INVESTIGATION INTO THE DEATH OF A WOMAN ON 22 SEPTEMBER 2004

REPORT BY THE PRISON AND PROBATION OMBUDSMAN FOR ENGLAND AND WALES

JANUARY 2005

As well as being responsible for investigations of deaths of serving prisoners, I also have the discretion to investigate deaths that occur soon after release from custody. The tragic death of this woman falls into this category.

She had served five previous sentences at HMP New Hall and was released from her final sentence on 17 September 2004. Comprehensive resettlement arrangements had been made and she was to live with a specialist drug rehabilitation provider for 12 months. Sadly, she was found dead some five days later.

Because this is a discretionary inquiry, I have limited it to reviewing the release arrangements and have contacted the prison, Nottinghamshire Probation Service, the HDC monitoring company and Portland House, who were to provide her accommodation. I have been assisted by the Suicide and Self-Injury Prevention consultant with the Prison Service Women's Team, who has also audited the detoxification arrangements at the prison. A review of the woman's clinical care was carried out by my Deputy Ombudsman. The final part of the inquiry has been for my Family Liaison Officer to make contact with the woman's family and solicitor to ensure that their concerns were also considered. I would like to take this opportunity to add my condolences to those already expressed.

I would like to thank the staff at all the organisations concerned who have provided information to the investigators.

STEPHEN SHAW CBE
PRISON AND PROBATION OMBUDSMAN

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SUMMARY

1 The young woman was 27 years when she died. She was adopted soon after birth and grew up with her adoptive parents and brother in the Mansfield area. She went to school there before working as a secretary for several years. In 1988, she gave birth to a son who has lived with her parents for the past few years.

2 Between 2000 and 2004 she was convicted of a number of offences, all of which were related to her abuse of drugs and alcohol. The last conviction was on 13 July 2004 and she was sentenced three weeks later to eight months imprisonment for the offences of arson and shoplifting. This was her sixth prison sentence and it was served at HMP New Hall. She had already been held on remand and so her release date was set for Friday 17 September.

3 She was identified as at risk of suicide at two points during this period in custody, first on reception and secondly prior to sentence being passed. She experienced further periods of depression and was supported by the chaplaincy team. However, both the prison and her mother described her as more motivated to stop reoffending during this sentence than ever before.

4 Careful arrangements were made for her release from prison. The CARATs drug rehabilitation team at New Hall referred her to Portland House which provides accommodation and specialist treatment for drug users and is located in Newark. A place was accepted and she was released on Home Detention Curfew (HDC) licence, with a condition to live there and, as is customary, with a travel warrant for her journey. Drug tests prior to her release were negative.

5 She never arrived at Portland House. Premier Monitoring Ltd was the company with the contract to monitor her curfew and they contacted Portland House that evening and the following day. On Sunday 19 September, Premier notified the Home Office of her failure to arrive at Portland House and her licence was revoked. Nottinghamshire Police were notified, but as it was a report of revocation of licence, rather than a report of a missing person, it received less priority and no action had been taken by the time of her death.

6 During the five days between release and her death, she met a number of her friends and telephoned her mother. She contacted her solicitor for advice via a third party. On 22 September, she was found hanging in woods in Mansfield and a syringe and drugs were found on her. The Home Office pathologist has confirmed that the cause of death was hanging and the police are satisfied that there were no suspicious circumstances.

7 The inquest took place on 16 November and the verdict was suicide.

BACKGROUND

8 The woman was born on 11 April 1977 and came to live with her adoptive parents some three weeks later, with her adoption becoming legal when she was six months old. She attended local schools until she was 16, leaving to take an office job. In the following year, she experienced symptoms of depression and was a voluntary out-patient at Mill Brook Hospital. Her family believe that her abuse of alcohol began when she was 23, which is when she was first convicted for driving with excess alcohol. They say that later she began to use illegal drugs, took an overdose and was admitted as an in-patient. It was at this point that her son came to live with his grandparents.

9 After her first conviction in 2000, she was convicted of 11 offences of theft, one offence against the person and six Bail Act offences. She was sentenced to several community penalties, but did not comply with the conditions and each was revoked. Her offences were said to be related to her drug habit. She served five prison sentences prior to the last one – the first in January 2003 – and ranging in length from five days to the last and longest of 88 days. When she was remanded in custody for her last, and most serious offence she had only been released three days earlier. Since her first prison sentence, the longest period she had remained in the community was seven months between November 2003 and June 2004.

10 A pre-sentence report was prepared for her last offence by Nottinghamshire Probation Area. It recommended a further community sentence, stating that she was motivated to become drug and alcohol free. The assessment evaluated the woman's risk to herself and said that she was at no risk of suicide, but that her history of depression and self-harm meant that she was assessed as at medium risk of self-harm.

THE WOMAN'S SENTENCE AT HMP NEW HALL

11 She was held in custody by the police on 20 June, charged with arson and shoplifting. It was three days after her previous release from New Hall. On arrest she was assessed as standard risk of self-harm but, the following day, she cut her left wrist and was escorted to the prison accompanied by a suicide and self-harm warning. She was remanded in custody and returned to New Hall on 21 June 2004. The reception procedures included health screening and the prison self-harm warning (F2052SH) was opened. The form gave a detailed explanation of events and her situation, but it did not set out standards for observations or specify how other departments should be consulted.

12 She was assessed as fit for detoxification, and was located in the detoxification wing where all the cells are single. An eight day detoxification programme was completed successfully and drug tests during her sentence were clear.

13 Whilst the F2052SH was open, observations of her were regular and timely, but the records did not reflect the quality of interactions or suggest any remedial action. Contact with other parts of the prison was not always included, such as feedback from Visits after she had been there. The Senior Officer checked the form, which was reviewed and closed after 72 hours, with a detailed record of her current state of mind, though it was not apparent that she had herself participated.

14 Soon afterwards she referred herself to the prison CARATs team, requesting help with drug abuse through the Short Duration Programme (SDP). This is a four week course which focuses on stopping reoffending and reducing drug use. It aims to increase awareness of harm minimisation and act as a gateway to further treatment.

15 A second F2052SH was opened on 6 July following observations by the workshop instructor who thought that she was worried about facing a lengthy sentence. Anti-depressant medication was recommended and a request for a psychiatric assessment made. Again the F2052SH was closed after 72 hours, following a review which unfortunately did not include multi-disciplinary staff who knew her, such as the chaplaincy and CARATs team. It was closed nearly three weeks before sentencing, fortunately without mishap. No actual incidents of self-harm took place during sentence. She attended the psychiatric clinic and was referred to a nurse who specialised in trauma and abuse counselling.

The Governor should ensure that all staff working with a prisoner are invited to F2052SH reviews. The prisoner herself should also be involved.

16 On 3 August, she was sentenced to eight months imprisonment. The SDP began the following week and was completed at the end of the month. Reports from the programme are comprehensive and demonstrate that she participated well and contributed effectively. The assessment by the programme tutors was that she appeared highly motivated to abstain from drugs, was willing to discuss personal matters and could identify triggers to relapse.

17 She was upgraded to enhanced status on 22 August and moved to C wing. Chaplaincy staff who knew the woman described her as a lovely person to talk to. She complained of feeling low in mood at the end of August and Healthcare staff commented she needed more time on the medication.

18 As part of the woman's preparations for release from New Hall, the CARATs team referred her to Portland House, Newark, with the intention that she would have secure accommodation and be able to continue to treat her drug and alcohol use. Portland House Women's Service consists of self-contained flats for women who undertake a therapeutic drug rehabilitation programme within the residential setting.

19 Her applications for accommodation and funding for specialist drug rehabilitation were both successful. A multi-disciplinary assessment for HDC at Portland House was carried out. It referred to her awareness that she would need considerable support in the community to continue her abstinence from drugs and alcohol. It was considered that the short period on HDC licence would encourage a new structure to her lifestyle. The prison probation officer interviewed her and said that she was happy with the rules and regulations involved in HDC. Prisoners should also complete an application but, on this occasion, she did not herself complete or sign the form. (This is a housekeeping matter to which I draw the Governor's attention.)

20 The HDC release board met on 16 September and confirmed that she was fit for release and for tagging. She was seen by Healthcare as part of this process and again found fit for release. There does not appear to have been any medical advice regarding risks from drug use after release back into the community. There is also no evidence of a discharge letter to a GP, which would have been appropriate for a woman with a history of substance misuse and depression who was moving to a new area.

Prison Healthcare should contribute to discharge planning by advising prisoners on the effects of drug use after a period of abstinence and by providing a discharge letter to GPs.

21 Because her sentence was less than 12 months, she was not required to be supervised by the probation service.

22 Throughout her sentence she received gifts of money and was released with £140.44, including £80 she received anonymously on 13 September. It is prison policy that sums over £50 may only be passed to prisoners if the donor is identified, but the policy was not implemented on this occasion.

23 She was placed on HDC licence from 17 September 2004 to expire on 19 October. The address to which she was curfewed was Portland House, between the hours of 19.00 each evening and 7.00 each morning. The curfew times for the first day of release were different and were from 15.00 on 17 September to 7.00 the following day. She was released on 17 September, having first telephoned a long-standing friend to arrange to meet her at Newark station.

AFTER RELEASE FROM HMP NEW HALL

24 The woman left New Hall in the morning with another prisoner and they travelled together to Wakefield station. Instead of using the travel warrant to go to Newark, it seems that she had a change of heart and went instead to Mansfield. Both her mother and solicitor have expressed concern about her travel arrangements and consider that she would have benefited from transport being provided between the prison and Portland House. Since this investigation began, Portland House have decided that they will offer transport in similar situations.

25 Because she did not arrive at Portland House, and so did not sign her tenancy agreement, the accommodation did not consider that their missing person procedures were relevant. They use their treatment provider's operational procedure for clients missing from adult services which refers to their reporting obligations and their duty to the client's safety. The procedure does not specifically refer to women who fail to attend at all, but does say that the degree of risk should be assessed. If the client is believed to be at significant risk of deliberate self-harm, the police, next of kin, purchasing authority and any other interested agencies should be notified immediately. No risk assessment was carried out in this case and neither the next of kin nor relevant agencies were notified by Portland House.

The Governor should ask Portland House to review their missing person procedures to include action to be taken when someone fails to attend and ensure that these are put into place.

26 Records from Portland House state that, when she did not arrive there, about five unsuccessful attempts were made to notify the prison CARATs team of her failure to report. The records do not include the time or number of calls. Later in the day the same member of staff reported that she had spoken to the prison and confirmed that the woman had been released at 9.30 that day. She also recorded that the HDC monitoring company, Premier Monitoring, had telephoned and been told that she had not reported. Again the time of the calls was not logged. The Portland House record of the telephone contact by Premier is not consistent with Premier's own record, which states that they made one visit at 19.06 to perform her induction but no access was gained to the premises and staff were advised that she was not present.

The Governor should ask Portland House to log the time of incoming and outgoing calls.

27 The Statement of Operational Requirement between Premier and the Home Office states that if the curfewee is absent when the contractor visits to install the equipment …the contractor must make at least one

further attempt to install it during the first curfew period. It is not apparent that this requirement was complied with on this occasion. Contractors are also required to complete installation within 24 hours of the start of the first curfew period, which in this case was by 15.00 on 18 September. The records from neither Premier nor Portland House indicate that a further visit was made before that time and it does not appear that this requirement was complied with either.

28 A further requirement is that if the contractor fails to complete the installation, it must be treated as an unauthorised absence violation of curfew and either the original sentencing court or the Sentence Enforcement Unit of the Home Office be notified. The Early Release and Recall Section (ERRS) of the Home Office confirm that they were not notified until two days after release on 19 September. On the same day the woman's recall was agreed and the revocation of licence was signed on the grounds of inability to monitor.

The attention of the ERRS and the monitoring company should be drawn to my comments on the company's failure to comply with all their operational requirements.

29 Portland House staff recorded that the police attended their premises at 23.15 on 17 September. The ERRS notified Nottinghamshire Police of her recall on 19 September, and referred them to Home Office Circular 1/1999 which states that the priority to be given to individual cases is an operational matter for the local police, but that the Association of Chief Police Officers Crime Committee has indicated their view that HDC recalls should be treated as urgent action cases. Had she been reported under the missing person procedures, the police investigation would have received a higher priority. Nevertheless, the Mansfield division did attempt to visit one of her previous addresses but could not gain entry and the next and final information in the police log was when her body was found.

CONCLUSIONS

HMP New Hall

30 During the woman's sentence she was supported by staff throughout the prison including the wing, workshop, chaplaincy and the CARATs team. Risk of self-harm was appropriately identified and acted upon and she successfully underwent a detoxification programme.

31 Staff are also to be commended for their comprehensive rehabilitation plans for the woman. They responded to her request for support and made detailed plans with her, which involved successful applications to specialist community provision. Although no staff were formally interviewed for the investigation, it was clear from those who were spoken to that they felt a sense of disappointment that the plans were not achieved. Had the prison been able to provide transport to Portland House, it may be that she would have been able to achieve her goals. Since this investigation commenced, Portland House have changed their arrangements so that they will go to the prison and provide transport for women in circumstances similar to hers. I welcome this.

32 There were omissions to two aspects of the Healthcare contribution to her discharge arrangements, in that there is no evidence in her records of either advice on the risks of drug use after a period of withdrawal, or of any letter for a GP at her new address.

Portland House

33 After her release, Portland House attempted to inform the prison CARATs team that she had not arrived. Their missing person procedure did not refer to circumstances such as these and it was not implemented. The police and monitoring company became aware of the woman's absence when they made contact with the accommodation, but her absence was treated as a breach of HDC rather than as a missing person.

Premier Monitoring Services Ltd

34 The monitoring firm did not comply with three of its operational requirements which meant that the woman's recall was ordered a day later than required.

RECOMMENDATIONS

Recommendation to HMP New Hall

1 The Governor should ensure that all staff working with a prisoner are invited to the F2052SH reviews. The prisoner herself should also be involved.

2 Prison Healthcare should contribute to discharge planning by advising prisoners on the effects of drug use after a period of abstinence and by providing a discharge letter fro GPs.

Recommendations to Portland House

3. The Governor should ask Portland House to review their missing person procedures to include action to be taken when someone fails to attend and ensure that these are put into place.

4. The Governor should ask Portland House to log the time of incoming and outgoing calls.

Recommendations to Premier Monitoring Services Ltd

5 The attention of the ERRS and the monitoring company should be drawn to my comments on the company's failure to comply with all their operational requirements.