REPORT ON THE CIRCUMSTANCES SURROUNDING THE DEATH OF A MAN IN NOVEMBER 2005 WHILST RESIDENT AT APPROVED PREMISES

REPORT BY THE PRISONS AND PROBATION OMBUDSMAN FOR ENGLAND AND WALES

NOVEMBER 2006

This is the report of an investigation into the death of a young man. The man, who was 23, was discovered dead in a car parked at his parents' home in November 2005. The post mortem report indicates that the cause of death was carbon monoxide poisoning.

The loss of a son in such tragic circumstances must be especially difficult to bear. I would like to add my personal condolences to those already expressed to the young man's parents by my Family Liaison Officer.

The man who is the subject of this report had been released on licence from HMP Wymott on 19 August 2005 and was resident at the Approved Premises at the time of his death.

The investigation was undertaken by two colleagues from my office. Simultaneously, a review was commissioned by the Assistant Chief Executive of Mersey Care NHS Trust into the care provided by mental health services to the young man. I thank the colleague from Mersey Care Trust who led that review for her unfailing co-operation throughout my investigation. The man had extensive contact with a range of mental health services throughout 2004 and 2005 after being diagnosed with paranoid schizophrenia.

I would like to express my thanks to the manager of the approved premises and his staff for their help and active co-operation throughout this investigation. The man's death came at a time when he appeared to be settling in at the approved premises. Although there were failings in the auditing of medications, I comment very favourably on the quality of care and support he received there.

The need to improve inter-agency co-operation is a feature of both the recommendations I have made.

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

Stephen Shaw CBE
Prisons and Probation Ombudsman **November 2006**

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Summary

1. The man who is the subject of this report was born in 1982. He was 23 years old when he died on 6 November 2005 in a car parked on the drive of his parents' home. A pipe led from the car's exhaust through a window into the vehicle's cabin. The post mortem report indicates that the cause of death was carbon monoxide poisoning.

2. In May 2003, the man was sentenced at Liverpool Crown Court to four years imprisonment for a serious offence. He went to HMP Liverpool for three months before being transferred to HMP Acklington in Northumberland in August of that year. His first few months at Acklington were unremarkable, but then his mental health began to deteriorate and the visiting psychiatrist recommended a return to Liverpool for further assessment.

3. The man was admitted to a medium secure unit in July 2004. He was diagnosed with paranoid schizophrenia and remained at the medium secure unit for a lengthy period of treatment. The man did not return to the prison system until January 2005 when he was received at HMP Wymott, near Leyland in Lancashire.

4. The man was held at Wymott until his release on licence on 19 August 2005. There were further concerns about his mental health whilst he was at Wymott because he did not always take his medication. He was seen by a visiting psychiatrist on a number of occasions and his condition stabilised somewhat. He was also placed on a suicide and self harm observation regime for the last two and a half months of his time at Wymott until his release.

5. One of the conditions of the man's release was that he must reside at approved premises. On 19 August, he was taken there from Wymott by his parents. The man was very apprehensive about being at the approved premises because he feared that other residents knew about the circumstances of his offence. His first stay at the approved premises lasted less then 36 hours. When a curfew check was conducted at the Approved Premises at 11pm on 20 August, the man was not present. The man's mother rang the hostel at 5.18am on 21 August to say that he had turned up at the family home. She took him to a nearby hospital where it was discovered that he had fractured his right ankle from jumping off a wall after he had been drinking.

6. On 30 August, a psychiatrist decided that the man should be admitted to hospital. On 2 September a bed was found for him on a ward at an acute admissions facility within the grounds of a large hospital. Later in the month, the man was transferred to a male ward at the acute admissions facility. He declared he was determined not to return to the approved premises but he was eventually persuaded to do so, on a phased basis.

7. The man returned to the approved premises on day visits on 6, 10, 12 and 14 October. He returned to the hostel on a more permanent basis from 17 October. The managers at the hostel made very careful plans to make the man feel as safe and comfortable as possible. He was allocated the only ground

floor room in the hostel, and integrated much more successfully with other staff and residents than he had during his brief stay in mid-August. He was described as the life and soul of the party on one minibus outing, and mixed successfully with other residents in activities such as cookery classes and playing pool. On the morning of 26 October, the man was issued with the wrong medication and he found this experience stressful. That evening, he consumed a significant quantity of alcohol and he was subsequently given a verbal warning by his probation officer.

8. The man was last seen at the approved premises on the morning of 5 November. At approximately 9:30am, he was given his daily medication and he then made his way to his parents' home town where he bought a car from a local man. The man's parents had just gone on an overseas holiday and their home was being looked after by his grandmother. The man had a long visit with his grandmother during the afternoon of 5 November. At approximately 7:45pm, he told her that he was catching a bus back to his approved premises. He did not return to the approved premises and was discovered to be missing at the 11pm curfew. Around 1.00 on the afternoon of 6 November, the man was found dead in the car he had bought the previous day.

9. In view of the man's diagnosis of schizophrenia, the state of his mental health features prominently in this report. I have made recommendations about medication issues at the approved premises, and about the transfer of information between the prison and probation services regarding the risks an individual presents. The report prepared by colleagues at Mersey Care makes 11 recommendations. I attach particular importance to the two recommendations in that report referring to Effective Care Co-ordination.

The Investigation Process

10. This investigation was conducted by two colleagues from my office. Their first visit to the approved premises was on 11 November 2005, five days after the man's death. My investigators studied all relevant prison and probation records relating to the man. These included his probation files, his main prison record and his medical records.

11. Interviews were conducted with residents and staff at the approved premises who had significant contact with the man during the last months of his life. Mersey Care NHS Trust commissioned a review of the mental health support provided to the man. I am most grateful to the Community Services Co-ordinator for the Specialist Teams in Mersey Care NHS Trust for undertaking this review.

12. One of my Family Liaison Officers made telephone contact with the man's parents to discuss the investigation process and any concerns they had. The man's mother raised questions about incorrect medication given to him on 26 October and my report attempts to answer her questions fully.

13. My lead investigator discussed the last two and a half years of the man's life in detail with his experienced supervising officer (probation officer) in Southport. He also made contact with the Merseyside Mental Health Probation Liaison Officer. The man's mental health problems were also discussed with the Assistant Chief Officer in Merseyside Probation Area who has particular responsibility for mental health issues.

14. The Safer Custody Co-ordinator at Wymott and a member of the Safer Custody Group in the National Offender Management Service in London supplied valuable information on the release of at risk prisoners.

The medium secure unit

15. The medium secure unit has 50 beds and is the in patient unit of the Mersey Forensic Psychiatry Service, which covers the Cheshire/Merseyside areas (approx 2.4 million population). The clinic opened in 1983, following the closure of the interim medium secure units in Macclesfield (14 beds) and Rainhill (20 beds).

16. The aim of the service is to provide advice to other mental health providers, the Prison Service, local authorities and the private sector. This also includes providing intensive assessment, treatment, rehabilitation and aftercare (in appropriate cases) of mentally unwell offenders, or others without criminal convictions but displaying similar behaviours.

17. Patients are usually transferred from prisons, the courts, or other adult mental health services under the Mental Health Act. For those transferred from prison, the aim is to assess their mental state, provide appropriate interventions, and, if they are still serving a sentence, to return them to the Prison Service where they are followed up by their local mental health in-reach teams. The service is staffed by consultant forensic psychiatrists, psychologists, nurses, occupational therapists, social workers and a dedicated community team.

The Approved Premises

18. The approved premises (the new term for what used to be known as probation or bail hostels) was purpose built and opened in 1993. It has both single and double rooms and can accommodate up to 24 male residents. All residents are either on licence, bail or community orders with a condition to reside on the premises. Residents are mainly considered to be at medium to very high risk of harm to the public. The approved premises operates a curfew for the majority of residents from 11:00pm to 7:00am.

19. The hostel is staffed 24 hours a day. A local NHS medical centre provides comprehensive health checks on all residents together with continuing health care. Staff at the premises act as a conduit between the residents and their probation case manager. Premises staff liaise with other relevant bodies, help residents to identify suitable alternative accommodation and discuss day to day issues which may be hindering a resident's progress towards effective resettlement. Residents undergo a full assessment with the Deputy Manager and are required to tackle the causes of their offending as part of the conditions of their residency at the approved premises. Staff are encouraged to spend their working hours with the resident group rather than in the office.

The man's time at the approved premises

20. On 19 August, the man was accompanied by his parents to the approved premises. Over a number of months, different agencies had carefully planned for his release and rehabilitation.

21. A Multi Agency Public Protection Panel (MAPPP) meeting took place on 4 May 2005 at the Merseyside Probation Headquarters. The action points agreed were:

    - Manager of the approved premises to be kept appraised of the man's mental health leading up to release to ensure an appropriate management plan is in place.
    - Criminal Justice Mental Health Unit to arrange ECC (effective care co-ordination meeting) as soon as possible prior to release.
    - Mental Health support package to be in place with named psychiatrist and named community mental health team.
    - Merseyside police to liaise with Probation Offender Manager and the approved premises on an ongoing basis.

22. The ECC meeting took place at Wymott on 2 June 2005, the same date that the man was placed on an F2052SH regime. The meeting was attended by the Deputy Manager at the approved premises, although he had to leave the meeting before the man was brought there. My investigator asked the deputy manager about the planning he and the manager had done before the young man arrived at the approved premises. The deputy manager replied:

    "It was far in excess of what we would normally do. We cannot afford to take that amount of time over most referrals. We felt that he was quite a vulnerable person and once we had satisfied ourselves that we could cater for him as a vulnerable person then we were happy to take him. The fact that I went to the prison to visit, that is an unusual step. We don't usually take those kinds of steps."

23. In a later answer, the deputy manager explained that it was better for the man to come out of prison under a licence:

    "Then the longer we have him on licence, means the longer we have to set plans in place for his eventual move on while he is still under some kind of supervision … If vulnerable people eventually come out [of prison] only with weeks left on a licence or even no licence, then the likelihood is they are going to break down in the community because there is no support package in place."

24. The man's licence explained to him that his supervision commenced on 19 August and was due to expire on 19 December 2005. The licence conditions included a requirement to reside at the approved premises and not to live

elsewhere without obtaining the prior approval of his supervising probation officer. Another requirement was that he must attend all appointments with mental health services and co-operate fully with any care or treatment they recommended.

25. The deputy manager recalled that the man looked rather sheepish and apprehensive as he arrived at the hostel on the afternoon of 19 August. The deputy manager said that the man stayed very, very close to his parents. His facial expression was like, "a school boy a little bit frightened of going through the school gate."

26. The deputy manager did his utmost to help the man settle in at the approved premises as smoothly as possible. He took the man and his parents into the gardens outside the hostel. He wanted to show the man, "the lads mixing together, generally working, to show him the type of atmosphere that the place had, which was very calm." One of the other residents had grown some tomatoes. He gave the man's father a couple of potted plants to take home which made the man extremely pleased.

27. The normal procedure is that an induction document is completed on a resident's first day at the approved premises. The deputy manager decided that would not be appropriate in the young man's case. The induction document is called a Resident's Record. It is 30 pages long and was described as ''hefty'' by the deputy manager. It poses a lot of questions, some of them personal. The deputy manager said he was not satisfied on day one that the man was fully well. He decided that the induction interview should take place the following day, a Saturday. The deputy manager thought that his colleague, a very experienced member of staff with a calm demeanour, would be able to go through the induction questions at a leisurely pace during the next 24 hours.

28. At Wymott, the man had been continuously on form F2052SH from the date of the ECC meeting on 2 June until his release on 19 August. F2052SH is a prison document that puts in place a regime used to provide additional levels of monitoring and support for prisoners who have self-harmed or are thought to be at risk of doing so. However, the deputy manager and his hostel colleagues were completely unaware of this level of concern at Wymott and, as a result, no self-harm prevention measures were implemented when the man arrived. Although the deputy manager had been at the ECC meeting on 2 June, it was not until after the meeting that the F2052SH was opened. On 19 August, while in his bedroom at the hostel, the man cut his left wrist with a razor blade. His parents observed the cut in the early hours of 21 August whilst they were waiting with him in the Accident and Emergency department of a nearby hospital. They told nursing staff who cleansed, glued and steri stripped the wound.

29. The Contact Report is a document showing the contacts between the man and various staff employed by Merseyside Probation Area. The deputy manager made an entry in the Contact Report on Monday 22 August about the man's behaviour on Saturday 20 August. He wrote that the man had got it into his mind that other residents knew what he had done. The man said that another

resident knew both the nature of his offence and the victim. The deputy manager commented that this was highly unlikely as the other man was from Manchester and had only been in the man's home town for a short while before coming to the approved premises. When staff spoke to the man, he said he did not know the new resident and had engaged him in general conversation simply to make him feel welcome.

30. Hostel staff are required to keep a log book each day. The log book shows that lunch was served at 11am on 20 August but the man did not attend because he said he did not feel hungry. At 11.30am, a member of staff went upstairs to have a word with him. By 1pm, the next entry noted that the man was downstairs. He had had a drink, was playing pool and appeared to have settled a bit better. At 3.10pm, another entry refers to a television belonging to a former resident being loaned to the man from the storeroom.

31. The first rule of the hostel is that, unless otherwise ordered by the court or specified in the licence, residents must be inside the hostel between the hours of 11pm and 7am the following day. At 11pm on 20 August, staff made a curfew check and could account for all residents except the man, who had failed to return to the hostel. A hostel supervisor confirmed in interview that he obtained the television from stores so that the man had something to occupy him. The supervisor's recollection was that the man had left the hostel at around 8pm.

32. Hostel staff rang the local police station to report the man's absence just 20 minutes after his curfew failure. The next information about his whereabouts came in a telephone call from the man's mother to the hostel at 5:18 on the morning of Sunday 21 August. She reported that the man had arrived home about 20 minutes previously. He had apparently been to a nearby town and had tried to hand himself in at a police station but was allegedly told by a police officer to "go home son." The man's mother reported that he had deliberately cut his right wrist in the hostel the previous evening. She said that he was scared to come back to the hostel as he believed that two residents were aware of the circumstances of his offence. His mother was about to take the man to hospital as he had hurt his ankle when jumping off a wall. The man's mother telephoned the hostel again later in the morning to report that the hospital had found her son had fractured his right ankle. He also had a bad sprain to his left ankle.

33. The hospital staff were concerned about the man's mental state and contacted the crisis team at Ashworth Hospital to ask a psychiatrist to come out and visit him. On 22 August, the deputy manager made an entry in the Contact Report after a phone call from the man's community psychiatric nurse (CPN). She had accessed the notes of the psychiatrist who had seen the man that day. The man had reportedly told the psychiatrist that when he jumped off the wall he was not trying to kill himself. He said that it was because of the alcohol he had been drinking. The psychiatrist's assessment was that, without alcohol, the man was stable and at low risk of harm. Under these circumstances, he was unlikely to be admitted to hospital for mental health reasons.

34. The deputy manager was aware that, if the man was discharged from hospital and refused to return to the approved premises, the only remaining option would be a recall to prison. In interview, the deputy manager referred to the seventh condition of the man's licence, that he must reside at the approved premises and must not leave to live elsewhere without obtaining the prior approval of his supervising officer. The deputy manager was doing his utmost to prevent a recall at this time because, "for me he would not have been getting recall to prison because his risk of re-offending was any big deal, but simply because his mind was not functioning the way it might have been. He would have been getting recalled because he was ill or frightened or afraid." The deputy manager felt this was the wrong reason for the man to be recalled and believed he would be better off in the hostel. On 22 August, the deputy manager said that he wanted a psychiatric assessment before the man returned to the approved premises. He added:

> "Without that assessment I can't take him back, with that assessment I am being assured that it is not his mental health that is causing a problem. I couldn't get that assurance, I was getting mixed messages, it is mental health, no it isn't, yes it is, no it isn't."

35. The Contact Report indicates that, on the morning of 24 August, the man attended for assessment at a psychiatric unit where he was assessed as being psychotic and requiring inpatient treatment. A note on 25 August states that the general hospital was not happy to discharge the man at that time because of his mobility problems.

36. On 30 August, the Contact Report records a phone call from the man's CPN to his supervising officer (offender manager), saying that the psychiatrist wanted the man admitted to hospital and was looking for a bed. A further entry made by the supervising officer on 2 September stated that the man was on a ward at an acute admissions facility as a voluntary patient. The supervising officer visited the man on 6 September when he clearly stated to her that he did not want to return to the approved premises. On 8 September, the man was transferred from the first ward to another ward. The second ward is for men only and the Contact Report refers to "risks re nature of offence."

37. On 19 September the man was assessed by a psychiatrist who had treated him previously at the medium secure unit. On 27 September the supervising officer received a copy of the psychiatrist's assessment report which she logged in the contact report:

> "Not yet sufficiently stable for the approved premises. Psychiatrist feels he is still psychotic although not as florid as previously."

38. On 20 September, the possibility of the man making a phased return to the approved premises was discussed by the supervising officer and clinical staff responsible for his treatment at the acute admissions facility. The supervising officer telephoned the hostel manager on 21 September and he wrote an Observation Report which said:

"No discharge date from the acute admissions facility – in view of huge anxieties about being in probation hostel continuing (believes he will be beaten up) felt some leaves from the acute admissions facility to our approved premises may be helpful. Agreed day here 3/10/05. Subject to his response on 3/10/05, may then consider overnight stay at here later in that same week."

39. There was a flurry of activity in the late afternoon of Friday 30 September 2005. An entry in the Contact Record at 4:11pm referred to a telephone call from the acute admissions facility to the supervising officer's office. At that time the man was still at the hospital in his parents' home town where he had been admitted as an in-patient on the orthopaedic ward on 26 September. The caller said that when the man returned to the acute admissions facility from the general hospital, "He is going to be assessed by a consultant and if they think he is okay he will be discharged today back to the approved premises." By this time on Friday afternoon, the supervising officer had left her office. When she was contacted by telephone, she said it was not possible for the man to be discharged that afternoon in view of the recent report by the psychiatrist that he was still psychotic.

40. The Contact Report for Monday 3 October refers to considerable confusion about when the ward round at the acute admissions facility would take place. The supervising officer eventually attended a lengthy meeting on the ward at 2pm on 3 October. It was agreed that the man should attend the approved premises for two days a week to get used to it. He would be accompanied by his CPN for the first visit on 6 October.

41. The man's parents also attended the ward round. In a letter to my investigator, his mother wrote that the man consented to the two initial days at the approved premises "under duress" from staff at the ward round.

42. The man's visit to the approved premises on 6 October went well. The Observation Report written by the manager of the approved premises noted that the man had spent a very successful day there, and that the CPN was pleased with how well he did. The man's second visit to the approved premises was on Monday 10 October. The supervising officer noted in the Contact Report that she collected the man from the acute admissions facility and took him to the hostel. He was more positive, engaging better and seemed more confident. He did cookery and enjoyed it, although he saw someone of whom he was fearful. It was agreed that the man would return to the hostel on Wednesday 12 and Friday 14 October with four days to be spent at the hostel in the following week.

43. In interview, the hostel manager recalled that the man's visit on 12 October went very well. He was escorted to the hostel by his CPN at 9:45am. He left by himself in a taxi at 4:35pm. The manager explained the significance of the taxi by saying that on all previous visits the man had been brought to the premises and escorted back by a CPN. By 12 October, "We had reached a point where the man had established a degree of confidence in the place and with himself within this place that we felt it was quite suitable to be able to trust him to make his own way back." As planned, the man made a further visit to the approved premises on Friday 14 October.

44. The man’s reintegration at the approved premises proceeded more swiftly in October than had been anticipated or hoped. The plan made on 10 October envisaged that the man would stay at the hostel for four days and one overnight during the week beginning 17 October. In fact, he arrived at the hostel during the afternoon of 17 October (when the induction procedures in the Resident’s Record booklet were completed by the man and a supervisor) and remained there without interruption until Saturday 5 November. The manager wrote an Observation Report about the man’s arrival on 17 October. It said:

> “Brought here by Mum and Dad. Some basic assurances again given to the man. Mum revealed that the man still, periodically, having suicidal thoughts – his own thoughts, not auditory hallucinations. Tried to get idea of frequency of these thoughts from the man – got a vague “about once a week.” Emphasised need to inform staff, as and when these ideas occur. No current such thoughts.”

45. In a letter to my investigator the man’s mother wrote that by 17 October, when she and her husband attended a further ward round, the man told his parents that he felt resigned to moving into a hostel full time. He confided that “because staff at the acute admissions facility believed he shouldn’t be in the hospital and that he found it awkward/difficult to answer residents’ questions at the hostel as to why he came and went, The man thought it was better to ‘just go full time.’ His mother felt “it was unfair of the Mental Health sector to expect hostel management at the approved premises to deliver the security and care that they, the Mental Health Team, should have been implementing at that time.”

46. The man’s apparently successful reintroduction at the approved premises was the result of careful and thoughtful planning. The manager explained in interview that one of the arrangements set in hand was that the man would be accommodated at ground floor level in room 1, the only ground floor room at the approved premises. The manager explained:

    “It is within the immediate vicinity of the Staff General Office and also we thought it would give the man greater assurances as it would not mean that he would be in the upstairs accommodation with the rest of the residents. It also gave us the additional facility of being able to monitor him and assess him much more closely because we also knew that the man may need some time to acclimatise … so being at the ground floor level would mean I could devote one member of staff, in most circumstances the hostel supervisor, to pay particular attention to him if he wasn’t in any of the programmed activities going on with the rest of the residents.”

47. The manager added that the decision to locate the man at ground floor level had nothing to do with issues of mobility. Although the man had needed crutches in August after fracturing his ankle, he was walking without any physical aids by the time of his return to the hostel two months later. The manager wanted to prevent the man from isolating himself upstairs as he had sought to do on the night of 19 August.

48. In interview, the manager spoke about the programme that residents at the approved premises are required to undertake. Sessions run for two hours in the morning and a further two hours in the afternoon. Staff at the approved premises were flexible with the man because they understood that his personal problems might not always enable him to participate fully in the programme, although he did find particular activities enjoyable. The manager recalled that he was becoming very interested in the gardening and landscaping activities which were led by some residents and overseen by the staff. The man also seemed to particularly enjoy and gain a lot of confidence from working with the cookery instructor who came to the hostel each Monday.

49. The manager indicated that staff were trying to get to the stage where the man could participate fully in the life of the hostel. The manager is a firm believer in outside activities and the hostel log shows that two members of staff took groups of residents, including the man, for activity days on 20 October and 3 November. The manager "always thought in terms of seeing his face and judging his moods when he came back from such activities, it was obvious that he had hugely enjoyed them."

50. My investigator asked the manager how the man appeared to be responding at the hostel in the last few days of October and the first few days of November. The manager answered as follows:

> "I think everybody was hugely pleased with the way things were going with the man. He was getting to feel increasingly comfortable here, he was able at this stage to voluntarily involve himself with some informal activities of an evening with other residents. So we had a picture of a young man who was hugely fearful of being here to someone who was really starting to blossom here in the sense of he felt comfortable here, he felt safe here, his confidence and ability to deal with other people was growing; not just staff but also other residents. We thought that was a thorough vindication of the kind of approach that we decided upon in terms of his move back here."

51. The manager's assessment that the man was making good progress at the approved premises was shared by both staff and residents. A supervisor carried out the induction interview with the man on 17 October. He recalled that the man did not appear anxious and, as the two men were of similar age, they were able to build a rapport easily. The supervisor at the approved premises recalled that the man was forthcoming with his answers, even to difficult questions about topics such as self-harm. The supervisor said that the man appeared fine during his second spell at the hostel: he was interacting with other residents and staff and there was no indication of an intention to harm himself.

52. A female supervisor at the hostel said in interview that the man was much more relaxed and settled during his second stay at the hostel. She said that the man played pool and Xbox with other residents, and he mixed much more with them. She confirmed that nothing in the man's behaviour had raised her concerns. He had been talking about going back to college as he was

interested in yoga and relaxation classes. She recalled that on 3 November the man had been on a day trip to the town where his parents live with other residents in the hostel minibus.

53. My investigator interviewed a resident. (At the time of this interview in December 2005, he had been a resident at the approved premises for several months.) He and the man had spoken about employment opportunities. The first resident had been liaising with an organisation called Tomorrow's People who provide assistance to people looking for employment or trying to start-up their own business. A few days before his death, the man had shown an interest in pursuing the option of self-employment. He asked the first resident to provide contact details for Tomorrow's People, and followed up his request a couple of days later as the first resident had forgotten to supply the information. In the resident's opinion, this illustrated that the man seemed to be thinking about the future.

54. My investigator interviewed a second resident. He had been a resident at the approved premises for nearly two years at the time of his interview. He recalled that, when the man first arrived at the hostel in August, the residents tried to make him feel welcome, but the man appeared to be very withdrawn and seemed unsure about the hostel staff and residents. The second resident said that the man seemed to open up after he returned to the hostel again in October. In the last few days of his life, the man appeared to be settling in quite well. The second resident recalled him playing on the Xbox console and associating with other residents and staff. He seemed happy to be at the hostel and other residents were going out of their way to ensure that the man was okay. The second resident said that the other residents were in shock when they heard the news of the man's death. They regretted the loss of such a young person. There had been no visible signs of distress. In the second resident's opinion, the man had been looked after by the hostel. Both staff and residents there had been supportive to him.

55. The man's time at the approved premises went so well in the week beginning Monday 17 October that he stayed at the hostel through the weekend of 22 and 23 October without returning to the acute admissions facility. On 17 October, the man's supervising officer in the community noted on the Contact Report that she had attended a ward round. The report continues:

> "Agreed man to have week's leave to hostel and if goes well will be discharged 24.10 without attending meeting. Will have week's medication and to stay on all med at present. Man asking to come off anti-dep (anti-depressants) but too soon.''

56. In the hostel log there is a record of a telephone call from the supervising officer on 17 October which conveyed the following information:

> "The man will be in hostel later today with one week's medication. He will stay for one week but his bed is still open at the hospital. If he does get through this week he will move in permanently on Monday 24/10/05."

57. The supervising officer's entry in the Contact Report for 21 October states that, "medication sorted via CPN and doctor's appointment made." She visited the man, as planned, at the hostel on 24 October. Her entry in the Contact Report says the man was aware of his discharge from hospital that afternoon and was also aware of his parents' forthcoming holiday. He would discuss plans with them at the weekend about seeing his brother in hospital and seeing his grandmother. Staff had no concerns about the man at that stage and confirmed that they would liaise with the CPN about his medication.

58. On 26 October, a problem arose with the man's medication. It was the man himself who complained that he had been given the wrong medicines. The issue of the medication mix-up was specifically raised by the man's mother in a telephone conversation with one of my Family Liaison Officers. (I deal with this matter at greater length later in this report.)

59. On 3 November a group of men from the approved premises, including the man, went to his parents' home town for their afternoon outing. Some of the men, according to the man, went to the pub but the man took the opportunity to visit his parents. During the visit the man's mother was telephoned by the supervising officer. The supervising officer told the man's mother that she had tried to discuss with him his thoughts on future plans for life outside the hostel when his licence was completed. The supervising officer felt that the man had been uncomfortable while the subject was being discussed. The man's mother could see that the mention of future planning was clearly discomfiting to him and she reassured her son that he had plenty of time to explore these areas when he felt more secure and stable. When the man walked the few yards to the hostel bus to rejoin the other men, his parents observed that his injured leg was still causing him to limp slightly and limited the amount of walking he could manage.

60. On the afternoon of Friday 4 November, just before they set off for a holiday abroad, the man's parents came to visit him at the approved premises. In the days leading up to that visit, the deputy manager observed that, "The man had reached the stage where the approved premises was no longer a problem for him, he wasn't worrying about residents in here so he was safe." The deputy manager made a point of having contact with the man every day of the working week, "first of all because he was a charming young man and secondly to satisfy myself that he was actually moving forward because we are looking at a process of his moving into the community and he wouldn't have had much time left by the end of his licence."

61. The deputy manager described the last contact between the man and his parents on 4 November:

> "The man's very close to his parents, you could see that and they were very, very supportive of him and it was a very loving gathering. I had a joke with him because I was leaning out of the window of the office and they were standing in the corridor and we were talking about where they were going on holiday and I was laughing with the man and saying, well if they are going

there, I am going to Egypt shortly and you might as well come with me. And the man was laughing and his parents were laughing."

62. On 5 November, the female supervisor gave the man his medication around 9:30am. Soon afterwards she saw him on the public phone but she could not hear what he said. After finishing his call, the man left the hostel. He caught a bus to his parents' home town where he bought a Toyota Carina car. The man paid for the car in cash and made the purchase at approximately 12 noon. The previous owner told the police that he had advertised the vehicle in the North West Auto Trader. On the evening of 4 November, the man had telephoned and made an arrangement to look at the car the next morning.

63. On the afternoon of 5 November, the man went to visit his grandmother who was looking after the home of her daughter and son-in-law (the man's parents) while they were on holiday. The man's parents are carers for three adult men with learning difficulties and the man's grandmother was looking after them during the holiday. The man's visit began at approximately 1:15pm. During the visit, he appeared to be in reasonable spirits and was quite chatty. He left his parents' home at approximately 7:40pm, telling his grandmother that he would catch a bus back to the approved premises soon after 8pm. She heard nothing further from him.

64. The man did not return to the approved premises for the curfew check at 11pm. Staff at the approved premises observed the correct procedures in response to his non-arrival. Soon after midnight, they telephoned the Police Station in the town where the man's parents live, describing the man and giving the circumstances of his absence without leave.

65. At 8:30am on the morning of Sunday 6 November, two police officers arrived at the approved premises to take details about the man's absence. At 8:50am, the man's grandmother telephoned the approved premises to say that he had been with her the previous afternoon until leaving to catch his bus at 8:05pm. The man's grandmother made a second telephone call to the hostel at 10:15am to ask if staff there had heard any news. The staff reassured her that she would be contacted if they heard anything.

66. Around 1pm, one of the men who lived at the man's parents' home went outside to move the bin bags from the back of the house to the front gate. His speech can be difficult to understand, but the man's grandmother realised that he was saying that the man was outside in a car. At the time, the man's grandmother was being visited by a friend and when the two ladies went outside his grandmother saw a red car on the drive. She said she did not know who it belonged to. The man was in the driver's seat of the car, but when his grandmother shouted out his name he did not respond. His hand was very cold to the touch. She ran inside the house and telephoned for an ambulance. She returned outside and at that point she noticed that a pipe was running from the vehicle's exhaust to the inside of the car. When the paramedics arrived they broke the news that the man was dead. The post mortem report indicates that the cause of death was carbon monoxide poisoning.

67. The man's funeral took place just a few days later and was attended by the supervising officer. In discussion with my investigator, she recalled how she had last seen the man on 31 October when he was well enough to visit her at her office rather than receiving a visit himself at the approved premises. During that last meeting he seemed very well to her; he was more chatty and made more eye contact. The man was very proud of a watch his parents had bought for him and he showed her in considerable detail what it could do.

Report by Mersey Care NHS Trust

68. I am grateful to the Assistant Chief Executive of Mersey Care NHS Trust for making available to me a copy of the report on the circumstances of the man's death written by the Community Services Co-ordinator and another colleague at Mersey Care. The Mersey Care report provides additional information about the period the man spent in the care of the Trust between 31 August and 3 October.

69. Paragraph 23 of the Mersey Care report indicates that the Nursing notes kept at the acute admissions facility are at variance with information contained in the Probation Service's contact report. The contact report notes that a phone call was made from a ward at the facility to the supervising officer's office at 4.11 pm on the afternoon of Friday, 30 September. The caller said that the man would be assessed by a consultant and discharged that day "if they think he is okay" back to the approved premises. The Mersey Care report reveals that "none of the above was documented in the nursing or medical notes."

70. I have no doubt that the telephone call described in the contact report did indeed take place. I note that the care plan written after the man transferred to Beech Ward on 8 September did not indicate who the man's named nurse was and that "it is not recorded in the notes that staff made real efforts to engage the man."

71. The third recommendation made by the reviewer and her colleague at the end of their report is that nursing progress reports should reflect an accurate account of a 24 hour period and should "encompass all actions, interactions and relevant information."

72. The Mersey Care report pays close attention to events in the run-up to 26 October, when the man received incorrect medication. Paragraph 31 of the report confirms that the man was discharged from the acute admissions facility at the ward round on 24 October. In paragraph 32 of their report the Mersey Care reviewers say

> "There is clear evidence of a discharge plan in the notes. The man was placed on an enhanced Effective Care Co-ordination plan (ECC). There is documentary evidence of the ECC but unfortunately this is neither signed nor dated and was poorly completed. The risk assessment document, also not signed or dated, identifies "low risk to self or others."

73. After the man's discharge from the acute admissions facility his community psychiatric nurse thought that he had a supply of medication and had been registered with the GP for residents at the approved premises. The clinical reviewers asked the psychiatric nurse how the GP and the approved premises knew what medication the man was taking. His understanding was that the ward would inform the GP. In a significant section the reviewers write

> "The investigators could find no documented evidence of information regarding discharge medication having been sent to the GP. They were informed that in the first instance the ECC documentation would be faxed to

the GP. The ECC documentation in this case did not have the medication written on it. They were also informed that the discharge letter sent by the SHO (Senior House Officer) would also include the current medication. The investigators noted the discharge letter sent to the GP was dated 5 January 2006, which was after the date that the man had died on 6 November 2005."

74. The Mersey Care reviewers' seventh conclusion is surprising. They refer to the assessment conducted by the forensic psychiatrist from the medium secure unit on 19 September. The psychiatrist's report is also mentioned in the Probation Service's contact report on 27 and 30 September. The psychiatrist's report indicated that the man remained psychotic, albeit lower grade. He noted that, should the man deteriorate, the risk of suicide was an issue of concern in his short and medium term management. The reviewers then add

> "There is no evidence to suggest that the content of the psychiatrist's assessment and opinion that had been sought by the care team at the acute admissions facility played any part in the treatment and care plan of the man."

75. One of the terms of reference set for the Mersey Care reviewers required them to examine the relationship between Mersey Care NHS Trust and the approved premises in relation to communication. Their twelfth conclusion is that the process with regard to discharge medication being communicated to GP and the approved premises was extremely vague. The investigators added that during the interview process they "could find little clarity of how this process normally happens." In that context their second recommendation is particularly welcome. It is as follows

> "It is recommended that discharge medication is documented clearly within ECC documentation and a copy of the prescription faxed to the GP within 24 hours of discharge."

76. The seventh recommendation of the Mersey Care report returns to the theme of Effective Care Co-ordination documentation and says

> "It is recommended that all staff are made aware of the importance of completing all ECC documentation and have been fully compliant with the ECC policies. A robust audit process must be in place to ensure compliance."

77. I concur completely with these two recommendations made by my Mersey Care colleagues. I observe that completion of the ECC documentation is not merely a bureaucratic nicety but is a critical communication tool if the ongoing duty of care to an individual patient/offender is to be maintained.

78. The penultimate conclusion in the Mersey Care report is that the man settled well into the approved premises. I assume from the context that this is a reference to the time after mid-October when the man returned to the approved premises full-time. The Mersey Care reviewers say

"There is no evidence to suggest that there was any deterioration in the man's mental state that would have given rise for concern. Up to the time of his death the man's mental health appeared to be stable."

79. The final conclusion in the Mersey Care report is that communication and liaison between the ward, community mental health team, probation service and hostel was good and generally effective. This judgement is based on the nursing and community nursing notes but my assessment is that there is still some room for improvement. The report's third recommendation points to the need for nursing notes to reflect an accurate account of a 24 hour period which should include all actions and relevant information. An entry in the contact report on 3 October refers to an apology from a CPN for all the "messing around" about the time and location of the ward round on that day. On 30 September it appears that probation staff were told that the man would be transferred to the approved premises at very short notice although no documentary evidence of such a conversation was recorded in the medical or nursing notes.

I highlight and endorse the two recommendations referring to Effective Care Co-ordination in the anonymised report on the man's death supplied by Mersey Care Trust. They are as follows:

1. **<u>Medication Issues</u> – It is recommended that discharge medication is documented clearly within ECC documentation and a copy of the prescription faxed to the GP within 24 hours of discharge.**

2. **<u>ECC</u> – It is recommended that all staff are made aware of the importance of completing all ECC documentation and of being fully compliant with the ECC policy. A robust audit process must be in place to ensure compliance.**

Issues Considered During the Investigation

(1) The man's move from Wymott to the approved premises on 19 August 2005

80. A suicide and self-harm "at risk" form (F2052SH) had been opened at Wymott on 2 June following an effective care co-ordination (ECC) meeting to consider the support plan prior to the man's release. At that meeting, the man had told staff that he thought he was ''bad'' and the only way out or remedy was to "end it all". The F2052SH remained open continuously until his release from Wymott on 19 August. While the document was open, reviews of the risk that the man would self-harm were held at regular intervals. At each of these reviews, it was felt that the man posed a continuing risk of self-harm and that the document should be kept open. Although the deputy manager had attended the ECC meeting, staff had had difficulty locating the man to attend the meeting. As a result, he did not arrive until a later stage by which time the deputy manager had left. For this reason, the deputy manager was alerted neither to the man's suicidal ideation nor to the F2052SH opened shortly thereafter. No information about the man's perceived risk of self-harm was made available to the approved premises.

81. The Prison Service Order on Suicide and Self Harm Prevention (PSO 2700) devotes several paragraphs at chapter 4.3 to the movement of at risk prisoners. However, the instructions in the PSO relate only to prisoners who are being moved within the prison, from prison to court, or from one prison to another. There is no explicit guidance in the PSO about the need to supply this information to other agencies if a prisoner is on an open F2052SH at the time he/she is released into the community.

82. This is a loophole that is addressed in Prison Service Instruction (PSI) 18/2005. The subject of that PSI is Introducing ACCT (Assessment, Care in Custody and Team Work) – the replacement for the F2052SH (risk of self harm) procedures. Paragraph 30 of the PSI is devoted to the transfer of risk information to the Probation Service. The paragraph states that if the prisoner is to be under the supervision of the Probation Service upon discharge, a photocopy of the final Case Review and other ACCT documents must be provided to the Offender Manager or Approved Premises Manager in accordance with local protocol. Ideally, this should be provided at least 48 hours before the prisoner's discharge. A record must be maintained to show this has been done.

83. At Appendix B of the PSI, governors are told, that before commencing the use of ACCT in their prison, they must ensure "there are local arrangements in place to ensure that where an at risk prisoner is to be discharged from custody, the relevant external offender manager and/or approved premises manager is invited to participate (preferably by attending in person) in the final Case Review and in updating the CARE MAP to reflect the care required in the community."

84. My investigator discussed these issues with the Principal Officer (PO) who is Suicide Prevention Co-ordinator at Wymott and with the policy lead on this issue at Safer Custody Group in the National Offender Management Service

(NOMS). The PO confirmed that there are usually 10 to 15 F2052SHs open on any given day at Wymott. He added that Wymott intends to move over to the ACCT system around April 2006.

85. In response to his discussion with my investigator, the policy lead immediately sent an e-mail about at risk prisoners on discharge to his network of outreach colleagues and Area Safer Custody Co-ordinators. He correctly pointed out in his e-mail that it is unclear whether such information transfer would have averted this particular tragedy. Nevertheless, he asked colleagues to emphasise to prisons yet to implement ACCT that they should follow the good practice on information exchange and pre-discharge case reviews for those on F2052SH. I welcome the policy lead's actions. I agree with him that the sharing of information might well not have averted this tragedy. However, the approved premises should have been informed to enable them to make informed judgements based on a fuller history of the man's suicidal ideations.

86. Although there may be no direct link between the man's death on 6 November and the fact that Wymott did not transfer risk information on 19 August, I am concerned that the information was not transferred. All the more so, given that the man had been continuously on F2052SH for the last 10 weeks of his prison sentence. I believe that such information should be transferred from prisons that are not implementing ACCT in exactly the way required of those already on ACCT.

87. It may be many months before all prisons change over from F2052SH to ACCT. I note the reference at paragraph 29 of PSI 18/2005 that the Prison Service has a legal duty to inform other relevant agencies of the self harm or suicide risk that a prisoner presents: "The duty can be paraphrased as the duty of care to take reasonable steps to avoid reasonably foreseeable risks."

    I recommend that Safer Custody Group reviews, and advances, the target date by which all prisons must provide partner agencies with information about prisoners who present a risk of suicide and self-harm and who are due for discharge.

    (Safer Custody Group indicated on 7 March 2006 that they accepted this recommendation.)

(2) The medication issued to the man on 26 October 2005

88. One of my Family Liaison Officers made telephone contact with the man's mother a month after his death. The man's mother said that when he returned to the hostel full-time he went to see the GP who gave him a prescription for the wrong medication, Aricept instead of Abilify. His mother said that the man was supposed to have anti-psychotic medication (Abilify) but on this occasion he was given medication for dementia (Aricept). Psychotic episodes were a possible side-effect of the wrongly prescribed medication.

89. There is no doubt that incorrect medication was issued to the man on the morning of 26 October, as confirmed in the eleventh conclusion of the Mersey

Care report. I have also been able to gather a good deal of evidence from the approved premises staff and their records about the confusion that occurred that morning. The Contact Report entry made by the supervising officer on 17 October stated that the man would be discharged from hospital on 24 October if all went well in the meantime. The report added that he would have a week's medication. A further entry by the supervising officer on 21 October refers to the man's medication being "sorted via CPN and doctor's appointment made." The Mersey Care report establishes that a discharge letter, containing information about the man's current medication, should have been sent to the GP for approved premises residents when the man was discharged from the acute admissions facility. This vital letter was actually sent to the GP in January 2006, two months after the man's death.

90. In interview, the deputy manager gave a lengthy explanation of arrangements at the approved premises for issuing medication in general, and to the man in particular. The deputy manager said he expected arrangements would have been made for Mental Health Services to inform the GP of any medication that the man was on. (The GP is the local doctor contracted to provide medical services to residents at the approved premises from his practice nearby.) The normal system is that the GP prescribes the relevant medication which is then made up by a pharmacist near his practice. The medicines are delivered to staff at the hostel by the pharmacist. Medication is held in a locked cabinet inside a locked room. Residents have individual medication sheets which indicate the drugs they are to receive and when they are to be given to them. At medication time, two members of staff go into the room, take out the medication and issue it according to the doctor's prescription. The medication record is signed by the resident and the member of staff on each occasion the medication is given.

91. The deputy manager immediately confirmed that there had been a problem on 26 October. The hostel log for that date has an entry at 9:30am which states:

    "On giving the man his meds this morning he has been prescribed Aricept tabs. These are the wrong ones. Doctors have admitted mistake and will fax the man's tabs to chemist for delivery."

92. The deputy manager explained that on 24 October it was brought to his notice that there was either little or no medication left for the man. He instructed staff immediately to make an appointment for the man with the GP at the local medical centre. The deputy manager's understanding is that hostel staff got an appointment ''pretty quickly'' and new medication was delivered to the hostel on the afternoon of 25 October or morning of 26 October. The man was indeed given two Aricept instead of the two Abilify tablets he should have had. The deputy manager thought the mistake arose because the usual GP was on leave and the locum doctor who was taking his place prescribed the wrong medication.

93. The deputy manager's later entry in the Contact Report about events on 26 October indicates that the man was worried because his eyes "felt funny". That evening, the man went out for a walk and returned to the hostel heavily under

the influence of alcohol. The next morning, the man was hung over and vomited on his bed and carpet. The deputy manager interviewed him and he admitted that he had been drinking but he could not remember anything of the night before. The man was still concerned about his eyes and the deputy manager called the man's CPN out to the hostel so that he could be reassured. When the man saw his supervising officer on 31 October, he confirmed that he had felt stressed after being given the wrong medication so he decided to drink. He acknowledged that he had been very drunk and was able to identify the associated risk issues. He accepted the verbal warning that the supervising officer gave him.

94. The twelfth conclusion in the Mersey Care report on the man's death uses blunt language to explain why he did not have a sufficient supply of his medication. ''The process with regard to the man's discharge medication being communicated to GP and bail hostel was extremely vague.'' I must also point out that there were some procedural deficiencies in the process governing medication issue at the approved premises at this time. My investigator examined the man's medication records, particularly those for the weeks beginning Monday 17 and Monday 24 October 2005. Details of each medication that the man was receiving are set out on individual sheets. The top of the sheet shows the number of tablets at the start of the week and the bottom of the sheet indicates the number left at the end of the week. At the end of each week, staff conduct a check whereby the number of tablets at the foot of the medication record and those in the locked cabinet should reconcile.

95. My investigator detected a number of apparent errors in the man's medication records for the weeks of 17 and 24 October. The Record of Aripiprazole (Abilify) issued from 17 October shows there were 12 tablets in the cabinet on Monday and by Saturday 22 October there were just two left. On 23 October, the man was given two tablets which ought to have meant none were left but in fact Nil in the central column at the foot of the record has been crossed out and replaced by the number four. On the same date, there was also an error in recording how much Citalopram (anti-depressant) medication remained for the man. The record showed that 15 tablets remained at the beginning of 22 October and the man was given one that day, bringing the number down to 14. The next morning, the man was duly given his Citalopram tablet at 9am but the "Brought Forward" figure was wrongly entered. Accordingly, the "Number Remaining" column was also incorrect until a red ink alteration was made (presumably at the weekly check).

96. On 26 October, although the Contact Report states, I presume correctly, that the man was given two Aricept tablets, the documented evidence on the medication records refers to only one Citalopram tablet being given at 9:30am and no other medication.

97. A Medication Audit undertaken just a month previously by the manager and his deputy had emphasised the need for improvements. The manager's report observed that the number of instances where the medication sheets and cabinet contents failed to reconcile approached a 20% error rate "and is simply unacceptable." The audit report concluded:

"We have a system designed to ensure reliable, safe and accountable administration of medication. Regardless of the quality of the system, it is essentially useless, if not operated consistently by all involved in its daily operation. It is a matter of concern to me that failings previously identified are again in evidence. Given past instructions and repeated confirmation of them, these failings should simply not exist."

98. It is clear that management at the approved premises has focussed on creating a safe and reliable system for the administration of medication. However, on examination of the man's medication records, it was apparent that the system was still not operating reliably by October 2005. I do not believe that the human errors which led to the man being given incorrect medication on 26 October contributed in any way to his death 10 days later. Staff at the approved premises can only issue the correct medication and account for it adequately if they receive timely and adequate support from the relevant clinical professionals.

I recommend that a senior Merseyside Probation Area manager, in conjunction with the local PCT and Mersey Care NHS Trust, reviews existing arrangements at the approved premises for receiving, issuing and accounting for medication and arranges such staff training as may be deemed necessary.

(The Chief Officer of the Merseyside Probation Area indicated on 6 March 2006 that he concurred with this recommendation in full.)

Conclusions

99. I have no doubt that the man received a very high standard of care from his Supervising Officer in the community, and from the management and staff at The approved premises. The supervising officer supervised the man from the time he received his sentence of imprisonment in May 2003 until his death two and a half years later. The man's mother told my Family Liaison Officer that his probation officer was wonderful and they could not have asked for a better one. The supervising officer and the managers at the approved premises promoted the man's interests in every way they could. They made careful plans for his admission to the approved premises while he was still at Wymott. When the man was a patient at the acute admissions facility in September 2005, a well considered plan for his phased return to the approved premises was put into place. Managers at the approved premises allocated him room number one when he returned in October so that they could monitor him closely and address his fear of other residents. Probation staff continuously supported and encouraged the man without ignoring their disciplinary responsibilities. For instance, appropriate and swift action was taken when the man got very drunk on 26 October and he received a verbal warning.

    The overall level of care and guidance that the man received from the supervising officer and from staff at the approved premises was impressive. I formally draw their performance to the attention of the Chief Officer for Merseyside Area for such action as he sees fit.

    (The Chief Officer has commended the staff involved.)

100. At the time of his death, the man appeared to be settling in very well at the approved premises. His last meeting with the supervising officer on 31 October was positive. His anxieties about the approved premises that had been so apparent when he arrived in August seemed to have been put behind him. There was no indication to staff at the hostel that he was at risk of harming himself. All staff at the approved premises spoke of the great strides he had made between his first and second stay there. A Probation Residential Officer (PRO), for instance, said the man was very apprehensive when he first arrived in the hostel but there was an "amazing difference" in his demeanour when he returned in October/November. He invited the PRO to have a game of pool, something he would never have done before. The PRO remembered taking the man and a group of other residents out for an activity day in the hostel minibus on a Thursday. He described the man as being the life and soul of the party on that occasion.

101. In the last week of the man's life, there was no evidence at the approved premises that he was at risk of harming himself. The deputy manager remembered laughing and joking with the man and his parents on 4 November when they came to say goodbye before their holiday.

102. It is clear that at certain times during September and October there could have been better communication between Mental Health and Probation Services. The possibility of the man's sudden discharge to the approved premises in the

late afternoon of 30 September is a case in point, as is the supervising officer's uncertainty about the ward round arrangements on 3 October at the beginning of the following working week. The Mersey Care report describes the process with regard to discharge medication (when the man left the acute admissions facility) as being "extremely vague". My Mersey Care colleagues nevertheless obtained expert advice that Aricept, wrongly dispensed to the man on 26 October, "would be highly unlikely to exacerbate or cause psychotic thought disorder given the amounts and for the duration that the man had taken it."

103. Early on the afternoon of 6 November, the man was found in a fume filled car which he had bought the previous day. There is no evidence of third party involvement in his death. The man appears to have given no indication either to his family, or to staff looking after him, of what he intended to do. It appears that the man intended to kill himself, but I have uncovered no information about the stage at which this intention was formed.

Recommendations

I recommend that a senior Merseyside Probation Area manager, in conjunction with the local PCT and Mersey Care NHS Trust, reviews existing arrangements at the approved premises for receiving, issuing and accounting for medication and arranges such staff training as may be deemed necessary.

I recommend that Safer Custody Group reviews, and advances, the target date by which all prisons must provide partner agencies with information about prisoners who present a risk of suicide and self-harm and who are due for discharge.

I highlight and endorse the two recommendations referring to Effective Care Co-ordination in the anonymised report on the man's death supplied by Mersey Care Trust. They are as follows:

3. **Medication Issues – It is recommended that discharge medication is documented clearly within ECC documentation and a copy of the prescription faxed to the GP within 24 hours of discharge.**

4. **ECC – It is recommended that all staff are made aware of the importance of completing all ECC documentation and of being fully compliant with the ECC policy. A robust audit process must be in place to ensure compliance.**

Good Practice

The overall level of care and guidance that the man received from the supervising officer and from staff at the approved premises was impressive. I formally draw their performance to the attention of the Chief Officer for Merseyside Area for such action as he sees fit.