PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man at an Approved Premises managed by the Wales Probation Trust

Our Vision

‘*To be a leading, independent investigatory body,*
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision’

This is the report of the investigation into the death of a man at an Approved Premises managed by Wales Probation Trust. The man was found hanging in his room on 14 November 2012. He was 64 years old. I offer my condolences to his family and friends.

The investigation was carried out by one of my investigators. Staff at the Approved Premises cooperated fully with the investigation.

The man had been in custody since 1999 and he arrived at the Approved Premises on 31 August 2012, after being released on licence from HMP Shrewsbury. He was allocated a key worker who carried out his induction. The man had no recent recorded history of any acts of self-harm and he appeared to be settling into life at the Approved Premises.

On 13 November, the man was interviewed by staff and the police after an accusation had been made about an inappropriate relationship with another resident who had learning difficulties. He denied the relationship. His offender manager spoke to him about the situation and believed the man was reassured that he was not being recalled to prison at that stage. During the evening of 13 November, the man went to a local public house for an hour or so. When he returned he gave no indication that he was upset or depressed about the events earlier in the day, although he spoke to a friend on the telephone and told him he was worried. The next morning another resident found the man hanging from the door of his room. Resuscitation was not possible as it was clear that he had been dead for some time.

Although the man had been interviewed about the alleged inappropriate relationship, which he denied, staff at the approved premises did not think there was anything to indicate he was at risk of self-harm or suicide. I am satisfied that it would have been very difficult for probation staff to have predicted or prevented the man's death.

The 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.

Nigel Newcomen CBE
Prisons & Probation Ombudsman **April 2013**

SUMMARY

1. The man was 64 years old when he died on 14 November 2012 at an Approved Premises managed by Wales Probation Trust. He was found hanging from the door of his room. On 29 September 1999, the man had been sentenced to 10 years imprisonment for a number of sex offences and in 2002 was sentenced for further offences. On 31 August 2012, he was released from HMP Shrewsbury on licence. As part of his licence conditions the man had to reside at an Approved Premises. During his induction at the Approved Premises the man said that he had taken an overdose in 1995 and had cut his wrists over 30 years previously.

2. During the evening of 12 November, staff at the Approved Premises were informed of a rumour that the man had an inappropriate relationship with another resident who had learning difficulties. On 13 November, the man and the other resident were interviewed by staff and police (although not as a criminal matter) about the alleged relationship, which the man denied. During a search on the same day inappropriate DVDs were found in the man's room and he agreed to their disposal. His offender manager spoke to him about the events but said he was not being recalled to prison at that stage. She believed he was reassured. During the evening of 13 November, the man went to visit a local public house where he usually had two glasses of wine. He returned around 9.00pm and he seemed to be in good spirits. He telephoned a friend that night about 10.30pm and told him what had happened that day and that he was worried about the possibility of being recalled to prison. They arranged to meet the next day.

3. At around 8.45am on 14 November, one of the other residents went to the man's room as he was concerned he had not seen him that morning. As he was unable to get a response he tried to open the door to the room which was not fully closed and discovered the man hanging on the other side. The resident immediately informed the two members of staff in the general office.

4. The staff could see the man was hanging from the door frame by a scarf but were unable to get into the room. Initially they were worried about causing further injury so they did not force the door fully open. They summoned help before using force to open the door and cut the man down. It was apparent that he had been dead for some time so staff did not attempt to resuscitate him. An ambulance was called and paramedics pronounced the man dead at 8.57am.

5. From interviews with staff, the man appeared to be a well liked and respected man. He appeared to be very happy at the Approved Premises and was well supported by staff. While it is evident that the man would have been upset about the accusation which had been made against him, we are satisfied that there was nothing to alert staff at the Approved Premises to his subsequent actions and there was nothing staff could reasonably have been expected to do to prevent his death. This report makes no recommendations.

THE INVESTIGATION PROCESS

6. The Ombudsman's office was informed of the man's death on 14 November 2012. The investigator issued notices to staff and mans at the Approved Premises informing them of the investigation and asking anyone who had relevant information to contact him. He also contacted staff and prisoners at HMP Shrewsbury. No one came forward. The investigator examined the man's relevant probation and prison records, including his medical records.

7. The investigator visited the Approved Premises in November 2012 and January 2013 to conduct interviews with staff. The investigator spoke to the man's offender manager[1]; staff at the Approved Premises, the man's key worker and a nurse who works at the approved premises. He also spoke to the offender manager for the resident with whom the man had an alleged inappropriate relationship. The investigator also conducted an interview at Shrewsbury. On 9 January, the investigator gave initial feedback to the manager of the Approved Premises and subsequently confirmed this in writing.

8. Her Majesty's Coroner for Cardiff and Vale of Glamorgan District was informed of the investigation and provided a copy of the post-mortem report. The inquest held on 13 February, found that the man took his own life. Our report has been sent to the Coroner for information.

9. One of our family liaison officers contacted the man's family. She outlined the purpose of our investigation. The man's family did not have any specific issues they wanted the investigation to consider. The man's family received a copy of the draft report. No further representations were made in response to the findings.

[1] The offender manager is responsible for assessing an offender's risks and needs, planning how a sentence will be organised, deciding what activities need to be carried out and how they will be delivered. They are also responsible for reviewing the offender's progress against their sentence plan and for adjusting the plan in the light of changing circumstances.

APPROVED PREMISES

10. Approved Premises (formerly known as probation and bail hostels) are approved by the Secretary of State under 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 as part of a supervision plan, agreed with the person's offender manager (probation officer).

11. Residents must be aged over 18 and include those who have committed serious, violent and dangerous offences and who have completed the custodial part of their sentence. The majority of residents are required to stay as a condition of a court order or prison licence.

12. The Approved Premises can accommodate men who are on bail, on community orders or on licence following prison sentences. The building has closed circuit television (CCTV) and residents are required to sign in and out of the building and follow curfews which are determined by the man's offender manager. During induction, new residents are told about the local house rules. Residents are also allocated a key worker to be their primary contact. They help with practical issues and provide one-to-one sessions underpinned by the objectives outlined in the offender's sentence plan.

13. Residents are responsible for their own health and usually register at one of the local doctors' surgeries. If they require a consultation with a doctor or visit to hospital then, unless it is an emergency, the onus is on the man to arrange the appointment and transport. There are identified staff who are trained in first aid and cardio-pulmonary resuscitation (CPR)[2]. As part of the conditions of residence, most prescribed medications are held by the Approved Premises and are issued by staff to residents daily. Residents collect their medication from staff during the day and must sign to confirm the type and quantity on each occasion.

[2] Cardio-pulmonary resuscitation (often described as mouth-to-mouth resuscitation) is a combination of rescue breaths and chest compressions to keep blood and oxygen circulating in the body.

KEY EVENTS

14. The man was born in 1947. In 1999, the man was sentenced to 10 years imprisonment at Crown Court for sexual offences. In 2002, after additional offences had come to light, the man was sentenced to 18 years imprisonment.

15. The man was released on licence on 31 August 2012 to reside at an Approved Premises.

The man's licence conditions

16. As part of the man's licence conditions, he was to have regular contact with his offender manager and live at an Approved Premises. He was subject to a curfew and had to be inside the building between 8.30am and 9.00am, 12.00pm and 1.15pm, 7.30pm and 8.00pm and like all other mans, during the night between 11.00pm and 7.00am. The man was forbidden to enter the area of his offence and had to notify his offender manager of any developing relationships with women. He was not to seek or communicate with his victims or their families without the approval of his offender manager, and was not allowed to have unsupervised contact with or live in a household with anyone under the age 18 years. The man knew that if he failed to obey these licence conditions he could be recalled to prison. His licence was due to expire on 28 May 2014, when he would no longer be subject to conditions.

The man's time at the Approved Premises

17. When the man left prison he was met by staff from a local housing association who accompanied him to the Approved Premises. His stay at the Approved Premises was intended to be for three months, after which he would move onto live in the community. The placement was to enable him to have a stable base to help his resettlement into the community.

18. An Approved Premises Service Officer (APSO) conducted the man's induction at the Approved Premises. He noted that the man's last act of self-harm was an overdose in 1995 and he had cut his wrists over 30 years previously. The APSO's initial aims were to settle the man into the Approved Premises and the community and to ensure he was fully aware of his licence conditions and curfews.

19. The APSO explained the implications of the man not complying with his licence and the Approved Premises' rules were fully explained. The man had a single room (Room 12) on the first floor. He was later prescribed co-codamol (pain relief medication) and this was issued to him daily.

20. The man's key worker met him regularly to discuss his progress. The key worker told the investigator that he had read the man's records before his arrival at the Approved Premises and had no concerns about his risk of self-harm or suicide. The key worker said when they first met he was a "very nervous man" and who, due to his long period in custody appeared to have forgotten how do things for himself. He estimated that it took the man about

four or five days to start mixing with the other residents but said that once he started mixing he settled in well.

21. On 3 September, his offender manager visited the man at the Approved Premises. They discussed his licence conditions and his concerns about another resident who used to live near him before he was convicted of his offence.

22. On 7 September, the offender manager visited the man again. The resident the man had been worried about had been recalled to custody so this was no longer an issue. The man told her that he lacked confidence and was afraid of going out. When they met three days later, on 10 September, he seemed more settled. The offender manager visited the man on 18 September and they discussed his risk factors of re-offending. When she saw him a week later, on 25 September, they talked about his relationship with this family.

23. On 5 October, the man attended a meeting at a local police station about his supervision arrangements. At the meeting it came to light that the man had savings which would affect any claims for housing benefit. It was agreed to revise and remove his curfews and signing in times. The next meeting was scheduled for 7 December.

24. The offender manager visited the man on 12 October to discuss the meeting and his accommodation arrangements after he left the Approved Premises.

25. On 6 November, as the offender manager was on leave a colleague contacted the man. The man was concerned about being given a notice to leave the Approved Premises on 30 November. The local housing service was contacted and they confirmed that arrangements were being made to find accommodation for the man.

26. The APSO told the investigator that he saw the man around the premises during the three months after his induction and they engaged in conversation. He said the man settled in very quickly to life at the Approved Premises and was an enthusiastic man who was very helpful. On 8 November, when the APSO took a new resident, Mr E to visit a local museum as part of his familiarisation with the local area, the man accompanied them. The APSO said that the man was very knowledgeable about the exhibits and was looking forward to the future after he left the Approved Premises. According to the approved premises contact logs and records of his key working sessions, the man regularly visited local places of interest (such as museums) and spoke very positively about these experiences.

27. During the evening of 12 November, an member of staff at the Approved Premises was informed by one of the residents that he had heard rumours that the man was involved in an inappropriate sexual relationship with Mr E, who had learning difficulties, and was paying him for sex.

Events on 13 and 14 November 2012

28. Around 2.00pm on of 13 November, a Detective Constable attended the Approved Premises to speak to the man about his alleged relationship with Mr E. The Detective Constable worked in the Public Protection Unit and part of her responsibility was monitoring registered sex offenders including the man. The man denied that he had a sexual relationship with Mr E, and said he had given him money because he felt sorry for him. The Detective Constable advised the man to break all contact with Mr E, which he agreed to do. There was no suggestion of any criminal activity.

29. Mr E's offender manager spoke to him about the allegations. Mr E said that he and the man did have a sexual relationship and that the man had some inappropriate DVDs. She told the investigator that Mr E had learning difficulties and was known to make things up and make false allegations. However, she felt that on this occasion there might be some truth in what he had told her.

30. Approved premises staff searched the man's room while he was being interviewed by the police and discovered DVDs which were considered inappropriate due to their subject matter. The Detective Constable subsequently spoke to the man about the DVDs and he agreed to their disposal.

31. At around 3.00pm, the man's offender manager saw him to check how he was feeling and to discuss the allegations made against him and the inappropriate DVDs. The offender manager recorded that the man was very nervous and embarrassed when they met. He was aware that staff had been informed of the rumour that he had paid Mr E to carry out sexual acts. The man said that he bought some clothes and a meal for Mr E but denied having a sexual relationship with him. The offender manager reassured him that he was not to be recalled to custody at this time. The offender manager planned to talk to her manager and then contact staff at the Approved Premises on the following day to discuss the next steps. In her statement to the police, the offender manager said she had no concerns about the man in relation to suicide or self-harm at the end of her meeting with him.

32. At around 6.00pm, a member of staff visited the man in his room. In his statement, he said that the man was a little dishevelled and unshaved. They spent 20 minutes discussing what had happened. The man denied the allegations but said the rumours were upsetting and he would rather just stay in his room. The member of staff encouraged him to leave his room and he followed him downstairs to the lounge where he had a cup of tea with the other mans. He said there appeared to be no tension within the group.

33. A little later at around 7.30pm, the man left the Approved Premises to go to a local public house where he usually had two glasses of wine. He returned at around 9.00pm and was booked in by the night supervisor who gave him his room key. The man was seen at around 9.15pm when he said he was going to bed. His behaviour was normal and relaxed and staff did not observe anything unusual in his demeanour.

34. Staff recorded details of the events of 13 November about the man in the approved premises contact log. No-one identified any concerns that he might be at risk of self-harm or suicide.

35. CCTV footage, viewed in detail after the death, shows that at 10.32pm, the man went into his room (room 12). At 10.41pm, Mr E went into the man's room the door stayed open and he left the room within a minute when the door closed. At 10.57pm, Mr E then went into another resident's room and left shortly afterwards carrying a DVD player and then knocked on the man's door. The man opened the door and Mr E took the DVD player in and then left almost immediately without it. The man's door then closed.

36. When interviewed by the police, Mr E said that when he saw the man (at 10.41pm) he had told him he would return his DVD player. He said they only had a very brief conversation as the man appeared to be very tired and wanted to go to bed. According to Mr E, they did not discuss what had happened that day.

37. CCTV shows that at 11.16pm, the man left his room and went to the bathroom on the same floor. Two minutes later the man went back to his room. At 11.19pm, the door closed and a scarf was hanging down from the top of the outside of the door. At 11.25pm, the scarf slowly began to move upwards and at 11.29pm it moved suddenly up to the very top of the door. (It is likely that this was the time the man hanged himself.) CCTV is used to monitor movements of mans and for security purposes. The movement of the scarf would have been very difficult to notice while staff were conducting routine tasks in the general office and around the Approved Premises.

38. At around 8.45am on 14 November, a resident went to the man's room to check on him as he was usually up at that time. As he did not get a response when he knocked he tried the door which was a bit heavy. He pushed it open and discovered the man hanging on the other side from a scarf attached to the door. The resident immediately went downstairs to the general office and told a member of staff what he had discovered. Another member of staff in the general office called for an ambulance. The emergency services logged the call at 8.48am.

39. Two members of staff went up to the man's room but found the door closed and locked. It is likely that the door locked shut after the resident found the man and left the room. One of the members of staff used his master key, but only managed to open the door slightly and saw the side of the man's head slumped. The members of staff decided not to try to force the door at this stage in case they caused further injury to the man. They went back downstairs to get help. One of them brought the Community Psychiatric Nurse (CPN) who is based at the Approved Premises to the man's room while his colleague ensured other residents were kept away.

40. The CPN and the member of staff pushed the door open and went in. They cut the man down from the door. The CPN could not get a response from the man and was unable to find a pulse. He said the man was very cold and rigor

mortis[3] was also present. The CPN concluded that the man had been dead for some time, but he began to apply a defibrillator[4]. At this point paramedics arrived. The paramedics took over the man's care but after conducting an electrocardiogram (an ECG is a graphical recording of the electrical activity of the heart) they decided not to attempt to resuscitate the man, and pronounced death at 8.57am.

Events after the man' death

41. After the man's death, staff at the Approved Premises immediately invoked their contingency plans and began to inform all the appropriate agencies. The manager informed residents about the man's death. Staff were offered the services of the employee assistance programme if they needed support.

42. The police interviewed staff and residents and found no suspicious circumstances. The police informed the man's next of kin of his death.

43. After the man's death, the manager spoke to his family who later visited the Approved Premises. They met staff and residents and collected the man's personal belongings. Approved Premises contributed financially towards the man's funeral in line with national policy. The funeral took place on 30 November 2012.

Post-mortem report

44. The post-mortem report listed cause of death as asphyxia due to hanging. The verdict of the inquest held on 13 February 2013 was that the man took his own life.

[3] Rigor mortis is a condition of extreme stiffness affecting the arms and legs after death making it virtually impossible to bend the wrists, elbows or knees.
[4] A defibrillator measures electrical activity in the heart and issues audible instructions about treating the patient including, when appropriate, delivery of an electric shock. A defibrillator can restart the heart in some cases of cardiac arrest by giving an electric shock. It detects the electrical activity in the heart and gives automated instructions to the rescuer.

ISSUES

Suicide and self-harm monitoring

45. The man was described as embarrassed about what had happened during the day on 13 November. However, after talking to staff he agreed to come out of his room and associate with the other residents. Soon after he came downstairs, he went to the local public house for a couple of glasses of wine. Staff said that when they spoke to the man he did not indicate that he was concerned that he might be recalled to custody. Staff said that they did not consider the man to be at risk of self-harm or suicide at any time at the Approved Premises.

46. The man's offender manager completed an OASys[5] assessment for him before his release from prison, in which she assessed the man's risk of self-harm as "low". The offender manager told the investigator that she had no information that made her think that the man might harm himself at that time. Neither did she have any indication that the man would harm himself after the events on 13 November.

47. In his statement to the police, the man's friend said that during a telephone conversation, at around 10.30pm on 13 November, they had discussed what happened that day. The man had told his friend that he was worried about the possibility of being recalled to prison. They agreed to meet the next day to discuss what had happened.

48. The manager of the Approved Premises told the investigator that, although the man had experienced a difficult day he did not have any recent history of self-harm or suicide. From his previous experience of working in prisons, the manager had extensive knowledge of dealing with prisoners who had self-harmed and did not think the man was displaying any signs of suicidal behaviour. The man had been supported by staff after he was seen by the police and his offender manager and no one thought him at risk of self-harm or suicide.

49. Although there was nothing recorded by staff to show that they had considered whether the events of the day might have made the man so distressed that he would contemplate suicide, we are satisfied that the man gave them little reason to consider he was at risk. Neither did any of the other residents see any signs of what the man intended. Although the friend he telephoned said the man was concerned about the possibility of being recalled to prison, they had made plans to meet up the next day. We therefore consider it would have been very difficult for staff at the Approved Premises to predict or prevent his actions.

[5] The Offender Risk Assessment System (OASys) provides automatic sharing of data and operational information between the Probation Service and Prison Service IT systems so that updated offender information can be accessed instantly and securely by either organisation. This in turn should improve the consistency of offender assessment, provide courts with better informed sentencing advice, and support informed decisions on release and interventions.

The emergency response

50. The man was discovered at around 8.45am. Within a few minutes the staff involved had radioed for and received assistance and an ambulance had been called. As it was evident that the man had been dead for some time staff did not attempt resuscitation. Paramedics arrived within ten minutes of being called and pronounced death at 8.57am. We are satisfied that the emergency response was swift and appropriate. Staff acted quickly and in a considerate and professional manner.