Investigation into the circumstances surrounding the death of a man, resident at an Approved Premises, in the Humberside Probation Area, in December 2008

Report by the Prisons and Probation Ombudsman for England and Wales

July 2009

This is the report of an investigation into the circumstances of the death in December 2008 of a resident, at an approved premises. He had had travelled to Sheffield and jumped out of a hotel window to his death. He had only been released from HMP Moorland ten days earlier. He had a long history of mental illness.

I would like to extend my condolences to the man's family and friends for their sad loss.

My colleague conducted this investigation. I am grateful for the assistance he received from Humberside Probation Trust and, in particular, from the staff of the approved premises. I also thank the independent clinical reviewer appointed by the NHS, for her review of the man's prison records which assisted me in understanding the healthcare provided to him.

One of my family liaison officers spoke to the man's mother to inform her of my investigation and to offer the opportunity to raise any concerns. I hope this report answers any questions she may have about the circumstances surrounding her son's death.

Continuity of care is critical for released prisoners with mental health problems. It is reported by the Sainsbury Centre for Mental Health that men recently released from prison are eight times more likely to commit suicide than the general population. One-fifth of these suicides occur within 28 days of release.

I make one formal recommendation relating to the sharing of information between prison, probation and the NHS. My report will be shared with all three agencies so they can consider my findings.

Stephen Shaw CBE
Prisons and Probation Ombudsman **July 2009**

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SUMMARY

The man had a history of mental health problems, self harm, and misuse of drugs and alcohol from a young age. He was taking an antipsychotic medication at the time of his arrest in October 2005 when he was charged with a serious offence against his mother. He was subsequently detained in prison custody (HMP Hull) to await court proceedings.

During the man's prison reception health screening, it was noted that he was receiving psychiatric treatment and taking antipsychotic and antidepressant medication. He had also previously harmed himself by cutting his wrists and taking an overdose. He told the reception nurse that in 2004 he had attempted to jump off a tall building (later discovered to be the same building where he subsequently took his life) because he was suffering from depression.

Having been located on a prison wing, the man soon complained of delusions and hallucinations and felt that his current medication was ineffective. He was assessed by the prison psychiatrist and was later transferred to a secure hospital unit (a mental health unit which specialises in forensic psychiatry) where he could be assessed by psychologists and psychiatrist. He spent seven months at the secure hospital before being discharged back to prison custody. By the time of his discharge, he was not taking any medication. Staff completed an assessment and believed that he did not suffer from a mental illness but was predisposed to anxious and depressive personality traits.

In October 2006, the man was sentenced to five years imprisonment and transferred to HMP Moorland. His time in prison was not easy. He complained of hallucinations and was relocated to the prison healthcare unit, under the care of the prison psychiatrist and the Mental Health In-Reach Team (MHIT). He also had suicidal thoughts and attempted to harm himself by making superficial cuts to his hand. He referred twice to harming himself after his release from prison. His antipsychotic medication was reinstated and changed and it was noted that, as his medication dosage was increased, his mental well being improved.

In July 2008, the man returned to normal prison location where it was noted he was settled and no concerns were reported. He was due for release from prison, on licence on 1 December. As part of his licence conditions, he was to reside at an approved premises (AP). In October, his probation officer arranged for him to reside at an approved premises. He was also allocated Community Psychiatric Nurse (CPN) Care Coordinator who would help to meet his mental health care needs upon release. Although both had access to a previous psychiatric assessment carried out on the man, they were not aware of the full extent of his psychiatric involvement with the MHIT whilst he was in prison.

When the man was released from prison and first arrived at the AP, he was nervous but soon appeared to settle down. He received a full induction from staff who, aware of his past attempts at harming himself, monitored him under their self harm procedures. He was also visited twice (and once whilst in prison) by his probation officer and CPN. Both created care plans in order to support his needs and a

referral to a psychiatric doctor in the community was made. He was encouraged to try and gain employment and make use of his time.

Throughout his ten days at the approved premises, the man raised no concerns with staff. He had been prescribed medication for his mental health whilst in custody, and this continued on release. He appeared to manage his medication well and staff did not suspect that he was considering harming himself.

On his penultimate day at the approved premises, the man met with his CPN. He talked about his previous mental breakdowns and said he was currently having visual hallucinations. He later spoke with approved premises staff who noted no concerns.

The following morning, on10 December 2008, the man left the approved premises around 9.00am. All appeared normal, except that he did not collect his medication before leaving. Later that evening, the police contacted staff at the approved premises and enquired whether the man was a resident. The hostel was later notified by the police that he had jumped out of a hotel window to his death. Having searched his room, staff found he had left a suicide letter.

The man's death was the fourth death of a resident at the approved premises since my office became responsible for investigating deaths in custody and approved premises. None of my previous investigations raised issues relevant to this one.

THE INVESTIGATION PROCESS

1. The investigation was conducted by one of my senior investigators. I am grateful for the assistance he received from the Humberside Probation Trust, especially from the manager at the approved premises. Although those interviewed were themselves coming to terms with the man's death, they made facilities available and participated fully in the investigation.

2. My investigator visited the approved premises. He studied records, and interviews were conducted with staff. None of the residents of the hostel came forward to offer any information regarding the man, although given the short time that he spent there this is perhaps not surprising. My investigator also obtained the man's Mental Health In-Reach records from HMP Moorland.

3. The NHS identified a clinical reviewer to carry out a review of the man's healthcare during his transition from prison to the hostel. My investigator also shared his interview transcripts and his In-Reach records with her. I am grateful to the clinical reviewer, Director of Quality Standards, for undertaking the review.

4. One of my family liaison officers contacted the man's mother and explained the investigation process to her. She was invited to raise any concerns or questions for the investigation to consider, and these are listed below.

    - The man's mother believed her son should have been sent to a hospital and not to prison. She said that he had paranoid schizophrenia and she felt that getting out of prison, after such a long period inside, might have been too much for him. Prison was a controlled and structured environment and a phased release period could have benefited him.

    - His mother was in contact with the man at the approved premises and had visited twice. He appeared well although on one occasion was concerned about a meeting he had had since his release, when he had been told that he would need to get a job. He believed if he did not get a job he might be taken back to prison. His mother said this impacted on his condition and asked whether it was known that this type of stress could affect him.

    - The man's mother asked my investigator to consider one central question - whether her son was treated like any other prisoner or whether he was treated as someone with severe mental health problems. She felt that staff at the hostel were trying their best, and the staff had been very helpful to her since her son's death.

5. Following receipt of my report, the man's mother has expressed her incredulity that in view of the statistics given on page two paragraph five, vital information is still not being shared between the prison service and the community agencies.

THE APPROVED PREMISES

6. The purpose of an approved premises is to provide an enhanced level of residential supervision in the community, alongside a supportive and structured environment. Whilst residents have to comply with their individual licence or bail conditions, curfews, and the approved premises, they are essentially free to come and go from the building.

7. The approved premises is one of 101 hostels in England and Wales. It normally accommodates 19 residents and has one additional emergency bed. It is staffed 24 hours a day by probation employees (Assistant Wardens) whose role is to provide support and to ensure that the rules and licence or bail conditions are complied with. A curfew operates from 11.00pm to 6.00am.

8. Information about relevant rules, procedures and expectations is given during induction. All residents are allocated a key worker. Regular key work sessions take place, giving the resident the opportunity to discuss any issues or difficulties in more depth. The day to day routine at the hostel is relaxed, although residents do have to surrender their room keys on weekdays between 9.00am and 11.30am to allow for cleaning. Key work sessions run during the day and some residents have to attend offender management meetings or appointments with other probation staff.

9. Residents are provided with breakfast and an evening meal at the premises. They make their own arrangements for their own lunch. A trolley is put out at around 8.30am with cereals and bread for residents to help themselves. The evening meal is provided at around 5.00pm.

10. On arrival, all residents are offered a tour of the hostel and the opportunity to register with a local doctor's surgery. The approved premises has an arrangement with the surgery to enable all new residents without a doctor of their own to register during their stay. There is also an arrangement with the surgery and local pharmacy to facilitate the delivery of medication to the premises. All prescription medication must be handed in to the staff at the front office, where each item is logged and stored safely.

11. If staff have any suicide or other health and welfare concerns about a resident, they can be monitored under their suicide and self harm procedures (SH1s and HC1s). This would entail a resident being checked upon at regular intervals during the day and night.

12. The approved premises keeps basic first aid equipment in the main office, including resuscitation face masks. There are also a number of other first aid kits located around the hostel. All staff are fully trained in first aid and attend a comprehensive four day course, with refreshers every two years. Staff receive other training including risk assessing, health and safety, and self harm and mental health awareness.

13. Her Majesty's Inspectorate of Probation last inspected the Humberside Probation Area in July 2005. The area was inspected under the Effective Supervision Inspection programme which did not include approved premises.

KEY FINDINGS

Prior to the man's arrival at the approved premises

14. The man was arrested on 31 October 2005 and charged with a serious offence committed against his mother. Whilst in police custody he was assessed by a Forensic Practioner/Approved Social Worker who was of the opinion that he was psychotic and should be committed to hospital to treat his mental disorder. When he returned to court on 2 November, he was remanded into prison custody to await a court hearing.

15. He was then transferred to HMP Hull. During his reception health screening, he told the nurse that he had a psychiatric appointment booked in December, had previously been treated, and had a psychiatric social worker. He was currently taking the medication amisulpride (an antipsychotic) and Seroxat (an antidepressant). In response to a standard question, the man said he had previously harmed himself by cutting his wrists and taking an overdose. He added that, in 2004, he had also attempted to jump off a tall building (later discovered to be the same building where he was to take his life) because he was suffering from depression.

16. At the time of his health screening, the man said he had no current thoughts of harming himself. The nurse referred him to the Mental Health In-Reach Team (MHIT) for an assessment. Having also seen the prison doctor, his medication was continued and he was later located on a normal residential wing.

17. Having complained of delusions, auditory hallucinations and insomnia, the man was assessed on 2 February 2006 by the prison psychiatrist. It was noted that his current medication was not effective and an application under the Section 48 of the Mental Health Act 1983 was completed. (This section relates to the removal to hospital of remand prisoners, and, in his case, would involve a transfer to a regional secure unit so that he could be assessed by a psychologist and a psychiatrist.)

18. In the meantime, the man's solicitor also arranged for an independent psychiatric assessment to be carried out. On 24 February and 2 March 2006, a doctor assessed him and reported that he was not wholly persuaded that he had a mental disorder of a nature and degree which would merit hospital care and treatment. He did say, however, that this could be further explored and assessed when the man was transferred to the secure unit.

19. The man moved to the secure unit on 15 March. He spent seven months there before being discharged and returned to HMP Hull on 16 October. On his return to prison, he came under the care of the psychologist. The psychologist wrote a summary in November 2008 of the man's psychiatric involvement and said about his time at the secure unit:

> "The discharge letter for the [secure unit] describes [the man] presenting with the belief he could communicate with the television, predict the future, hear voices or communicate with aliens. However their seven month

medication free assessment eventually concluded that he did not suffer from a mental illness but was predisposed to anxious and depressive personality traits."

20. As well as returning to Hull on 16 October 2006, the man also went to his court hearing. As there was no current evidence of any mental health problems, and he had not taken any medication for a considerable length of time, it was decided that he was not mentally ill. The court subsequently sentenced him to five years imprisonment. He transferred from Hull seven days later on 23 October to HMP Moorland.

21. The psychologists report noted that the man initially experienced difficulties during November and December 2006 following his move to Moorland. He described his behaviour as aggressive at times and that he referred to supernatural and psychic events. During September 2007, the man reported to prison staff that he was again experiencing visual and auditory hallucinations. His medication was reinstated and he was given amisulpride (150mg) to reduce his anxiety. His medication was increased daily (up to 600mg) until December when he complained of anxiety and suicidal ideas. He had harmed himself by inflicted superficial cuts to his left hand. He was placed on suicide monitoring and support (ACCT) measures, and moved to the prison healthcare unit. He was subsequently prescribed risperidone (an antipsychotic medication used to treat schizophrenia).

22. The man made two more attempts to harm himself in February and April 2008 by making superficial lacerations to his wrist. They were followed by attempts to hang and electrocute himself, although neither resulted in any harm. The following month, the prison psychiatrist noted that he said he would jump off a bridge after release if he did not successfully give up smoking. He also said he was contemplating suicide upon release because he was scared he would not be able to cope and was reluctant to move back to a normal prison wing.

23. Around 27 June, the man returned to the wing where he was again monitored under the ACCT procedures and by the MHIT and the prison psychiatrist. It was thought his suicidal behaviour was related to his fear of moving to normal prison location and release from prison, rather than as a direct response to psychotic symptoms. During the months between June and October, it was also noted that, as his medication was increased, his psychotic symptoms improved. He remained settled and raised no concerns about his medication. He had also started doing skill classes in his cell.

24. The man was to be released from prison on licence on 1 December 2008. Wanting to ensure continuity of his treatment after this date the Community Psychiatric Nurse (MHIT CPN, the Care-Coordinator), had contacted the man's appointed probation officer in May. The CPN discussed the man's aftercare and wanted to begin the process to ensure that he was referred to a community mental health team in the area where he would eventually live.

25. As part of the man's licence conditions, he was to live at an approved premises. On 31 October 2008, the probation officer created a referral and supervision

plan which was sent to the manager of the approved premises, for consideration. The referral contained information about the man's offence and background and included reference to previous self harm and psychiatric reports.

26. The man's supervision plan listed the following:

    - Hostel staff were required to carry out regular nightly checks (SH1) on him.
    - Hostel staff were required to search his room regularly with the emphasis on drugs, alcohol and blades.
    - He was to be compliant with his appointed CPN.
    - He was not to enter the two local areas.

27. The man's mother was also listed as someone he could possibly pose a threat to, although she had supported her son throughout his prison sentence. The referral to the approved premises was accepted.

28. A mental health (MH) nurse was identified as the CPN (from the Assertive Outreach Team) who would co-ordinate and deal with the man's mental health issues. The CPN wrote to the MH nurse on 12 November, informing him of the man's date of release from prison and giving brief details about his current medication which was risperidone 6mg taken twice daily.

29. The probation officer later went to the prison on 13 November and met the man and the CPN. The probation contact log notes that the man was happy to be going to a hostel and was "optimistic" about his release. He was informed that he had been allocated a community CPN, who would visit him in prison on 18 November to discuss his mental health and medication needs. In the meantime, the probation officer faxed a copy of the man's psychiatric report (completed in 2006) to the MH nurse.

30. At interview with my investigator confirmed that a Care Programme Approach (CPA) meeting was held on 18 November at the prison. (The CPA is the process under which mental health services assess users' needs, plan ways to meet them and check that they are being met. The MH nurse met the man and the CPN to explain how the Assertive Outreach Team worked and how he could access their services.

31. The MH nurse described the man as "very well kept, a very personable young man who readily made good eye contact". He was open and honest about his past and his illness over the years and discussed what he expected on release. The MH nurse talked about how this could be facilitated, and gave the man information about the services in the area and his psychiatric referral, and explained that he worked in conjunction with the Probation Service and the approved premises.

32. The man reacted positively and was described as practical about his release from prison, which included a discussion about resuming education in September. He also talked about getting fit and using the local swimming pool.

The MH nurse noted that the man was receiving a high dose of risperidone (12mg) and had no suicidal intentions at the time.

33. The MH nurse contacted the probation officer, the Mental Health Services, and the secure unit, as they all had relevant information relating to the man's mental illness. However, the MH nurse told my investigator that he only received information from the probation officer, which included the independent psychiatric report in February 2006.

34. The psychologist's psychiatric summary of the man (mentioned earlier) was written three days prior to his release from prison and copied to the CPN, the MH nurse (who did not receive it) and a consultant in Community Mental Health Services. The psychologist reported the following:

> "The diagnosis is considered to be that of schizotypical which is characterised by inappropriate affect, odd/eccentric behaviours, difficulties interacting with others, abnormalities of speech, odd beliefs and paranoia, and a variety of unusual perceptual experiences. These symptoms border on an atypical form of schizophrenia although [the man] always retains insight and is motivated to seek treatment.
>
> "There have been no risks of violence observed during his period in custody. The main risks observed have been those of self neglect and suicidal behaviours.
>
> "[The man] has responded positively to antipsychotic medication but continues to express anxieties as to how he will function in the community.
>
> "I would therefore recommend that [he] continues to receive antipsychotic medication upon his release and is referred immediately to the catchment area psychiatrist. The complexity of needs and potential risks will warrant continued multidisciplinary working and supervision under CPA."

35. Prior to the man's release from prison, the probation officer told my investigator that the man's OASys risk assessment (completed in 2007) was reviewed. Her referral to the approved premises said, "OASys indicated no current concerns but given new to hostel environment Manager asks for SH1 checks until further notice."

The man's arrival at the approved premises

36. On 1 December 2008, the man was released from HMP Moorland. At interview with my investigator, the assistant warden said that the man was accompanied by the CPN. She greeted them, after which the CPN left, leaving the assistant warden to carry out the man's induction. The CPN had taken him to the hostel by car because of the difficult public transport links between Hull and the area that the approved premises was based.

37. The man was nervous and the assistant warden tried to put him at ease by explaining the hostel rules and procedures as well as his licence conditions. He

was given a tour of the building and introduced to some of the residents. He arrived with his medication, omeprazone (for prevention of stomach acids) and risperidone. Having explained the procedures for handling medication, the assistant warden secured the tablets in a lockable cabinet in the office. She told the man that, as a matter of procedure, new residents would be checked a couple of times during their first night at the hostel.

38. The approved premises manager told my investigator that he reviewed the man's file. Given his history of self harm and as he was in a new environment, the manager decided that the monitoring should continue after his first night and at least until he had been linked with the local mental health services. The man was therefore placed on self harm monitoring (which included regular two hourly checks) until further notice. No concerns were reported during his first night in the approved premises.

39. The next day (2 December), the probation officer and the MH nurse met the man at the approved premises to discuss his well being and his licence conditions. The man said that he was reluctant to take up employment and said he could manage on his Disability Living Allowance. However, he agreed to be referred to an employment agency and also said he would like to do some studying. He was encouraged by the NH nurse to review his outlook and set himself goals and aspirations for the future, which should also improve his mental well being.

40. An action plan was completed and included the man adhering to his licence conditions, increasing his employability, assessing and improving his literacy skills, improving his problem solving and decision making skills and to maintain an abstinence from drugs. The MH nurse created a mental health care plan for him, which included contact numbers as well as a crisis plan. The care plans included an awareness of signs and symptoms which related to his mental health, his medication and who to contact in emergencies. The man was provided with a copy of the care plan.

41. The MH nurse said they discussed the man's referral to the consultant in the community. After the meeting, he returned to his office to confirm that an appointment had been booked. He told my investigator that, "much to his disappointment," the appointment was not until 9 January 2009, the delay due to the Christmas and New Year period. The MH nurse was concerned about the high level of medication the man was receiving. He said that he presented himself as looking and feeling well and so the MH nurse thought that his medication could be decreased. He had planned to try to bring the man's appointment forward, however events overtook him and this was not carried out.

42. As part of the requirements of being a resident at the hostel, the man registered with a medical practice on 3 December and went to the surgery for a new patient check. He was examined by a healthcare assistant who undertook the first part of the patient assessment and included details of his height, weight, smoking habits and alcohol consumption. The healthcare assistant also noted that a referral had been made to the CPN service. A letter was subsequently

sent to the mental health services stating that the man had been referred and was to be offered an outpatient appointment at the mental health unit. The man was also assessed by the doctor who prescribed risperidone, and he was given a sick certificate which indicated a diagnosis of schizophrenia for a period of three months. No concerns were noted about his well being.

43. Another assistant warden was appointed as the man's key worker and held his first key work session on 4 December. The key worker told my investigator that the man felt that he had settled well, enjoyed the food and got on with staff and residents. He told the key worker that he was aware that staff were available to talk to should he have any issues or concerns. He co-operated throughout their meeting and agreed to participate in hostel activities.

44. Over the next five days, staff noted that the man had settled well in his new surroundings and had not reported any problems to them.

Events on Tuesday 9 December

45. The man had his second meeting with the probation officer on the morning of 9 December. He appeared "comfortable" and said he had settled well. It was his birthday three days later and he told her that his mother was taking him out for the day. He updated her on his visit to the doctor and his claim for Employment and Support Allowance, and said he was managing financially.

46. The MH nurse had arranged to visit the man every Tuesday and did so at around 11.00am. In interview, he described the man as "very much the same as he had been, quite bright". He said he had been in contact with his mother, obtained his medication, attended the Benefits Agency and had no matters which were causing him problems. The MH nurse said that, although he did not discuss any of his previous attempts of harming himself, they discussed his illness. He said there was nothing in the man's demeanour to suggest he was contemplating harming himself.

47. The MH nurse said the man talked about having four previous breakdowns, which he said were related to the misuse of drugs. He specifically referred to having "peripheral visual hallucinations", and said he was having them at that time. When asked to describe what he was actually experiencing, he said he saw someone when he was preoccupied. The MH nurse told my investigator that it was difficult to understand exactly what the man was trying to explain. He talked in a "clinical and detached" way, and the MH nurse felt his descriptions were more of an academic description of an illness rather than his own words. The MH nurse was "slightly uncomfortable" with what the man had said, and thought he should see the psychiatrist who could also review his current medication.

48. The third assistant warden told my investigator that he spoke to the man on the evening of 9 December whilst making his hostel checks. He was aware that he spent a lot of time in his room and described him as quiet and pleasant. He said the man was relaxed and pleased to be out of prison. The assistant warden recorded that:

"[The man] has been around the hostel all day today. Been out this evening to shop, attended his appointment this morning in the hostel with [the MH nurse]. Spoke to [the man] several times today to see how he was and says he's fine."

49. On four separate occasions throughout the night, the man was checked and the record notes, "[The man] sleeping in his room and seems fine."

Events of Wednesday 10 December

50. The man left the approved premises at around 9.00am. From information provided to my investigator by the police, some time between 9.00am and 1.25pm he travelled to an area which is approximately 40 miles away, and checked in to a hotel room on the 11th floor. The hotel CCTV shows him entering the hotel alone. He was later found on the pavement in front of the hotel having apparently jumped out the window of the room wearing only his underwear.

51. The police telephoned the hostel around 5.45pm and spoke with the third assistant warden. They asked if the man was a resident and if he was missing. The hostel could not confirm if he was missing until the 11.00pm curfew time. The police told him that a man had jumped from a hotel window and died, and that they believed it to be their resident. Formal identification would take place and the hostel would be informed immediately. The third assistant warden immediately informed the Probation Trust Director and the approved premises manager of these events.

52. The third assistant warden then went to check the man's room where he found a suicide letter written by him and addressed to his mother. The room was locked and the assistant warden immediately reported this to the approved premises manager, who had now arrived at the hostel. The information was passed onto the police, who were in contact with the hostel during the evening confirming further details about the man. Later, when the police confirmed his identity, they contacted the man's mother and told her of his death.

53. The following day, the man's mother was contacted by the approved premises manager. She was invited to attend the approved premises to collect her son's personal belongings and spend some time in his room. He also sent her a condolence letter from all at the hostel. The other residents were also informed of the man's death.

Post Mortem

54. The post mortem report confirmed that the man died from multiple injuries sustained from falling from an upper floor window of a hotel. The toxicology results revealed no traces of alcohol and LSD type substances. No trace either was found of risperidone, his medication.

ISSUES RAISED IN THE INVESTIGATION

Clinical Care

55. The clinical reviewer makes five recommendations relating to the man's care before and after his release, and those pertinent to my investigation are included in this report.

56. Prison Mental Health In-Reach teams (MHITs) provide prisoners with the same care and treatment for severe mental health problems that they would receive in the community. The MHIT aims to ensure continuity of care between the community and prison by liaising with health services outside prison. Relevant information about the patient's background and history is obtained, as well as risks identified and reviewed.

57. When the man was released from prison, even though he had a significant risk history associated with impulsive acts of self harm, only partial information was relayed to the MH nurse. The MH nurse did receive a previous psychiatric report on the man which detailed four previous attempts of self harm, but he could not recall seeing the details. This report was over two years old.

58. The MH nurse had concerns about the man's level of medication which increased during their meeting on 9 December when he talked about experiencing "peripheral visual hallucinations". The information was not shared with his probation officer or a member of the approved premises staff as his appointment with the psychiatrist had not yet taken place. Unknown to the MH nurse, the man had experienced visual hallucinations whilst in Moorland. These were detailed in the psychologist's report which he received after the man's death.

59. The man's In-Reach file also noted that he had referred to committing suicide when released from prison, but this information was also not passed to the MH nurse. The clinical reviewer notes that there was no evidence that the MHIT had a good standard of record keeping and the collation of risk information was not undertaken during their involvement with the man. The clinical reviewer says that there was an absence of direct assessment and questioning of him regarding ideas of self harm or suicidal ideas he may have had prior to and following his release.

60. It is essential that risk assessments are completed thoroughly and medical information is shared with appropriate agencies. They play a fundamental role in providing good aftercare to prisoners with mental health needs. Staff making aftercare arrangements should ensure that all relevant information is shared appropriately, so that informed judgements can be made about a person's well being and to provide continuity of care.

61. The man was also required to register at the local doctor's surgery. Following his death, they conducted a review which is normal practice following a suicide of a patient. Although their review was incomplete at the time of my

investigation, the practice did inform the clinical reviewer that they had not received any medical information or discharge summary from either the approved premises or Moorland for him. This meant that their assessment would be incomplete.

62. This issue again relates to sharing of information. I am pleased to learn that the PCT and Probation Trust have agreed to work together to ensure that medical information is passed effectively between the two agencies. This should also ensure that doctors do not have to rely solely upon the patient to make their professional assessment of their treatment and medication.

63. However, it is also important that any prison releasing a prisoner with mental health problems shares such information with the probation area or probation trust which will have regular contact with the prisoner on licence. They too have a responsibility to ensure that other agencies have appropriate and up-to-date information.

The Governor of HMP Moorland should establish an information sharing agreement with relevant healthcare provider(s) to ensure continuity of healthcare for prisoners needing post release care and treatment. This should include up-to-date medical discharge information also provided to the Probation Trust for onward referral to doctors' surgeries.

The man's care at the approved premises

64. It is my view that the man received appropriate care from the staff at the hostel. In the short space of time that he was there, he was monitored and gave no indication of wanting to harm himself. He complied with the hostel rules, took his medication and appeared to have settled well into his new surroundings. Although his mother said he did not want to take up employment, he did not raise this as an issue that was causing him anxiety.

CONCLUSION

65. The man had a history of mental health problems and self harm. He had contact in the community and within prison with various mental health services. As such, arrangements were put in place prior to and after him leaving prison to manage his illness. He was taking antipsychotic medication when he arrived at the approved premises, which was believed to be treating his illness effectively. Staff welcomed him, helped him to settle and no concerns were identified. He also had contact with his probation officer and a psychiatric nurse who helped his transition from prison into the community, including monitoring and assisting his mental health needs.

66. When the man was released from prison, only a limited history was obtained and shared with his new CPN and the doctor's surgery. Neither thought that he required any immediate intervention. He appeared content with the level of care he was receiving and did not show any particular risk as he had done whilst in custody.

67. When the man left the approved premises on the morning of 10 December, it is not known what exactly was going through his mind. Why he travelled to the same building where he had previously attempted to take his life can also only be speculated upon.

68. I do not believe that the death of the man could reasonably have been anticipated by those responsible for his care. Nor do I think there were actions they could have taken that would have prevented it from happening.

69. I note that the post mortem examination found no traces of his prescribed medication in the man's body.

RECOMMENDATION

The Governor of HMP Moorland should establish an information sharing agreement with relevant healthcare provider(s) to ensure continuity of healthcare for prisoners needing post release care and treatment. This should include up-to-date medical discharge information also provided to the Probation Trust for onward referral to doctors' surgeries.

The Prison Service has partially accepted this recommendation.