

**Circumstances surrounding the death of a man
In June 2005, when he was resident at
an Independent Approved Premises used by the Probation Service and
managed by a Management Committee.**

Report by the Prisons and Probation Ombudsman for England and Wales

January 2006

This is the report of an investigation into the death of a man who died in June 2005. He had been a resident of an Approved Premises for ten weeks prior to his death. He was on conditional bail. The man died apparently by his own hand.

The purpose of my investigation was to discover whether the level of care provided for the man at the Approved Premises was sufficient, and whether there are any lessons that can be learned to help prevent a similar tragedy in the future.

During his time at the Approved Premises the man became known as a sociable man, popular with residents and staff alike. The man was due to attend court on the day after his death, but he had given no indication that he was unduly anxious about the forthcoming hearing. Members of staff at the premises who had worked closely with the man were shocked and distressed by his death. They were concerned that he must have been suffering inner turmoil that had not been apparent to them.

Members of staff in Approved Premises are responsible for the management of numbers of high risk offenders on a daily basis. I am satisfied that staff at this premises exercise their responsibility in a caring and supportive manner. I am also satisfied that the hostel is managed in a professional way, and operates in accordance with Approved Premises guidelines. I have found no evidence to suggest that the man had given any indication of intent to take his life, nor that his actions could have been easily predicted or prevented. However, I make one recommendation where the opportunity for improvement may exist.

The man was close to his mother, who visited weekly during her son's stay at the premises. I have no doubt that his death in such shocking circumstances affected her deeply and I offer the man's family and friends my sincere condolences on their loss.

**STEPHEN SHAW CBE
PRISON AND PROBATION OMBUDSMAN**

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Summary

1. The man appeared at a Magistrates' Court on 15 April 2005, charged with serious offences, said to have taken place many years previously. He was remanded on bail to be tried at the Crown Court, but he was unable to return home. A condition for him to reside at Approved Premises was therefore imposed. The man was admitted to the Approved Premises later the same day.
2. The man was described as a sociable man, popular with staff and residents at the premises. He conformed to requirements and caused no problems. He was considered to be an 'ideal resident' and, although he was known to be concerned about his forthcoming court appearance, he gave no indication that he was depressed. He met his mother each weekend and she told the police that she saw nothing to suggest he had considered self-harm.
3. The man was due to return to the Crown Court in June for a Plea and Directions hearing. On the day before the hearing, when he had been resident at the Approved Premises for some ten weeks, the man left the house shortly before the curfew hour, ostensibly to post a letter. He was spoken to by three residents on their way back to the house and he seemed to be in good spirits, assuring them he would return in time for curfew. When he failed to do so, the police were informed that he had breached his bail.
4. At approximately 1:20am on the day of the man's death, police officers called at the house to inform staff that the man's body had been found at a block of flats situated behind the Approved Premises. It was thought that he had hanged himself.
5. The man had no history of depression or mental health problems and there were no signs of any such problems during his period of residence at the Approved Premises. All the indications were that he was settled and coping well in the circumstances in which he found himself.
6. Key work sessions took place regularly as required. With the exception of one occasion in May when the man was worried about the possibility of people trying to discover his whereabouts, the investigation found no indication of other problems, apart from the forthcoming court appearance.

Investigation Methodology

7. A senior investigator from this office conducted the investigation. I am grateful for the assistance that the investigator received from the manager, staff and residents at the Approved Premises. I am conscious that the investigation placed an extra burden upon the manager and her staff who were trying to come to terms with the man's death. Nevertheless, they made facilities readily available and participated fully in the inquiry.
8. Notices were distributed within the Approved Premises, notifying staff and residents of the investigation. The investigator conducted formal interviews with the operation manager, three assistant managers, one of whom was the man's key worker, and with two residents. The investigator also examined documents provided by the premises.
9. Her Majesty's Coroner was contacted to inform him of the nature and scope of my investigation and to request a copy of the Post Mortem report. Upon completion, this report will be sent to the man's mother, to the Probation Area and the National Probation Directorate, and to the Coroner to assist in his enquiries into the man's death.
10. One of my family liaison officers contacted the man's mother. She spoke positively about the attention she received from the Manager of the Approved Premises at the time of her son's death.

The Approved Premises

11. Approved Premises were formerly known as Probation and Bail Hostels and are approved by the Secretary of State within Section 9 of the Criminal Justice and Court Services Act 2000. Their purpose is to provide accommodation for persons granted bail in criminal proceedings, and in connection with the supervision and rehabilitation of persons convicted of offences. Approved Premises can provide a supportive, structured environment in the community for high risk and difficult to manage offenders. The management of offenders accommodated in Approved Premises is governed by the National Standards for the Supervision of Offenders and the guidance contained in the National Approved Premises Handbook.
12. The house is one of four Approved Premises in the Probation Area. It is an independent, voluntary Approved Premises, managed by a Management Committee, and provides specialist services for offenders with drug dependency problems. The premises can accommodate 22 residents, 16 men in the main building and six women in separate cluster accommodation. The house accepts offenders on bail and subject to either community penalties or prison licences. Residents must be between the ages of 18 and 65, but any type of offender will be considered depending upon the level of assessed risk and the dynamics of the resident group at any particular point in time.
13. Until about a decade ago, Approved Premises offered accommodation for offenders who had nowhere else to go, but in recent years the resident profile has changed. Nowadays, Approved Premises cater largely for dangerous or serious offenders who are assessed as posing a high risk of re-offending or harm to the public. The purpose of the house is to provide an enhanced level of supervision for offenders in the community. Each resident is subject to curfew restrictions, usually from 11:00pm to 6:00am for those not working, although other curfew hours may be enforced if either court orders or licences stipulate.
14. In addition to treatment programmes for drug abusers, the house provides a programme for all residents to ensure their time is used gainfully. Residents are required to attend a weekly Life Skills Group, together with other regular educational activity groups. The house is staffed by a manager, an operational manager, seconded by the Probation Area, assistant managers and night supervisors. At least two members of staff are on duty at any time. Night cover is provided by a night supervisor who on waking duty throughout the night, and an assistant manager who sleeps on the premises. CCTV cameras provide oversight of communal rooms and corridor areas throughout the day and night.

15. Each resident is allocated an assistant manager as key worker. Key workers are responsible for monitoring the behaviour of their residents, and for providing advice and encouragement. Residents are expected to meet weekly with their key workers. The meetings are recorded and any areas of particular concern are noted. Close links are maintained between key workers and case managers, although those on bail are not convicted and consequently are unlikely to have allocated case managers outside of the premises. The focus of key work sessions is also different for those on bail as it is not possible to address offending behaviour. Instead, key workers provide practical advice and address any emotional issues that may arise.

The man

16. The man was 54 years of age when he died, and had been resident at the Approved Premises for almost ten weeks. He was born in the West Midlands, the only child in a family that moved when he started his secondary education. After leaving school, the man had various jobs before becoming a taxi driver. He remained unmarried but left the family home when he was able to purchase his own property. After spending holidays in Jersey, he decided to move there permanently and bought a newsagent's on the island.
17. The man's parents visited him regularly until his father died, after which he maintained frequent contact with his mother. During his stay at the Approved Premises, the man indicated that his business had been successful and that he had developed a wide circle of friends. He said that he had sold most of the business, but retained a newspaper delivery round.
18. In April 2005, the man was arrested as he arrived in England to visit his mother. He was charged with several serious offences, alleged to have occurred almost 30 years ago. The man had no previous convictions and had not been in contact with the criminal justice system before his arrest. He told his mother about the nature of the charges against him and said he was innocent. He said he intended to deny the offences when he appeared in court.

Events leading to the man's death

19. The man was referred to the Approved Premises on 15 April by a member of staff from the Probation Area who works at the Magistrates' Court. A comprehensive referral form was completed. The man was said to have no previous convictions, no problems with alcohol or drugs, no history of depression or self harm and no difficulty in coping. As an un-convicted person, referred from Court, there was no OASys (Offender Assessment System) assessment, but it is clear from the application form that the man was not considered to pose a high risk, either to his self or others.
20. The man was accepted for residency and, on the same day, he was granted bail with a condition to reside at the Approved Premises. Further conditions were that he should not contact witnesses and not go to a particular area without prior appointments with his solicitor. He was to appear at Crown Court on 22 April for a preliminary hearing. As the man was a man of previous good character, the Approved Premises was his first experience of hostel life.
21. Upon arrival at the hostel, the man was taken through the induction procedure during which the rules were explained to him. The result of a routine drug test was negative and the man said he had never used non-prescription drugs. He was placed in a double room, as it is the regular practice at the house for new residents to be allocated shared rooms until staff are satisfied that they are coping well.
22. Each resident of the house is allocated a key worker who is required to meet formally with his or her residents on a weekly basis. What takes place at those sessions depends upon the status of the resident, as it is not possible to focus on offending behaviour with residents who are un-convicted. The man met with his key worker the day after his arrival. They discussed the hostel regime and expectations. The various house activities and groups were explained to him and the man agreed to participate in as many activities as required.
23. Thereafter, key work sessions took place weekly and there is no indication in the session notes that the man was depressed or unhappy, above what might be expected from one who was facing trial on serious charges and was unfamiliar with the criminal justice system. The man made a claim for benefit in order to pay the required rent and he was actively seeking work. He appeared to settle well and the hostel log indicates that, although he seemed a quiet man, he was soon mixing with other residents. On 22 April, he appeared at Crown Court and was remanded again to June for a Plea and Directions hearing. Having quickly settled into the regime, on 7 May the man was moved to a single room overlooking the front of the house. He remained there until his death.
24. Those members of staff and residents who were interviewed by the investigator described the man as a quiet man who had no mood swings. His key worker said that, in the weeks they worked together, he did not see

the man angry or upset. The key worker described the man as level headed and well organised, but also light hearted and quick to smile. He also said that he found the man's calmness and equanimity refreshingly unusual in a hostel resident. The key worker told the investigator that the photograph taken of the man when he arrived at the hostel showing a 'half-smile' on his mouth and in his eyes, "summed him up well". The key worker said the man was always affable.

25. The man attended morning meetings and groups, regularly contributed in appropriate ways, and always did what was required of him. It was said that he spent much of his free time with crosswords and other puzzles, engaging with other residents, yet remaining slightly aloof. All drug tests were negative and routine searches of his room produced no results. In May, the man had a problem with his foot and was prescribed Diclofenac, an anti-inflammatory pain killing drug. On 15 June, he told a member of staff that he had sickness and diarrhoea, and a telephone call was made to NHS Direct. The man was advised to drink water and call again if his symptoms persisted. He did not report the problem again and otherwise, he remained healthy. The man was described as polite and compliant, in many ways a model resident.
26. At the beginning of May, the man told his key worker that he had lost his rented rooms and was soon to dispose of his newspaper delivery business. However, neither staff members nor other residents had any sense of the man being unduly troubled, apart from one occasion when he expressed anxiety over people trying to discover where he was living. He was concerned as an unknown person had called on his mother late at night. An assistant manager reassured him about confidentiality policies and the subject was not raised again.
27. The man had no known contact with anyone outside the house except his mother whom he met each weekend. He was not seen to have any particular friends and he received no letters. A resident who was befriended by the man, and clearly felt close to him, described him as a jovial person who did not take many things seriously. She said he was a kind, caring man, whom she had come to see as something of a father figure. She told the investigator that she had only seen the man "down" on a few occasions, in particular after he had been in consultation with his solicitor. He told her he was worried about the Plea and Directions hearing, but she tried to reassure him as she knew he would not be sentenced on that day.
28. On a Saturday in June, the man met his mother as usual. In her statement to police, she said she had found nothing unusual in her son's demeanour or behaviour. The man then spoke to his mother on the telephone a few days later and seemed to be in good spirits. On the Thursday before he died, the man spent some time with another resident who gave him £2 for cigarettes. She said it was unusual for the man to have no money, but she was aware that he often lent money to other residents and she thought perhaps he had not been repaid. The resident told the investigator that she

had seen nothing unusual in the man. On the rare occasions that he was less than cheerful, he would “stick his head in a magazine and smoke a lot” but the resident did not notice such behaviour on that day.

29. The man attended the morning meeting on 23 June, and was later seen in the common room by an assistant manager who said there was nothing unusual in his behaviour. With hindsight, the assistant manager recalled that the man was smoking hand rolled cigarettes rather than his usual ready made brand, but she said that she would not have found this significant even if she had noticed at the time.
30. Around 7.00pm on 23 June, the man participated in a planned meeting with his key worker. The key worker told the investigator that the man seemed no different, and he did not see signs of anything untoward. He knew that the man was due to attend court the following morning but said he did not appear unduly worried about this. The key worker said it was a pleasant evening and he and the man sat on the patio, talking in the sun. When the session came to an end, the key worker returned to the house while the man remained on the patio for a time. Later that evening, he played pool with another resident.
31. CCTV photographs taken on the night of his death indicate that the man left the premises at about 10:45 pm. He was carrying a holdall in one hand and what appears to be a letter in the other. As he descended the stairs, he glanced around him as if to ensure no-one was about. The man was not seen leaving the hostel, but three residents who had been for a walk and were on their way back spoke to him in the street. One resident told the investigator that they were surprised to see the man in the street as it was close to curfew time.
32. The resident said he asked the man, jokingly, if he was escaping. Without stopping, the man replied that he was going to post a letter and carried on walking. The resident told the investigator that the man’s response seemed to be “jovial”. Another resident said something to the man about hurrying back for curfew, but none of the three men was concerned at the time. The resident told the investigator that he discerned nothing different about the man’s demeanour or behaviour, either when they met at dinner or later in the street, and he found the manner of the man’s death surprising.
33. At 11:00 pm, the night supervisor and the assistant manager on duty carried out the required curfew check by visiting each room to ensure that all residents were in. The man’s room was empty. The night supervisor conducted a thorough check of the premises, but the man was missing. The assistant manager was surprised at his absence as he had been a ‘model resident’. At approximately 11:30 pm, the assistant manager checked the CCTV footage and saw that the man had left the house at 10:43 pm. The man’s absence at curfew placed him in breach of his bail conditions and the assistant manager immediately completed the paperwork necessary to breach him, as was required, and notified the police of the breach by telephone.

34. At 1:20 am, two police officers called at the hostel and informed the night supervising officer that a body, thought to be that of the man, had been discovered outside a block of flats close to the rear of the house. There had been scaffolding around the block for some time and the man had apparently hanged himself. The post mortem examination subsequently confirmed that this was the cause of death. The visiting police officers found a length of new rope in the man's room.

Consideration and Conclusions

35. It was the role of this investigation to consider if the risk of self harm had been properly assessed and managed, and whether the level of care provided for the man, during the time he spent at the house, was adequate. In doing so, I also considered whether the hostel procedures were commensurate with the requirements for all such hostels as defined in the Approved Premises Handbook and familiar to staff. It was clear that the premises provide a structured environment for residents who present a high level of risk. The members of staff interviewed were confident about their roles and procedures to be followed. Staff members were also caring and concerned to do their best for all residents.
36. The investigation found that there are procedures in place for the recording of day to day events of note in the hostel log and, additionally, for any specific issues of concern to be recorded in individual's files. The members of staff were familiar with these procedures. It was a matter of pride to them that records were made quickly after events occurred while they were clear in the mind. There was evidence in the detail of the daily 'hand overs' that members of staff are supportive of their colleagues, and work well as a team, so that there is continuity of care. It appeared that residents' issues are dealt with sensitively regardless of which staff members are on duty.
37. The investigation found every indication that the man was popular with the residents and staff at the house, and did all he could to be helpful. Apart from one or two health problems of short duration, he was healthy and had no difficulties with drink or drugs. The man had no history of depression or mental health problems and there were no signs of any such problems during his period of residence. All the indications were that he was settled, was coping well at the house, and appeared content.
38. Key work sessions took place regularly as required and were appropriately recorded. The man's key worker discussed practical issues and assisted him with areas of concern. The notes indicate that, on 24 May, the man was worried about the possibility of people trying to discover his whereabouts but he seemed reassured after speaking with the key worker. The investigation found no indication of other problems, apart from the forthcoming court appearance. The man was facing serious charges and the possibility of a lengthy period in custody if convicted.
39. The man had told his key worker that he expected to be at the house for some time, as he understood his court dates would be in August and beyond. With hindsight, it could be suggested that the man intended his behaviour to demonstrate all was well with him, thus enabling him to avoid closer scrutiny. However, staff at the house did not have the benefit of hindsight and, at the time, there were no signs that he intended to harm himself. Although we cannot be certain, the acquisition of a rope that was, apparently, cut to size may indicate that the man developed such intent and planned his actions in advance.

40. The man was referred to the Approved Premises by the court duty officer, and a referral assessment completed on 15 April gave no indication of a risk of self-harm. However, the assessment was not as detailed as it would have been if the man had been referred for residence following a prison sentence, or post conviction, when an OASys assessment including a risk management plan would have been completed. OASys is a system, used by both the Prison and Probation Services, for identifying and quantifying risk. The system can identify the risk of self-harm but it is, essentially, geared towards assessing the risk of harm to the public and the risk of re-offending.
41. I understand that the assessment of those released on bail pre-conviction presents a unique challenge, and in the man's case, given the lack of indicators, it is unlikely that OASys would have identified any risk of self-harm. Nevertheless, I question the practice of forgoing a system of thorough risk assessment in use throughout the Prison and Probation Services.

I recommend that the Probation Area reviews its procedures for assessing the risk posed by those on bail to themselves and others, and considers whether they can be improved

42. That said the investigator formed the view that members of staff work hard to ensure that residents are treated as individuals, with care and consideration. She was satisfied that the overall quality of care provided by the Approved Premises to the man was good. There was no evidence to indicate that the man's sad death could have been prevented by changes in either management procedures or policy.

Local Recommendation:

I recommend that the Probation Area reviews its procedures for assessing the risk posed by those on bail to themselves and others, and considers whether they can be improved.

(Since this report was produced in draft form, it has been confirmed that the Probation Area accepts the recommendation and is currently undertaking a review of its procedures.)