Investigation into the circumstances surrounding the death of a man at Cheshire Probation Area

Report by the Prisons and Probation Ombudsman for England and Wales

September 2007

The man who is the subject of this report died after hanging himself in his bedroom at an Approved Premises in Cheshire. He was 38 years old when he died.

The loss of any family member in such circumstances must be acutely distressing. This cannot have been helped by the delay in producing this report, for which I can only apologise. My colleagues and I offer our sincere condolences to his family and friends.

Two of my staff carried out the investigation on my behalf.

The man had been in prison prior to living at the Approved Premises and was released on licence in August 2006. He had an extensive history of drug abuse going back a number of years. It was whilst in prison that he learnt of an allegation of a sexual assault on a member of his family. He denied the allegation and was worried about the stigma that would inevitably attach to him.

I have been very concerned to learn of a practice in the Cheshire Probation Area that allowed probation staff to prepare in advance factually incorrect documents relating to breach of licence. Additionally, I am concerned at the suicide and self harm monitoring procedures at the Approved Premises, although I stress I do not believe that they were in any way responsible for the man's death.

I have been pleased to learn that a member of staff attended the man's funeral and that his partner wished to pay particular thanks to two staff. My report makes five recommendations for Cheshire Probation Area and one for the National Offender Management Service. It identifies one example of good practice.

Stephen Shaw CBE
Prisons and Probation Ombudsman **September 2007**

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SUMMARY

The man served a 12 month custodial sentence for affray. Whilst in prison, he was interviewed by police officers investigating an allegation that he had sexually assaulted a member of his family, an allegation he denied. Following a successful application to be released on licence, he left prison on 23 August 2006 with a condition to live at the Approved Premises in Cheshire.

Five days after his release, he was charged with two offences of sexually touching a male over the age of 13. He was bailed to appear in court at a later date.

In September, the man's partner telephoned his probation officer expressing concern at his state of mind. The probation officer alerted staff at the Approved Premises, one of whom opened an "Assessment, Care and Treatment" (ACT) document. The member of staff who opened the document had been trained in how to complete it and assess the information. The document was partially completed and, before fully assessing the man, it was closed by the same member of staff on the same day.

On 29 September, the man appeared at Chester Magistrates' Court. He pleaded not guilty to the charges against him and was bailed to appear at Chester Crown Court at a later date. Despite efforts by probation staff to discuss the allegations with him, he made it clear to them that he would not talk about the issue. Additionally, he would not discuss them with his partner.

On 19 November, after what appears to have been a normal day at the Approved Premises, the man returned to his bedroom shortly after 5.00pm. It's internal camera monitoring shows that he did not leave his room again after that time.

During a routine room check, a member of staff tried to go into the man's room but could not open the door. A second member of staff attempted to open it, but he too failed. The emergency services were called and paramedics managed to partially open the door. One paramedic looked inside, saw the man hanging and decided that attempting resuscitation would be futile. Shortly afterwards, police officers arrived and, after checking for themselves, closed the room pending the arrival of scene of crime officers. After confirming that the man's death was not suspicious, his body was taken to the local mortuary.

THE INVESTIGATION PROCESS

1. Once my office had been informed of the man's death, the investigation was allocated to one of my senior investigators. He was assisted by another investigator from my office and a member of my administration staff.

2. On 23 November 2006, the lead investigator and the administration assistant went to the Approved Premises to open the investigation and meet members of the Cheshire Probation Area management team. At the meeting were the Cheshire Probation Area Assistant Chief Officer, Approved Premises manager, Deputy Manager, and the police constable in charge of the police investigation.

3. The Deputy Manager briefed them about the discovery of the man's death. She provided a copy of the closed circuit television recording which showed the man's movements around the Approved Premises and gave accurate times. Copies of the man's probation record were also made available for the investigation team.

4. On 3 January 2007, the investigators returned to interview staff who knew the man, or who had been involved in the discovery of his body. Five staff had been identified, but only four could be interviewed at that time as the fifth person had other commitments. His interview was rescheduled for 17 January. All those interviewed cooperated fully with my investigation.

5. Seven days later, the lead investigator and one of my family liaison officers (FLO), met the man's partner at her home. The purpose of the meeting was to allow the family the opportunity to raise any concerns about the man's care and treatment at the Approved Premises. Both my staff received a warm welcome from his family. The man's partner provided useful information about his background and his time at the Approved Premises. It was clear from the meeting that the man had not given her any indication of suicidal intentions, but she was aware that he was concerned about the forthcoming court case.

6. My FLO contacted the man's sister and ex-partner. His sister mentioned that the man had been depressed and that she had told his probation officer and doctor. She believed that no more was done about his state of mind.

7. The man's partner wanted to know when the man was placed on suicide/self harm monitoring by the Prison Service when last in prison. She also asked me to pass on her thanks to his caseworker, and the Deputy Manager for their attempts to work with the man.

8. Following the final interview on 17 January, the investigators were concerned that local suicide and self harm monitoring procedures were insufficiently robust and not operating correctly, thus leaving any resident with suicidal or self harm tendencies potentially vulnerable. Before leaving the Approved Premises, the lead investigator met the manager and gave immediate

feedback about the concerns. He later followed up the feedback in writing, copied to Cheshire Probation Area.

THE APPROVED PREMISES

9. Approved Premises, formally known as Probation and Bail Hostels, are approved by the Secretary of State within Section 9 of the Criminal Justice and Court Services Act 2000. Their purpose is to provide an enhanced level of residential supervision in the community, as well as a supportive and structured environment. Each Approved Premises is the responsibility of the local probation area, which works to national standards determined by the National Offender Management Service (NOMS).

10. It is one of two Approved Premises in Cheshire area. The other premises, is nearer to the man's home town but was unsuitable for him because of the nature of the charges against him.

11. Both Approved Premises provide a resource to the Cheshire Courts and have the following aims:

- protect the public
- prevent re-offending
- provide residents with an opportunity to address their problems in a safe, stable environment
- enable residents to face up to their offending behaviour
- complete the conditions of their order or licence
- facilitate their resettlement into the community.

12. Outside agencies are available to provide support and advice regarding drug misuse and alcohol problems. A doctor and community psychiatric nurse are amongst those who support the work of the Approved Premises.

13. All residents are expected to abide by the rules and regulations of the Approved Premises, including observing a strict overnight curfew. During the day, residents are free to go out unaccompanied and without stating where they are going.

Key workers

14. Key workers support residents and carry out any offence related work after the resident has been convicted.

Relief staff

15. Relief staff are used in the majority of Approved Premises. They are employed on either a part time or casual basis and, depending on their level of expertise, carry out most of the tasks required. Relief staff are expected to

have the same level of competencies and skills as those of the permanent staff member they are standing in for.

Video monitoring

16. The Approved Premises has a closed circuit television system installed in the main areas of the building. The video images are recorded 24 hours a day, every day of the year. Recorded images are kept for a short period of time and, if required, give an accurate timed account of movement in and out of the premises, as well as internally.

Room checks

17. All residents are expected to abide by the rules and regulations of the Approved Premises, including observing a strict overnight curfew. To ensure residents are in the building during curfew times, a member of staff will look into the communal areas and bedrooms.

Conditions of Acceptance Rules

18. As part of the induction procedure, residents are required to read, agree and sign the Cheshire Probation Area 'Approved Premises Conditions of Acceptance' document. By signing the document, residents confirm they understand the rules and agree to abide by them. Failure to comply with any of the 15 listed rules means the resident can be returned to the court for possible breach action.

19. Sadly, this is not the first death that I have investigated at the Approved Premises. As part of an earlier investigation, my investigator discussed the wording of rule eight of the 'Approved Premises Conditions of Acceptance' document with the premises manager. The rule tells residents they must not be in possession of alcohol, illegal drugs, any equipment used to take illegal drugs, gases or solvents, pornographic material or offensive weapons within the Approved Premises or grounds. The rule does not make it clear that possession of such items away from the premises is also unacceptable.

20. My previous report did not make any formal recommendation about the rule as the finding was accepted and the investigator was assured by the manager that he would discuss the wording with his line manager. The investigator was assured that the rule would be amended to make it clear to residents what was and was not acceptable. Although not an issue in this case, I am disappointed to find that, despite the assurance given, the rule is still in place and has not been amended.

Multi-Agency Public Protection Arrangements (MAPPA)

21. MAPPA is a formal partnership between police, probation, prisons and other statutory and non-statutory agencies that assesses and manages offenders in order to minimise the risk of serious harm they pose to the public. There are four core functions:

- identification of offenders with the potential to commit serious violent and sexual offences
- sharing information to assess risks posed by identified offenders
- assessing risk of serious harm
- managing risk.

22. Offenders who fall within the MAPPA remit are classified according to the nature of their risk and its management. The higher the risk, the higher the level at which they are managed:

    - Level One offenders are managed by one agency, usually the police or Probation Service
    - Level Two offenders are managed jointly by the MAPPA agencies
    - Level Three offenders are managed by the Multi-Agency Public Protection Panel (MAPPP) which is made up of senior managers from the MAPPA agencies.

Suicide and Self Harm arrangements

F2052SH

23. The F2052SH was a Prison Service document, now replaced by the Assessment, Care in Custody and Teamwork procedure (ACCT). The document had a bright orange cover and could be opened by any member of staff concerned about a prisoner's safety. Any member of staff could initiate the document and raise their concerns. Once the document had been opened, the prisoner was interviewed and invited to attend a multi disciplinary team meeting whose role it was to understand what had caused the problem and to create an action plan designed to reduce or eliminate any risk. All prison staff received training in the suicide and self harm procedures.

Assessment, Care in Custody and Teamwork (ACCT)

24. ACCT has now replaced the F2052SH (the documentation retains an orange cover). Staff identify any concerns, take action, and document their actions for prisoners identified as at risk of suicide or self-harm. The document should be available to all the staff where the prisoner is located. Within 24 hours of the document being opened, the prisoner is seen by an assessor and has a case review which draws up a care and management plan known as a CAREMAP. Wing managers take on the role of case manager, oversee the management of the ACCT document, and attend case reviews.

25. As well as the CAREMAP, the ACCT document includes an on-going record of significant events, conversations and observations. There is an assessment section which covers eight specific areas, each requiring a comment and the action to be taken.

26. There are three training courses for prison staff, the first being Foundation training which is a half day event to show how to open and complete the basic requirements of the document. There is a one day course for case managers to learn how to complete the Immediate Action Plan, including support for the prisoner and the frequency of monitoring. The third course is for ACCT assessors. This lasts four days, including three days studying mental health issues and one day about completion of the documentation. Assessors are trained to restrict their recording to what has actually been said by the prisoner.

27. The ACCT document is divided into four sections. The person opening it is required to complete section one "Concern and keep safe form". Additionally, within section one, a member of staff (usually the wing manager) will complete the "Immediate action plan", which should last no longer than 24 hours from the risk being identified.

28. Section two, the "Assessment Interview", should be completed within 24 hours from the document being opened. It is divided into eight sections and asks the assessor to record their observations and conversations with the prisoner. After completing the assessment interview, a summary of the meeting is recorded on the "Action following interview" page. Additionally, section two records the time and date of the next review. The remaining two sections are as follows:

    - Section three records the CAREMAP decisions and subsequent case reviews.

    - Section four is an on-going record of significant events, conversations and observations. The on-going record allows anyone to make an entry of their contact or observations but, as a minimum, the entries should be made at the times specified on the front page of the document.

Approved Premises care of at risk residents "Assessment Care and Teamwork" (ACT)

29. Probation areas in the North West, including Cheshire, have developed their own version of the ACCT procedure, known as ACT. The document appears identical to that of the Prison Service, it too having a bright orange cover. In the first instance, ACCT training was given by the Prison Service to probation staff, after which the areas developed ACT which has subsequently been introduced in other parts of the country. However, it is not a national probation system and no arrangements have been made to monitor its implementation.

30. One day's ACT training was delivered by trained probation staff from Merseyside to managers and deputy managers of Approved Premises from other parts of the North West. They in turn cascaded their knowledge to permanent Approved Premises staff. The training mainly consists of a Powerpoint presentation concentrating on the history of the Prison Service system.

31. The ACT document front cover identifies the level of observation required and date of the next case review. Page five is used to note the reason for opening the ACT form and asks the writer to describe the reason for their concern. The next page (page six) is the immediate action plan which is usually completed by a manager or deputy manager. It is not intended to be used for any longer than two days, although it can extend to three days if over a weekend.

32. Page seven is the beginning of the assessment interview section. It is broken down into eight parts over three pages, all of which should be completed. This section is used to gather as much information about the resident's state of mind and intentions, and plays an important part of deciding how the 'at risk' resident is cared for.

33. The final page is the action following assessment section. This notes who attended the assessment interview and records a summary of the case review. It asks the person completing the document to assess the current level of risk. Unlike the Prison Service training, ACT training is completed in one day.

KEY FINDINGS

34. The first known record of the man's vulnerability was whilst he was in custody at Chester Police Station on 7 October 2003. The officer in charge of the cells began monitoring him under the Prison Service F2052SH system, because the Police National Computer records contained an entry noting a recent suicide attempt. However, the F2052SH document does not record the circumstances of the attempt.

35. The man was monitored for nine days, and during that time two case reviews were held to assess his needs. The first assessment on 9 October was a multi-disciplinary review with eight members of staff present. They decided to continue the monitoring.

36. Seven days later (16 October 2003), a second case review was held attended by 13 members of staff. After considering the reason for opening the F2052SH, they were of the opinion that it was safe for monitoring to end.

37. On 4 July 2005, the man was sentenced at Chester Crown Court to a three year prison sentence. The offences were not connected to the previously mentioned 7 October 2003 custody period, as that sentence had expired. The new offences ranged from assault, to possession of an imitation firearm with intent to cause fear. The man remained in prison until he was released on licence in July 2006 to live with his sister.

38. Whilst on licence, the man assaulted his sister's partner and had to leave the house. The man's Probation Officer, told my investigator that the man deteriorated into taking drugs and became chaotic in his life style. He was taking amphetamines, drinking alcohol and sniffing glue.

39. In October 2005, he went to live with his current partner. However, he was unhappy that another man was living in the same house and, after causing an affray, threatened to kill his partner or at least seriously harm her. He was charged with affray and recalled to prison on 27 October.

40. The man returned to HMP Altcourse. During the reception procedure, a prison custody officer opened an F2052SH. The reason shown in the document is that the man had apparently cut his wrists about nine days previously. The officer also noted a dog bite on the man's arm, and that he said he suffered from anxiety and depression.

41. For the new offences, the man received a further twelve month prison sentence. He told his probation officer that he had fully expected to be returned to prison.

42. Due to the nature of the man's offending behaviour, he was monitored under the Multi Agency Public Protection Arrangements (MAPPA). The MAPPA monitoring was agreed as single agency to be carried out by the Probation Service.

43. On 30 October 2005, police officers received an allegation that the man had sexually assaulted a member of his close family. The following day (31 October), he attended an F2052SH case review with two members of prison staff to discuss what level of support he required. The person completing the review noted that the man said he felt he had nothing to live for. The man told the panel that he had no thoughts of self harm at the time, but had highs and lows. It was agreed to continue the F2052SH monitoring.

44. Four days later (3 November), a second review was held to discuss the man's progress. The meeting was well attended with ten members of staff present. As before, the meeting decided to continue to monitor him with a further review scheduled for 10 November.

45. On 10 November, the third and final review was held with ten members of staff who decided that the man did not require monitoring any longer. The person completing the document noted that the man had settled into the prison and was mixing with others on the wing. He was attending the gymnasium as well as the chaplaincy. The monitoring and support appears to have been carried out correctly and appropriately.

46. One month later (10 December 2005), the man's former partner wrote to the prison and told them that, due to the sexual assault allegations, she did not want any further contact from him. The prison's records show that, five days later, a member of prison management told the man that he could not contact his ex partner or their children. The records do not show how he reacted to the instruction.

47. On 19 July 2006, the man was interviewed at the prison by police officers investigating the sexual assault allegation. The prison records do not show how he reacted to the allegations, or the content of the meeting.

48. During his sentence, the man became eligible to be considered for release on licence. His application was successful and he was released from Altcourse on 23 August 2006. (The expiry date for the licence was 4 March 2007.) The man was required to report to his probation officer at the Approved Premises at 2.00pm that same day. The licence contained nine more conditions which he had to agree to before he could be released. One of the conditions was that he was not to enter a particular area of Cheshire. Before leaving prison, he signed the licence confirming that the conditions had been explained to him.

49. Having been provided with a travel warrant by the prison, the man made his own way to the Approved Premises and arrived as planned. His arrival went as normal and, following a short induction session, he was allowed to move freely in and out of the building. He appeared to settle in well to his new surroundings and gave no cause for concern.

50. As part of the normal investigation procedures, my investigators examine any documents necessary to determine what happened, and create a chronology of events. During the examination of the man's records, they found a

partially completed, five page, restricted National Probation Service document. The document is entitled 'Report for the notification of breach of licence, request for recall and review by the Parole Board'. It is used to inform the Parole Board of any resident considered to have breached the conditions of their licence sufficiently to warrant a possible referral back to the courts, and can result in the resident's return to prison.

51. The document was written on 23 August 2006 by the man's field probation officer. Under one of the headings 'Circumstances and details of the breach', she had written:

"The man was released on 23 August 2006. He has a condition to permanently reside at the Approved Premises and must not leave to live elsewhere, without obtaining prior approval of your supervising officer. On 23 August 2006, the man failed to return to the hostel as instructed by hostel manager, therefore he is in breach of the condition as listed above."

The probation officer recommended an emergency recall within two hours.

52. One of the investigators telephoned the probation officer and asked her to explain what had occurred to recommend the breach. She said that she had been contacted on 23 August by a member of staff from the Approved Premises and asked to prepare the document. It would be used in the event that the man did not return to the Approved Premises in the evening. She explained that, whilst the request was unusual, it had happened previously. The Deputy Manager said that the reason for the request was that, in the event that the man breached his conditions that evening, it could be forwarded to the Home Office Early Release and Recall Section as soon as possible. The Probation 'Record of Contacts' shows an entry made at 3.39pm by the probation officer who wrote that, "Recall part one emailed to Deputy Manager at her request, should the man not return to hostel this evening or in future he breaches. This makes any out of hours recalls a lot more efficient for out of hours staff."

53. My investigator spoke to the premises manager about the document. He told the investigators that he occasionally asks for the documents to be prepared in advance as a precautionary measure. He added that they are not completed in every case, but the process is followed for residents judged likely to breach their licence conditions. He explained that completing the document in advance is a precaution used to alleviate the duty manager from attending the premises out of hours.

54. Whilst I accept that the document is a contingency, I am concerned that it appears to be accepted practice in the Cheshire Probation Area that an important document is pre-prepared and inserted into a resident's official record. Anyone accessing such files would be drawn to the conclusion that what they were reading was correct, and that the person had breached their licence conditions. Decisions about a resident's future are based on risk assessment, and erroneous documents such as this could seriously mislead

an assessor. I can confirm that the details relating to a breach on 23 August 2006 are untrue.

55. On 24 August, as part of his induction assessment, the man completed a questionnaire designed to assess individual literacy and numeracy skills. He scored seven, indicating a need for support. The assessor, is a Probation Officer who works between both Approved Premises and is responsible for the Skills for Life programme. He arranged for the man to be referred to South Cheshire College for assessment and ongoing provision.

56. The following day, the man's probation officer met the man at the Approved Premises as part of her planned visits to the premises. She made an entry in the 'record of contact log' that staff were impressed with the man's attitude. However, she also noted that he was unhappy about being kept away from his partner's home, but apparently understood why the restriction was in place. The probation officer completed her entry, adding that the man was unaware, until she told him, that he would be receiving a summons to appear at court in relation to allegations of sexual assault against a member of his close family. The man told her that he would seek legal representation.

57. On 28 August, the man was charged by police with two offences of sexually touching a male over the age of 13. He was bailed to appear at Chester Magistrates' Court at a later date.

58. On 7 September, the probation officer made a further planned visit to The Approved Premises and again met the man. She recorded in the contact log that he was resistant to the licence conditions, and had asked to be allowed to go to the other Approved Premises in the Cheshire Probation Area. She told the man that he had only been assessed as suitable for the Approved Premises he was living at. She noted in the record that she would check the allegations against him, as the charges would mean he was unsuitable for the alternative Approved Premises. Her final entry that day shows the court appearance date was scheduled for 29 September, and that the man believed the police had no evidence against him. She told the investigators that, whenever she tried to talk to the man about the allegations, he became angry and aggressive towards her. She added that he could at times be a difficult man to deal with.

59. The Duty Warden was the man's key worker at the Approved Premises and, like the probation officer, had a planned meeting with the man that day. He made a similar entry in the contact log, describing the man as upset at being at the Approved Premises. The Duty Warden told the investigators that he discussed the man's future plans and the man told him that he was hoping to join a fork lift truck licence refresher course. The Duty Warden added that the man discussed his previous history of self harm. The man apparently told him the self harm incidents were not to gain attention, but that he "meant business". The Duty Warden asked the man if he would tell him or other members of staff when he felt down. The man said, "No, but if I did I would not tell you anyway … I'm not going to fuck about, if I'm going to do it, I'm going to do it."

60. The Duty Warden described the man as pleasant but a difficult person to work with, as he would not discuss any personal issues. He told the investigators that he was aware of the man's pending court appearance, and he made it very clear that he would not discuss it with him or anyone else. He added that the man spent a lot of his time in his bedroom and did not mix with other residents. He said the man would speak very briefly when he was leaving or returning to the building.

61. On 20 September, the probation officer was in her office in Chester when she received a telephone call from the man's partner who was concerned about how the man was feeling. She made an entry on the computer system. It noted that the man's partner had told her that she was concerned about his emotional state, increase in alcohol use and temptation to take drugs. She told the investigator that the man's partner did not suggest that he was going to end his life. However, as she too was concerned, she immediately telephoned the Approved Premises to make them aware.

62. Another probation officer, is also a deputy manager and works at both Approved Premises. He has been trained in ACT. He told the investigator that he had not met the man. He opened an ACT document as soon as he was notified.

63. Under the heading 'Concern Form' at page five, he wrote 'Email received from case manager stating the man's partner concerned re increase in alcohol use and low mood. Previous suicide attempts.' As well as noting the concern, he ticked two of the six indicator boxes to show that the man was 'very low mood' and 'problems related to drug, alcohol, overdose, withdrawal'. The time of opening the form was 9.00am.

64. At 12.00noon, he completed the immediate action plan. He instructed staff to monitor the man's mood through normal conversation whenever he went in or out of the building. He then closed the document, noting that a "Post Closure Interview" should take place on 25 September, although no arrangements were made for the interview to take place. The assessment section had not been completed at this point, but was carried out the following day at 9.45am. The probation officer said he had carried out the assessment before closing ACT, but might not have recorded it until the following day.

65. When completing the assessment interview, it is good practice for as many staff who know the person to be present to give support and first hand knowledge of the individual. Although he had not met the man previously, he did not ask other Approved Premises staff or the man's probation officer to take part. Instead, he carried out the assessment alone with the man, having consulted the Duty Warden and the man's probation officer beforehand. The Duty Warden said he told the probation officer opening the ACT that the man would not tell him if he was going to harm himself and that opening an ACT would antagonise him more.

66. The assessment section has eight individual sub-sections which the assessor is asked to complete. Each has its own heading and guidance for the assessor to consider. The record shows that three of the eight sections i.e. section two, three and six were not completed. Instead, the probation officer wrote N/A in two of them. An important part of the assessment process is to analyse what is happening in the person's life to make them feel so desperate. Although we know the man had not shown any sign of wanting to end his life and it was his partner who raised the alarm, the same processes should have been carried out. One of the issues affecting the man was the impending sexual assault allegation. Although the probation officer at the Approved Premises noted the allegation, he appears not to have given much weight to it. He told the investigator that the man would not discuss the issue with him and became angry.

67. He noted that the man did not want a support plan, as apparently he felt that monitoring would make things worse. At interview, he said the man was "very, very clear and insistent. " The probation officer said the only way he could proceed was not to use ACT, but monitor the man informally. The man agreed that the probation officer would register 'Low Level Concern' instead and then close the ACT document. The man's reaction to the ACT was that it was unnecessary. It was his personal space and he did not want anyone invading it.

68. The main purpose of the ACT procedure is to ensure the person is kept safe. It is often the case in Approved Premises that those being monitored do not like staff checking them at varying times of the day and night. Despite the pressure from some individuals to stop the monitoring, it should not be a factor that influences the assessor's decision.

69. Two days later (22 September 2006), the record of contact log shows that it became clear to staff that the man was intending to leave the building to have contact with his ex-wife and son. As his ex-wife was a prosecution witness in the sexual assault charges, he was advised not to see her. However, no licence restrictions were in place, and he apparently ignored the advice.

70. A relief assistant warden who works at both the Cheshire Approved Premises told the investigators that she had previously been employed for 17 years as a probation officer, before leaving to become a lecturer. She said that she did not know the man all that well as, unlike other residents who stopped to talk when collecting their room keys from the office or leaving the building, he would not engage with her.

71. The assistant warden said she had received a telephone call from the man's probation officer telling her that she was due to see the man that day, but had decided to change the time of the meeting. When she told the man of the change he appeared happy about it, and told the assistant warden that he was going out for a drink. She asked the man if it was a good idea to be having a drink before meeting his probation officer. The man said that it was

more for “Dutch courage” as he was going to see his ex wife and son, whom he said he had not seen for about a year. He then left the building.

72. At that stage, the assistant warden was unaware of the allegations against the man. She spoke again to the man’s probation officer and told her that the man was relaxed about the change in the appointment, as he was going to see his ex wife and son. As a result, the man’s probation officer contacted the relevant Social Services Department and reported the man’s intentions. Social Services said they were going to action their ‘risk to children’ plan.

73. The assistant warden said that, when the man returned later to The Approved Premises, he was not drunk but had clearly been drinking. She described him as mellow. That afternoon, the man was in the manager’s office at a pre-arranged appointment with another member of the Approved Premises staff. Whilst the meeting took place, the assistant warden received a telephone call from the man’s probation officer wanting to speak to him. The assistant warden interrupted the meeting and the man took the call. Afterwards, the assistant warden was told that the man was unhappy because someone had told his probation officer of the meeting with his ex wife.

74. The assistant warden told the investigators that she immediately told the man how the probation officer became aware of his meeting with his ex wife. She told him that she had been unaware of the offence allegations prior to speaking to the probation officer. She said that it would not have made any difference, as she would have a duty to tell the probation officer, which the man found difficult to understand. She said the man was unhappy about any restriction because there was no licence condition preventing him seeing his ex wife or son. The man’s probation officer advised him not to see them again, and reminded him that he was due in court the following week in relation to the sexual assault charges.

75. The assistant warden said the man was “fairly cool” with her for the rest of the day and he left the building soon afterwards. She suspected that he would go for another drink and, as she would be still on duty later, she thought about how to approach him when he returned. She said that, when he returned, the man was still unhappy but containing his anger, and his return went relatively mildly. She thought that it was not the end of the subject, but they had no further contact until two days later.

76. When she returned to duty on 24 September, another assistant warden told her that he had spoken to the man. He told her that the man was angry with her and suggested that she needed to be cautious during the day. She told the investigators that she spent some time working out how she would deal with the man that day, but did not see him during her shift. She was next at work on 26 September when she expected some form of confrontation with him. She told the investigators that nothing of note took place and she thought that the man was someone who “brooded on things”.

77. The man's probation officer spoke to the man that day and tried to explain why she had spoken to Social Services. The record of contact log shows that the man was upset and at times aggressive towards her. She terminated the interview after 30 minutes, noting that the man needed time to reflect on what she had told him.

78. Three days later (29 September), the man appeared at Chester Magistrates' Court and pleaded not guilty to the sexual assault charges. The case was committed to the Crown Court for a pre trial hearing, scheduled to take place on 27 November 2006.

79. On 14 October, the man returned to the Approved Premises just before 11.00pm and was apparently intoxicated. The contact log shows that he was abusive towards staff and making a nuisance of himself by entering other residents' rooms. He was given a written warning and banned from taking alcohol for one week.

80. Over the next few weeks, the man appeared to settle down once again. He made an appointment to see his solicitor on 16 November and spoke positively about joining a folk lift truck driving course beginning on 17 November. The man was laughing and joking with staff about stopping smoking.

81. On Saturday 18 November 2006, the man and his partner, met in a public house. She told my investigators that the man was telling people how good their relationship was and how happy they were. However, in hindsight, she realised that this was unusual as he rarely spoke to people he did not know well. The man's partner dropped him off and he told her to text him when she arrived home. She did so and he replied.

19 November 2006

82. On Sunday 19 November, a residential support worker, was on duty at the Approved Premises. She told my investigators that it was a normal, quiet day. She said she was aware that the man had been in and out of the building, but did not know where he had gone. He appeared pleasant and smiling.

83. My investigators examined the video recording for 19 November. The images show that the man was first seen leaving his bedroom at 9.58am and going to the kitchen to make a drink. He returned to his room three minutes later. Shortly afterwards, the man left to go to the bathroom where he remained until 10.21am. He then returned to his room.

84. At 10.23am, the man began to clean his room. After cleaning his carpet, he left his room and then the building at 10.49am. It is not known where he went. The man's partner told the investigators that he sent her a text message at 11.20am, with a second at 2.00pm asking her if everything was okay. The message prompted her to telephone the man at the Approved Premises and ask if he wanted her to drive over to collect him. The man

declined the offer and told her that he had not slept well and was going back to bed. He agreed to call her later that day.

85. Ten minutes later at 2.10pm, the man sent another text message asking his partner to pass on his love to her daughter who was in hospital. (The man's partner told my investigators that, a few days earlier, the man had been to hospital with her and tried to spend his last £10.00. He bought her daughter a teddy bear and said he did not need the money where he was going. At the time the comment meant nothing to her.) The man's partner tried to telephone him on his mobile phone at 6.00pm, but received no reply. She then sent a text message, but again received no reply. She told the investigators that she thought his phone battery must have been out of power, or that he had gone out and left his phone in his room.

86. The man returned to the Approved Premises at 3.40pm and went almost immediately to his room. He was not seen again until he went to the kitchen at 5.00pm to make a drink and collect some food. Six minutes later, he returned to his room. This was the last time he was seen.

87. The residential support worker told the investigators that she remembered residents playing a pool competition in the evening between 7.30pm and 8.00pm. She said that the man was not there, but this was not unusual as he did not normally attend.

88. At 8.58pm, the video evidence shows that the residential support worker, who was carrying out a routine room check, tried to open the man's room door. She was unable to do so and told my investigators that the lock was stiff. She said she knocked on the door, but did not gain a response. She managed to open the door slightly but not enough to see inside. The residential support worker shouted into the room, but again did not receive a response. She also shouted to her colleague, for assistance.

89. One minute later, both members of staff can be seen on the video trying unsuccessfully to gain entry to the man's room. The residential support worker left the area and checked the remainder of the building to see if the man was elsewhere. In the meantime, the other member of staff returned to the office and telephoned for an ambulance and police. At the same time, the on call duty manager was telephoned. Whilst waiting for the emergency services to arrive, both members of staff returned to the man's room and tried once more to enter it.

90. At 9.13pm, paramedics arrived and managed to partially open the door, allowing one of them to look behind it. The video evidence shows that the paramedic looked inside and then withdrew straight away. I understand that the paramedic decided immediately that resuscitation attempts were not possible.

91. Two minutes later, police officers arrived and they too looked into the room but did not enter. I understand from the police officer dealing with the case

that the man was hanging by a ligature secured to the door. It was the weight of his body that prevented the staff from pushing the room door open.

92. The man's partner told the investigators that she telephoned The Approved Premises at 9.15pm as she had not heard from the man. She said a resident answered the phone and told her that he would get a member of staff. The resident came back to the phone and said the man was not in at the time. The man's partner asked the resident to tell the man to switch his phone on. Two hours later, she tried once again to phone the man on his mobile phone, but received no answer.

After the man's death

93. As with any untoward death, the area is treated initially by police as a scene of crime. After examining the room and the man's body, police officers were satisfied that his death was not suspicious. The police notified the man's next of kin of his death and his partner said that she was told at 2.40am the next morning.

94. The on call Duty Manager arrived at the Approved Premises, followed soon afterwards by the Manager. The residential support worker told the investigators that, once she had given her statement to the police, she received support from both managers. She said she received additional support from the Assistant Manager. Additionally, she was reminded of counselling available for probation staff.

95. After the man's death, all residents were asked to gather in a communal television room where they were told that he had died. Residents were told to speak to staff and the manager ensured information about the Samaritans was available on the notice board.

96. In my previous report into the death of a resident at the Approved Premises, I recommended that the Cheshire Probation Area should consider appointing an area family liaison officer. I am pleased to learn that, following the man's death, Cheshire Probation Area appointed the Assistant Chief Officer as their Family Liaison Officer. He took responsibility for liaising with the man's family and keeping them informed.

97. In that earlier investigation report, I also raised an issue about notification of the death to off duty staff and recommended that the probation area should review its arrangements for communicating important information to them. Although the internal communications within the Approved Premises went well, it is regrettable that the same did not apply to the man's probation officer. She told the investigators that she had found out about the man's death by email when she returned to work on Monday 20 November. She said someone had tried to ring her earlier that morning, but when they received no reply they decided to email instead. It would have been preferable if a manager could have passed the information to her. She said she had been supported by senior staff, but was not aware of any other support available.

98. At interview, a member of staff told the investigators that there had been a rumour going around the Approved Premises that the man made a suicide attempt about two weeks prior to his death. One resident told him that he believed the man had taken some pills, but that it was speculation. The investigators were unable to speak to the resident concerned, as he was no longer living at the Approved Premises. I have found nothing else to substantiate the rumour.

99. A member of staff represented the Approved Premises at the man's funeral where he met the man's partner and sister for the first time. The investigators asked him about the support available for staff. He said that he was aware of the support available, adding that the team looked after each other rather than using anything more formal.

Information from the man's partner

100. On 10 January 2007, one of my family liaison officers and the investigator, visited the man's partner at her home address. They were made very welcome. She said that she had not seen any signs that the man was planning to take his life.

101. The man's partner told the investigators that he felt isolated from everyone by living at the Approved Premises. She described him as a small person, but said he would try to intimidate people despite his size. She said that, following the allegations of sexual assault, his family broke off contact with him, although his sister did subsequently remain in touch.

102. The man had told his partner that he was worried about returning to drug use, saying that drugs were available in the Approved Premises and he did not know if he had the willpower to resist them. The man's partner was certain that he had not returned to drug use and thought that, by staying off drugs, he was progressing well. (Records show that the man had been tested for drug use whilst at the Approved Premises and had given a negative sample.)

103. His partner told the investigators that the man had met his ex wife and son at a public house near to the Approved Premises. Apparently, despite the assault allegations, the meeting went normally. However, due to the allegations and involvement by Social Services, they had no further contact.

104. The investigators asked the man's partner whether the sexual assault charges had affected him. She told them that the pending court appearance scheduled for 27 November was worrying him. She had tried to talk about it, but he would not open up to her. She was aware that the man did not want his son to have to give evidence in court. The man expected to return to prison if he was found guilty, but told her that he would not go back. The man 's solicitor had allegedly told him that it was up to the man to prove that he did not commit the offence and not for the prosecution to prove he did. The man was aware that the prosecution team were going to use his drug

history against him and he was worried about the stigma of being labelled a sex offender.

105. The investigators asked if there was any significance about the date of 19 November. Although she did not know with any certainty, the man's partner believed that the man first became aware of the allegations against him in November 2005.

106. The man was also aware of local concerns about Approved Premises and I am aware from the Manager that there is a local campaign to close The Approved Premises. About two weeks prior to his death, the man watched a television documentary programme about Approved Premises that gave particular attention to sex offenders being housed in the community. His partner said that the landlady of a local public house had asked if he was a paedophile, which upset him. The landlady apparently added that the local community was trying to close the Approved Premises down.

107. The man's partner said that she was shocked that he did not leave a note or letter of any kind when he died. When his possessions were returned to her, she examined his mobile telephone and found an unsent message in the draft text box. The message said "I don't know how to tell you", and she wondered if the message was meant for her. Additionally, in the phone calendar there was a reminder set for 19 November between 8.00pm and 8.59pm which said "the time". She believes the reminder indicated the man's awareness that residents' rooms would be checked between these times.

108. Finally, she asked me to pass on her thanks to two of the Approved Premises staff for the work they carried out with the man. She said that she appreciated what they had done for him.

ISSUES

Advance preparation of documents

109. The apparently routine selective completion of "Report for the notification of breach of licence, request for recall and review by the Parole Board" is questionable. It was evident to my investigators that the only justification given for preparing the document was to save a duty manager from having to attend the premises, complete the document and fax it to the Early Licence Recall Section during out of hours breaches by residents. Whilst I understand the argument, the practice seems more for the duty manager's convenience than any need to inform the recall section at the earliest possible moment. I cannot say that I like this practice at all. However, if the Cheshire Probation Area remains satisfied with the system, they should reconsider the contingency plan and not allow erroneous documents to be placed into official files. My recommendation below is intended to allow both the practice and the consequences thereof to be considered afresh.

The Cheshire Probation Area should review the contingency plans for dealing with a breach at its Approved Premises.

Approved Premises Rules

110. Rule eight of the Cheshire Area "Approved Premises Conditions of Acceptance" document is misleading. Although an assurance was given following my previous investigation that the wording would be amended, it was not. There should be no doubt in a resident's mind that being in possession of an offensive weapon or illegal drugs, whether on or off the premises, is a criminal offence.

The Cheshire Probation Area should review the wording of rule eight of its Approved Premises rules and clarify that possession of an offensive weapon or illegal drugs on or off the premises is a criminal offence.

Assessment Care and Treatment (ACT)

Introduction in Cheshire Probation Area

111. Cheshire Probation Area is one of several in the North West where the Prison Service ACCT document has been adopted for use in Approved Premises.

112. The introduction of ACT in the North West is undoubtedly well intended. However if the Probation Service is to continue to introduce ACT, it must be satisfied that it is fit for purpose and designed to meet the needs of Approved Premises.

113. I have described how ACCT operates in prison and the multi disciplinary nature of the system. Reducing the risk of suicide and self harm in Approved Premises is perhaps even more complicated. Unlike prisoners, residents are

free to come and go, making it almost impossible to monitor a resident regularly once they leave the building. And residents of Approved Premises are supervised by probation officers as well as Approved Premises staff, and both should be involved in ACT monitoring. All of this needs to be carefully thought through. ACCT is a complicated tool, and its extension to Approved Premises should be the subject of a detailed review.

Cheshire Probation Area should review the ACT system in Cheshire and assess whether it is fit for purpose.

The National Offender Management Service should receive the North West review of the implementation of ACT and consider whether and in what form it should be implemented nationally.

Implementation of ACT at the Approved Premises

114. I am satisfied that, when the man's partner made his probation officer aware of her concerns about him in September 2006, the appropriate action was taken and the Approved Premises was alerted. Equally, I am satisfied that it was appropriate to take the precaution of opening the ACT document. However, apparently at the man's insistence, the ACT document was quickly closed. This was without the contribution of the staff who knew him best and without completion all stages of the process. Informal monitoring was carried out instead.

115. If it is considered necessary to open an ACT form in the first instance, proper assessment should take place involving significant staff such as the probation officer and key worker. Only when the risk has reduced should the level of monitoring be reduced. It should not, indeed cannot, be the case that the resident's disapproval is the deciding factor in closing the ACT. The speed of opening, assessing and closing the document concerns me. However, I am satisfied that this was not relevant to the circumstances of the man's death some two months later.

ACT Training

116. Assessor training for prison staff takes longer than the few hours. Additionally, the Prison Service will not allow anyone to carry out an assessment unless they have received the appropriate training. This rule even applies to doctors working in a prison. Unless they have received the training, they cannot complete the assessment section.

117. At interview, the probation officer who opened the ACT document said he is experienced at interviewing and assessing people. I have no doubt that is the case and intend no personal criticism of him. However, I do not believe that professional capacity alone equips anyone to complete the assessment section without the appropriate training. He completed the ACT form on 20 September in the way he had been shown. However, the process he followed was flawed.

118. It is critical that the person completing and assessing information about risk of suicide and self harm is properly trained, considers all available information, and involves those who know the resident in the assessment meeting. I make the following recommendation:

Cheshire Probation Area should satisfy itself that ACT assessor training is sufficient to equip staff to assess residents and make informed decisions.

119. A further worrying aspect is that only permanent Approved Premises staff have had ACT training. Relief staff and mainstream probation officers were omitted. Yet the Approved Premises, like other Approved Premises, makes frequent use of relief staff to cover shifts - particularly at the weekend. I therefore recommend:

Cheshire Probation Area should review its training policy and ensure that all staff working in Approved Premises receive appropriate training in ACT. Additionally, the area should consider extending the training to include probation officers.

CONCLUSIONS

120. Although mistakes were made with ACT procedures in September 2006, I am satisfied that they were not responsible for the man's death. It was a further two months before he killed himself. However, the mistakes cannot be ignored and I hope that Cheshire Probation Area will reflect on the findings of this investigation, and review suicide prevention systems at both their Approved Premises.

121. I have also recommended a wider review of the ACT system at the NOMS level.

122. As to what caused the man to apparently take his own life is not known. However, it is likely that the pending court case was a major worry for him. He clearly would not discuss the issue with anyone, including his partner, and presumably did not seek other help or support. The man made it clear to his partner that if he were to be found guilty, as he expected, he would not return to prison (see para 116 above). It is open to speculation as to what he actually meant. Apart from the concerns in September which led to the ACT document being opened, there is no evidence of his intentions. He kept his feelings very close to himself and gave no indication that his safety was at risk. I am satisfied that the man hid his intentions well and that no one could have suspected what he was planning to do.

RECOMMENDATIONS

The National Offender Management Service should:

1. Receive the North West review of the implementation of ACT and consider whether and in what form ACT should be implemented nationally.

   The National Offender Manager Service has accepted the recommendation.

The Cheshire Probation Area should:

2. Review the ACT system in Cheshire and assess whether it is fit for purpose.

   Cheshire Probation Area has responded that it acknowledges the value of reconsidering the ACT process, and proposes to drive the reconvening of the Regional Group which devised the ACT process originally. The Area feel that this group could consider the criticism of ACT application made in the report and determine whether they necessitate procedural change and/ or staff retraining.

3. Review the contingency plans for dealing with a breach at its Approved Premises.

   Cheshire Probation Area has replied that they have already changed this practice with a new procedure detailed in the Area's redrafted Approved Premises Policy launched in June 2007. This change was carried out independently from the investigation into the man's death, and links to the Area's intention to improve links between Offender Management and Approved Premises interventions.

4. Review the wording of rule eight of its Approved Premises rules and clarify that possession of an offensive weapon or illegal drugs on or off the premises is a criminal offence.

   Since the draft report was published, Cheshire Probation Area has informed me that they have now adopted the National Approved Premises Rules along with other Areas. They were implemented on 16 July 2007.

5. Satisfy itself that ACT assessor training is sufficient to equip staff to assess residents and make informed decisions.

   In line with their response to the recommendation for NOMs, Cheshire Probation Area have replied that they agree that ACT assessor training could usefully be reviewed to ensure that appropriate application of the process is sufficiently clear for all those being trained, and that assumptions are not made about staff members' generic offender assessment ability which could undermine the specific ACT purpose.

6. Review its training policy and ensure that all staff working in Approved Premises receive appropriate training in ACT. Additionally, the area should consider extending the training to include probation officers.

   Cheshire Probation Area have responded that they would seek to ensure that all Approved Premises staff (permanent and relief) receive revised ACT training, and that a training input is provided to all Offender Management Units.

GOOD PRACTICE

1. The appointment by Cheshire Probation Area of its own Family Liaison Officer is good practice.

ANNEXES

Documents considered during the investigation

1. Cheshire Probation Area Contact Log
2. Pre Sentence Report
3. Medical Record
4. Prison Service First Reception Health Screening Document
5. Prison Records
6. Breaches of Licence
7. The Approved Premises records
8. Offender Assessment Record
9. Key-worker record
10. Video log