the man's record. I have been informed that the member of staff edited two entries which were made on 14 and 21 September. The entry of 14 September was amended by the addition of a reference to an alcohol contract being a condition of bail. (The second amendment was a correction of a date.)

66. GMPT has investigated the matter and I am satisfied that the issue has been properly dealt with. However, it may be prudent for them to reissue their policy about retrospective records on Delius.

Greater Manchester Probation Trust should satisfy itself that approved premises staff are aware of the Trust's policy about retrospective amendments to offender records.

CONCLUSION

67. The man was bailed from prison while on remand for a serious offence. He was directed to live at an approved premises when he was released.
68. While at Chorlton, the man received inappropriate attention from a fellow resident. He also breached the terms of his bail conditions by returning to Chorlton House having consumed too much alcohol. This investigation has found that these incidents could have been dealt with more appropriately by staff.
69. On the night the man died, staff were sufficiently concerned to alert senior managers to his condition. As a result, they were asked to make frequent checks on him. I believe that it would have been appropriate at this time for suicide monitoring to have been put in place.
70. When the man was found, I believe that staff did the best they could to try and save his life. While it is difficult to say whether, had anything been done differently, the outcome would have been different, I make several recommendations about the emergency response.

RECOMMENDATIONS

1. Greater Manchester Probation Trust should ensure that appropriate action is taken when a bail condition is breached.

GMPT have responded: "GMPT agrees fully with the recommendation. The report highlights concern re level of discretion applied in this case. In regard to the circumstances of 27th August, when [the man] was tested for alcohol use and it proved positive, the RSW contacted the on call duty SPO who correctly advised the matter be dealt with by the PO the following morning. Contact with the police should have occurred the next morning for the Police to decide whether to proceed with the breach of bail conditions. GMPT is reviewing its procedures to ensure appropriate response to bail conditions."

2. Greater Manchester Probation Trust should ensure that significant events, such as bullying, are followed up by staff and appropriate action taken.

GMPT have responded: "GMPT accepts fully this recommendation. There is evidence of GMPT staff responding appropriately to bullying of [the man] (July 19th), but it is recognised that in regard to the "texts" further enquiries should have been made beyond logging them and further support offered to [the man]."

3. Greater Manchester Probation Trust should satisfy itself that approved premises staff are aware of the Trust's policy on ACT and ACT procedures.

GMPT have responded: "In 2009 a regional Approved premises working group adapted the prison self-harm and suicide procedures (ACCT) to fit more closely with the needs of an approved premises regime. In consultation with prison staff a new Policy, staff manual, procedures and training was developed. The training was delivered to all GMPT approved premises staff in January / February of 2010. In the six months subsequent to that training, a process of quality checks has been initiated and any concerns highlighted to individuals and teams."

4. Greater Manchester Probation Trust should provide training in the use of ligature cutters.

GMPT have responded: "In February of 2010 GMPT identified providers of Emergency Incident Training [EIT] and this was then made mandatory training for all staff. This EIT training was provided by Greater Manchester Ambulance Service who incorporated advice on the type of ligature cutters and methods of use."

5. Greater Manchester Probation Trust should consider whether residents of approved premises should be allowed to participate in the resuscitation of other residents in the absence of evidence of competence.

GMPT have responded: "Approved Premises do not benefit from the ability to draw quickly on a large compliment of staff. There is a need in emergency situations to make informed judgements about how best to meet the needs of a given situation. Involvement of other residents in resuscitation is not a practice the Trust advocates as a primary resource, however we encourage staff to utilise available assistance as they judge appropriate. We are in discussion with other agencies and seeking legal advice as to the implications of a total ban on resident involvement."

6. Greater Manchester Probation Trust should ensure that staff at approved premises have up to date first aid training.

GMPT have responded: "All new staff, as part of their induction into a role in approved premises attend a first aid course. The division has a training strategy and we are reviewing records of all staff attendance to ensure first aid is prioritised. The Emergency incident training (as mentioned in recommendation 4) has an element of both general first aid and resuscitation."

7. Greater Manchester Probation Trust should satisfy itself that approved premises staff are aware of the Trust's policy about retrospective amendments to offender records.

GMPT have responded: "GMPT has previously initiated disciplinary action where staff have made retrospective entries on case records. The system has been designed to ensure retrospective amendments are recognised. GMPT will take forward action on ensuring staff awareness of this issue."